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A narrative inquiry into the couple experience of living with trauma and distress after leaving the UK military

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A narrative inquiry into the couple experience of living with trauma and distress after leaving the UK military

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Abstract

The aim of this study was to explore the lived experiences of couples, one of whom has left the UK military and is living with a PTSD diagnosis. Research in the field of military mental health has only recently explored the partner/spouse experience. Across the literature internationally and in the UK there is a lack of research projects on couples experiences of living with mental health issues, particularly that brings both members of the couple dyad together. Historically the focus has been on researching serving personnel and more recently the experiences of ex serving personnel. Such research has mostly been quantitative, with ex service personnel reporting higher mental health issues than actively serving counterparts.

In this study three couples were each invited to share their story together as part of a qualitative narrative inquiry. The stories were collected in semi structured narrative dialogues. Three overarching themes emerged in relationship to the couple. First **military culture and identity** where participants descriptions were caught up in a powerful military discourse, the impact of being discharged from the military for mental health reasons, their struggles with changing identities and the shame and stigma associated with mental health issues. The second theme was **the impact of living with traumatic symptomology**, including the duration and severity of symptoms, the struggle to receive help, finding their own way of coping and the impact of PTSD on the relationship. The third theme was the significant **partner impact** that occurs through secondary trauma, the role of the caregiver and loss of self.

This research proposes that where there is a couple relationship it can be integrated more effectively in treatment of ex service personnel with mental health issues and that partners require education and support themselves to minimise the adverse impact to their mental health and potential for secondary traumatisation.

This study supports a tailored and integrated (multi agency) support package for ex service personnel discharged for mental health and their partners, including the access to lifelong mental health services, particularly where a diagnosis of PTSD is made.

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Introduction

Origins of this research

At the beginning of this research project, before I had recruited any participants, I was reflecting on my own story of how I came to be involved in considering the mental health of veterans through the lens of the couple experience. I personally had no military experience and was not in any form of couple relationship. Despite this I have held a curiosity about military life for many years, which brought me to write about an encounter that has stayed with me when so many others are forgotten. 'Beirut morning' is a short story about a meeting I had in 2007 on the way home from a business trip. I had yet to start training as a counselling psychologist and psychotherapist and had never experienced any kind of therapy. As I wrote almost 10 years later I realised that there were more connections from my past than I had first realised that drew me to this topic of research.

Beirut Morning

It was a clear crisp winter's morning as she boarded the London bound plane from Beirut. She had that resigned, determined look that seems to cloak so many weary business travellers. It was the end of another long week of listening to the problems of the local team while holding the strategic corporate view that so often seemed to disadvantage the individual.

She wore a long black woollen coat. It felt soft to her skin, but made the tired traveller look pale. Her face stiffened as she saw the rather dapper looking man sitting in her seat. Immediately thoughts burst into her head, bringing a sudden surge of energy. Typical she thought, he thinks he can sit anywhere

with disregard for others. He looks entitled, with his soft wisps of short blond hair and tweed jacket that had the casual elegance of someone with money. City Banker was her first bet with herself.

'I think you'll find you are sitting in my seat. Would you mind moving?'

'Sorry, not at all. Are you expecting it to be cold in London?'

'Possibly.'

'I have just come from XXXXX and am not sure I am ready for the cold.'

She smiles politely, sits in her seat and brings the papers out of her bag that she was planning to work on. Effectively ending the discussion. However as the flight progressed she could sense the curiosity of the man next to her, as he was looking at the paperwork on performance reviews and talent management that she was working on. As breakfast was served he took the opportunity to ask her what she was doing. His interest was piqued because, he said, he had been involved in officer training in the military and wondered how leaders were evaluated in the business world. What followed was one of the most interesting, engaging, inspiring and influential conversations the women had had in a very long time.

It transpired that he was heading up a multinational mission in XXXXX and had been called back to speak with government officials about the difficult situation there. She thought, ok not a city banker, but definitely posh! However the papers were pushed aside and the conversation ranged from his family tradition in the military, his promise to his wife that this would be his last

posting (the one before was supposed to be that), life after retirement, the conditions of British troops deployed and working with the African military personnel.

Over the previous few months the woman realised that unconsciously she had been soaking up information from the media; stories about mothers paying to send packages of clean underwear to their sons serving in Afghanistan and Iraq. As they spoke she realised she had been shocked by this as she had assumed that soldiers were given all of their kit. Too many movies where she had seen newly head shaved youths picking up their uniforms. Politically she did not approve of the choice to go to war, but could not remain detached from the consequences of the decision; the raised terror threat, the increasing number of injuries sustained by young men and women in the prime of their lives and the sense that this could have been her, escaping unsettled home life to the military.

Her childhood experiences of being brought up on a working class council estate just outside Glasgow and the prejudices against the English, or anyone that spoke with a 'posher' voice than you, had surged to the foreground as she put her hand luggage in the overhead locker. Her equilibrium returned with coffee and every moment of the enlightening conversation between the two fellow travellers.

She was impressed and deeply touched by his passion and commitment to duty, honour and service; values that she could relate to. In what seemed like

no time at all, their conversation was interrupted by the preparations to land, and like so many meetings on planes with a few well wishes and a casual wave, they went their separate ways.

Connecting with my narrative

Seated next to the senior British Army Officer on that Beirut morning I was conflicted by old anti-authoritarian feelings being evoked, but admired his sense of care and duty towards the men and women of his command. He was beginning to think about his transition into civilian life. I thought about his wife expecting to start a post army life with her partner only to be told that he was doing one more dangerous tour. This conversation stayed with me on many different levels. It captured my own insecurities and the tendency I had to be judgemental as a form of defence and the positive experiences opening up and being less defended can bring. It hinted at my desire to be an advocate for the individual and was the beginning of my own decision to transition from my job in a demanding global organisation that dominated my life.

As alluded to in the story I almost joined the military, straight from school, attracted by the opportunity of escape from a small town and an emotionally uncertain home environment. Instead I went to University to study History and Politics and was studying in the USA in 1982 when The Falklands War began. I have always felt that my experience of The Falklands was disconnected from the experience people were sharing in Britain given that I was out of the country. I had found an alternate home with my university friends and in left wing student politics. I supported the anti-apartheid and anti-nuclear

movements and away from the strict rules of my father had found my anti-authoritarian voice.

Long before that in 1943 my father was 23 years old and a Sergeant in the Royal Engineers. His younger brother, a Sub Lieutenant of the Fleet Air Arm was killed when the plane he was flying overshot the aircraft carrier and crashed. My uncle was just 19 years old. A few years before my father's death in 2012 he retold this story in a way that I had never heard before. It was Christmas Eve and he and I were alone watching a midnight service from the RAF chapel on The Strand, London. He was so angry. He blamed the American commander who had ordered the operation when weather conditions were bad. My father told the story as though it happened on 'the last day of the war'. It was only later that I realised that the dates didn't match up. For me that made my father's pain even greater. His retelling made the loss of his brother more poignant and unnecessary framed as a last act of war.

In the description of his brother's death I began to understand where so many of my father's disproportionate responses had their origins. I had just started training as a counselling psychologist and psychotherapist at the time and found his raw emotion in this moment very powerful. His story helped me make sense of parts of my childhood. I became aware of the impact that his wartime experiences and unresolved grief had on him and subsequently on our family life. The seeds of this project were taking root.

One year after the encounter on the plane I had left corporate life and embarked on a different sort of journey. I set up my own consulting business, which started as an organisation development/change management and coaching practice. I started studying psychology and training to be a psychotherapist and later integrated seeing therapy clients into my consulting practice. I moved out of London and now live near a large military garrison, in a rural area directly impacted by the military. In my clinical practice I have seen clients who are still serving in the military, those who have left and the partners of both. Their stories confirm to me that this community requires support with issues of mental health and that better understanding of their needs would improve access to support services and the design of what is available.

During the early stages of developing my project I was put in touch with a former soldier suffering with mental health issues. He was a possible participant in my project, which at that time was only focused on veterans. His wife joined in the conversation describing his symptoms and how they had impacted family life. I realised that so much of his experience after leaving the army was shared with his partner. I became curious as to her role in his recovery and how their relationship impacted on his mental health. In my focus on the veteran I realised that I had unconsciously overlooked the partner. Issues of inclusion and exclusion have always evoked my sense of fair play and my own struggle for identity. And so a confluence of stories, thoughts and feelings brought me to this place; choosing a narrative inquiry,

exploring the couple experience, and focus on living with mental health issues after military service.

The military mental health in context

Iversen et al's (2005a) paper on 'What happens to British forces when they leave the armed forces?' takes the perspective that most do well. This is a phrase and sentiment that pervades much of the research and government sponsored publications regarding former military personnel in the UK. However with this as the headline message there is a danger that those veterans with mental health issues, that the authors recognised were the population most vulnerable, at risk and least likely to do well, become marginalised. It also demonstrates the power dynamics involved in designing research. The selection of specific hypotheses that frame the areas to be considered can exclude important aspects pertinent for those veterans suffering with mental health issues. More research is required that prioritises the population with the greatest need of support. This study takes a unique perspective on veterans' mental health by considering co-jointly with the couple the experience of living with a mental health diagnosis.

The information produced by much of the quantitative research is used to identify the scale of resources required for support services and the type of offering that they might provide. However following findings from Lord Ashcroft's 2017 report that the public overestimates the extent of mental health and other problems among former service personnel it was announced that the priority action was to change the public's perception. The focus of attention diverts through a lens, which continues to marginalise a vulnerable

client group of ex serving personnel and their partners living with mental health issues. The research study that I have conducted brings the attention back on to the lived experience of the couple and the findings provide insight that will assist mental health practitioners improve the support they give to this client group.

Before continuing with the story of this research I will clarify my use of certain terms used throughout the dissertation.

Definitions of terms

Veteran

The term veteran can be confusing across research literature. In the US veteran is used to describe someone who has been deployed and returned from an area of conflict. However this can mean both ex service personnel and those still on active duty. In the UK the term veteran denotes anyone who has served more than 1 day in the military and has left the service (Burdett, et al, 2012). This does not differentiate between early service leavers of less than 4 years service, or those who do not complete basic training and does not distinguish between deployment experience and those not deployed. Each of these categories has their own issues around mental health. However, for me veteran in the UK does include anyone who has served in the armed forces and I place the focus of attention on the lived experience of those involved to prevent the human story being missed. I will mostly use service personnel and military personnel to denote active serving members of the armed forces and ex- service personnel and veteran to describe the populations that I am discussing. Combat veteran is someone

who has been specifically deployed to a conflict zone. However trauma, which may lead to a diagnosis of Post Traumatic Stress Disorder, DSM-5, 309.81 (APA, 2013) does not happen exclusively to combat veterans and can be experienced by auxiliary services.

Post Traumatic Stress Disorder

DSM-5 includes indirect exposure as diagnostic criteria for PTSD; such as learning that a close friend, relative or spouse was exposed to trauma, as explicit criteria of how an individual can be traumatised (APA, 2013). Where the paper is not of origin in the UK I will use the terminology of the authors and make distinctions as transparent as possible.

Similarly I also use the terms Post Traumatic Stress Disorder (PTSD) and post traumatic stress where researchers have used this terminology in their published materials. Van Der Kolk (2014, p.19) identifies the new diagnosis of PTSD in 1980 as a 'turning point' in research and improving the treatment of veterans. However Judith Herman (2015) 25 years after first publication of Trauma and Recovery is still arguing the case for an understanding of prolonged and repeated traumas beyond the DSM definition. I support her concept of complex posttraumatic stress disorder. Although, I agree with Nancy Sherman (2015) who refers to the growing movement to drop the Disorder in PTSD because of the stigmatizing effect. This was echoed in the language being introduced into popular culture in the reporting of events such as the Invictus Games 2016, where mental health issues have been referred to as an 'invisible injury'.

The evolution of the Diagnostic and Statistical Manual of Mental Disorders (DSM) highlights how the human story can be missed. In 2013 DSM 5 was published revising DSM 4 (APA, 2000). There has been some controversy over the changes with a view that the changes do not improve clinical utility and may now exclude people who previously had the diagnosis and for whom there was treatment, and conversely there are people now included in DSM 5 definition, who would have previously been excluded and for whom no generalised treatment has been developed (Hoge et al, 2016). Therefore papers prior to 2013 will be using the earlier classification and those after 2013 will be using the newer DSM 5 definitions.

Becoming part of the military family

This project has a focus on life living with PTSD after military service. However in order to understand the potential magnitude of the change from military to civilian life it is worthwhile considering the effort that goes into the socialisation process military recruits experience to become part of the military family, particularly in the army. This part of military training has been described as a 'dispossession of civilian identity' (Hockey, 1986, p.23) and is justified by the military as a requirement to ensure the adherence to authority and the need for predictable responses to orders. It is intended to create social cohesion, which is a requirement to be battle ready against an enemy. The formation of a military identity and adherence to certain aspects of military culture provides insight into ex service personnel behaviour after leaving the military and how this may contribute to their mental health and wellbeing.

The target age group for army recruits is 16-24; young people, mostly male, often with only a high school education and from an area of lower economic opportunity. This is the development stage that Erikson (1968) considered significant. He described this as a formative stage when young people can experiment with different identities before settling in to a secure sense of self, or ego identity as Erikson would describe it. Rather than experimentation the army recruit is required to assume the military identity. For some this provides an answer to who they are, without much reflection. Older soldiers can become role models and in this way cultural norms are maintained and passed on. However the identity crisis that adolescents face before assuming adulthood is interrupted for military recruits and can increase confusion on exit from the military when they are again faced with choices regarding identity and how they see themselves. Trauma leads to a disintegration of self and so for veterans they manage that on several levels.

Military masculinity and gender

The military is a predominantly masculine environment, even with the technological changes that have reduced some of the physical aspects of warfare and have given increased opportunities to women. It still maintains what in civilian society would be considered an anachronistic male culture where softer skills are deprioritised. However civilian society is seen as 'soft' an attribute considered derogatory (Higate, 2003).

This predominantly male culture reflects a male hegemony in Western society and has been entrenched in military culture and slow to change. Basic training has been developed as a rite of passage in which boys are turned into men

(Hockey, 1986). This includes a change of external appearance due to the fitness training and endurance exercises, as well as the uniform, which is the wrapping of the collective ‘we’ and the surrender of the ‘I’ required for troop cohesion. This is part of the concept of military masculinity (Higate, 2003) that is a hyper masculinity that amplifies aspects of masculinity that are found in civilian life. The army has a key objective to be battle ready for combat. Therefore certain traits, such as anger and aggression are valued as the belief is that they contribute to the ability to survive combat situations. They are actively encouraged in the military whereas they would be inappropriate in civilian workplaces. Stress is relieved through ‘booze, ‘birds’ and brawling’ (Hockey, 2003, p.22).

Within this culture poor performance is equated as a feminine attribute and there is a polarity of male as a good attribute for a soldier and female as bad. Therefore insults are given feminine attributions, as are emotions; a clear indicator that expressed emotions are considered a sign of weakness.

The Howard League (2010) inquiry into former military personnel in prisons concluded that ex service personnel in the US and UK faced the same problems on leaving military service; housing difficulties, unemployment, mental health difficulties, relationship breakdown and substance misuse. A recurring theme was the sense of social isolation experienced by those having difficulty mentally and socially adjusting to life after military service.

My focus in this review is mental health and as a result I do not include reports on housing, employment, finances etc. However I do recognise that as part of a broader social inclusion and integration into civilian life these areas are part of psycho-social stressors which can impact on mental health and wellbeing.

Research aims

The cultural divide between civilian and military life adds complexity to those leaving the military, especially where there are mental health issues. Duane France, retired US Army combat veteran and now mental health practitioner, calls for counsellors and therapists to be 'culturally competent' (France, 2018, p.12), to help the veteran establish a therapeutic bond (Bordin, 1979) and to ensure that the therapist has a better understanding of the veteran's experience.

The aim of this research is to explore the experience, through the narratives used by each couple, of living with trauma and distress after leaving the UK military. By gaining a deeper understanding of the lived experience this research aims to address part of the gap in the literature available on how to support couples cope with the impact of mental health. This will hopefully contribute to the models of therapy and other mental health support services available. The research will provide mental health practitioners and support services with insights and learning to improve support, both within the military and in the civilian services responsible for care of veterans and their families.

As my approach to the research is narrative inquiry I have ‘research puzzles rather than research questions’ (Clandinin, 2013, p. 42), which underline the fluidity of this type of research. I will discuss this aspect of design in more depth later. The areas of inquiry that I am interested in exploring are how adverse mental health issues, such as post-traumatic stress, impacted the experience of leaving the military and transitioning into civilian life. I am curious to hear what this experience was like as a couple and what their experience was of accessing support. I am interested in what implications there may be for the provision of future support to veterans and their partners.

Research question

A narrative inquiry into what is the couple experience of leaving the UK military and living with trauma and distress.

Literature Review

Introduction

I searched PsychInfo, Psych Articles, Sage Journals, Middlesex University library platform selecting search terms such as transition, mental health, military to civilian life, veteran, wife, partner, spouse, marriage, couple, qualitative. In addition I did a grey search and accessed the Kings Centre for Military Health Research online publications archive, The Forces in Mind Trust Research Hub and websites linked to the Armed Forces (Ministry of Defence, Royal British Legion), the National Health Service and charitable sectors. Reports such as, The Armed Forces Covenant Annual Report (2020), Lord Ashcroft's Veterans Transition Reviews (2014; 2015; 2016; 2017), The Murrison Report (2010) provided signposts to other research material.

I conducted Google searches using my project title and combinations of the above phrases leading to third sector organisations and related veteran organisation websites. Additionally I conducted a References review of articles and books that emerged from my search, to catch any additional material that I may have missed.

Most of the research that has been conducted in this area is quantitative. Hilgate and Cameron (2006) reported the lack of reflexive approaches to military and veteran research and in recent years there have been increased use of qualitative research to better understand what lies behind the quantitative data. Others have recognised the lack of helpful information for mental health practitioners regarding military families and children (Kelley and

Jouriles, 2011; Paley et al, 2013; Chandra & London, 2013; Chan, C.S. 2014), but this falls outside the parameters of this study as I am focusing on couples rather than the wider family including children, siblings and parents.

I recognise that in the field there has been a general lack of diversity in relation to minority groups, with most research covering male female couple relationships and male ex service personnel and female partners rather than the other way around. For example, Brunger et al (2013) explored experiences of transition from the military to civilian life, but recognised that they did not speak to any female veterans or any partners. Stack (2013) includes both male and female ex-service personnel in exploring their experience of psychological therapies. However spouses/partners were not included in this study.

As the field has developed there has been an expansion from a focus mainly on active serving personnel to increased research interest in ex-serving personnel and their wider social support relationships. A large amount of the research regarding ex-service personnel has been conducted in the United States of America where a Department of Veterans Affairs was established in 1989 (Cabrera, et al, 2007; Grossman, 2009; Moore and Penk, 2011; Gottman et al, 2011; Moore, 2012; Monson et al, 2012; Russell and Figley, 2013; Castro, 2014; Kimbrel et al, 2014; Castro et al, 2015; Ainspan et al, 2018; Albright et al, 2018).

Australia also has a dedicated approach to veteran and military mental health (McKenzie et al, 2010, Creamer and Singh, 2003; O'Toole et al, 1996). I aim to be explicit in identifying country of origin of information within this proposal as factors such as the social, cultural and political climates in the UK and the US, Canada, Australia, the Middle East are not always the same. For example there is a growing body of work coming from Israel. However in Israel military service is a legal requirement of both men and women. This changes the perceptions and impact of experiences of military service for the local population and makes comparisons with countries that do not have conscription ill matched. Similarly with countries where military conflict has occurred impacting the civilian population comparisons with countries that have not had war at home need to be viewed in this context.

In the UK transition from the military has had a significant increase in attention in the last 10 years stemming from recommendations from pieces of work such as the Murrison Report (2010), which made 4 main recommendations including incorporating a mental health check into existing military medical examinations for serving personnel, an increase in the number of mental health professionals conducting veteran outreach, a trial of an online early intervention service for serving personnel and veterans and a veteran information service to be available 12 months after a person leaves the military. Lord Ashcroft's Review and Updates (2014; 2015; 2016; 2017) came to the conclusion that most service leavers do well and included the recommendation that all leavers who complete basic training should be entitled to a full transition support package. Due to the lack of many of his

recommendations being translated into operational plans the 2015 update did not review against the main reports outputs. By 2016 the update concluded that much of the work done to date was about policy and structure and had not come to fruition. The report stated that the benefit would be for those 'yet to join the Armed Forces' (Ashcroft, 2016, p.4). It had been recognised that many leavers were not prepared for the culture shock of leaving the service including the loss of their personal social networks.

This review maps out an overview of the field of military mental health research, identifying three key areas relating to my research topic:

- Impact of military service on mental health of veterans
- The impact on partners mental health
- The couple experience of living with and receiving support for mental health issues.

Impact of military service on mental health

In the UK the Kings Centre for Military Health Research (KCMHR) has up until recently conducted most of the research on military mental health having direct access to large cohorts of serving military personnel. Every organisation has it's own 'house style' and there is also the potential for confirmation bias. There has been more inclusion of qualitative research and a recognition of the 'importance of moving away from a one size fits all treatment response for veterans to one that takes in the idiosyncratic presentations of individuals' (Murphy and Busuttil, 2019, p. 2).

Initially focus was concern for troops returning from deployments in the Gulf War 1990 – 1991(Unwin et al, 1999) and understanding what has been called Gulf War Syndrome (Greenberg and Wessely, 2008). The research provides an insight into large scale postal surveys across all three parts of the UK armed forces, with highest number of active service non responders followed up through their commanding officers. Although those deployed to Gulf War reported more fatigue, symptoms of posttraumatic stress and psychological distress, the research did not conclude that this was unique to a particular syndrome and was more likely the result of a vaccine. In subsequent research (Lee et al, 2002; Stimpson, et al, 2003; Greenberg and Wessely, 2008; Sundin, et al, 2011) it was accepted that exposure to combat can have psychological impact post conflict, including posttraumatic stress.

Iversen et al (2005b), conducted a phone survey of vulnerable ex services personnel titled 'Goodbye and good luck' claimed an overemphasis that post-traumatic stress disorder (PTSD) was the biggest issue for this group, with 16.3% reporting PTSD compared to 11.8% probable alcohol dependence, 53.4% depressive spectrum disorders and 18.2% anxiety disorders. In their study the most common issue was depression. The type of treatment that help seekers received was mostly medication and some were receiving support from a charity or cognitive behavioural therapy. Those who did have PTSD generally had a co morbid diagnosis.

An increase in those experiencing posttraumatic stress was tracked in longitudinal cohort studies in Iraq and Afghanistan (Hotopf et al, 2006; Fear et

al, 2010; Stevelink et al, 2018). Service information was part of the questionnaire including, rank, deployment duties, current mental and physical status, and lifestyle behaviours such as smoking and alcohol consumption. In 2018 just over 20% of respondents reported suffering common mental health disorders with 6.2% reporting probable PTSD and 10% alcohol misuse. Results showed that ex serving personnel who have been deployed and experienced a combat zone have a higher risk of probable PTSD than serving regulars and those ex service personnel who were not deployed or in a combat support role. The researchers quantitative data provided a lower incidence of reported probable PTSD in active serving personnel. However without a deeper discussion this does not provide any insight further than this was the number of individuals prepared to report issues, rather than give an actual picture of how many individuals are having difficulty.

These results suggest that for the first time the UK figures were equivalent to the US veteran figures that have previously always been higher than the UK. In addition in the UK ex service personnel were more likely to experience PTSD than the general population (Murphy and Busuttil, 2019).

The replenishment group used to top up numbers of active serving personnel sent the survey were more reluctant to participate than original members of the cohort. Again no insight into their reticence is provided by the quantitative nature of this research, although I will later make links to the impact of stigma on seeking help for mental health issues. There are similar quantitative studies on reservists and women (Forbes et al, 2011; Demers, 2013; Diehle et

al, 2019) providing more data of this kind but limited insights into what the experience of living with mental health issues is like within these groups.

This has shifted the landscape and although common mental disorders (CMD) and alcohol misuse remain the most prevalent conditions, PTSD has been found to be the most frequently endorsed mental health difficulty of treatment seeking ex service personnel (Murphy et al, 2017). This is also supported by the tendency of ex service personnel to seek help when they reach a crisis point.

Brewin, Andrews and Hejdenberg (2012) found that for UK veterans with a diagnosis of PTSD and depression, they were more likely to have been diagnosed when in service. However, it was mental health issues linked with alcohol abuse that were least likely to be diagnosed unless part of a co morbid diagnosis with PTSD and depression. The fact that those treated for disorders were mostly downgraded in pay or discharged would not encourage serving personnel to disclose mental health issues and may contribute to the increased prevalence of mental health issues reported by ex service personnel.

The position that serving personnel are at no greater risk than the general population is often not presented alongside the data that serving personnel are more likely to under report mental health issues for concern over their career, being seen as weak, viewed differently by their leaders and unit.

The increase in reporting once personnel have left the service has been explored from the perspective of not being purely military experience related.

However recent research suggests there is an opportunity to consider the positive aspects of dominant military and masculine narratives in designing support and therapeutic interventions for veterans (McAllister et al, 2019). For charities and other organisations providing support to veterans the concepts of brotherhood and solidarity may provide a safe space where emotional experiences can be shared and emotional connections made (Caddick and Smith 2017; Caddick et al 2015).

Adverse childhood experiences

Individuals who have had adverse childhood experience are more likely to suffer mental health, physical health and poorer wellbeing difficulties in adulthood (Felitti, 1998).

Being medically discharged from the armed forces may for some individuals be a repeat of isolation and abandonment from childhood, which is replicated in the rejection by an ‘army parent’ and the system inadvertently re-traumatising the individual (Greenman and Johnson, 2012).

Pre-enlistment vulnerability has been identified as an important risk factor for ill health in male service personnel, which included ‘general psychological ill health, PTSD and self harming behaviour, heavy drinking and smoking’ (Iversen et al, 2007). Army males who are younger, single, less educated and of lower rank have increased vulnerability according to Iverson, which was

identified by looking at the areas of family relationships and externalising behaviours.

Similarly in the US adverse childhood experience was found to be a predictor of depression and post traumatic stress symptoms, over and above combat experience (Cabrera et al, 2007). Service personnel recently returned from combat in Iraq and who had reported two or more traumatic childhood experiences were more at risk of showing symptoms of depression and PTSD, both pre and post deployment, compared to individuals who had reported fewer or no adverse childhood experience.

A comparison between Veterans seeking treatment for mental health difficulties and the general military population found that 44% of ex service personnel who reported experiencing 6 or more adverse events in childhood, compared with 24% in the general military population (Murphy and Turgoose, 2019). Given treatment seeking has previously been identified to be likely to be an unrepresentative comparison it seems odd to compare with the general population. The more significant factor is that almost a quarter of the general military population are in a higher risk category.

Murphy and Turgoose (2019) consider that veteran typically respond less well to mental health treatments than other groups, due to complexity of presentation. However this does not take into account that the cognitive based approaches that are offered may be more helpful in short term but do not address developmental issues effectively in the way that counselling

psychology and psychotherapy would if available to veterans through the NHS.

Moral Injury

An encouraging expansion of the field of military mental health in the UK is the attention being given to the concept of moral injury. Shay (2012) worked with veterans in the US developed the concept of moral injury. This has been developed into a framework by Litz et al (2009) describing the types of experience that might cause moral injury to service personnel. These are 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations' (Litz et al, 2009). Shay (2012) makes the distinction that in his own version of moral injury the 'violator' can not only be the self but also 'a power holder' who can be different from or the same as the self. Shay (2012) believes that cohesion, leadership and training can protect against moral injury, which he defines as a betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation. Shay (2012) takes a holistic view that includes the body, the mind, the social system and culture.

In the UK clinicians that took part in a semi-structured qualitative interview responded that their belief was that moral injury was common in the ex-service personnel that they worked with (Williamson et al, 2019a). Symptoms of PTSD were found to be common, such as intrusive thoughts of the event, flashbacks, feelings of shame and guilt. The ex-service personnel engaged in numbing behaviours such as substance misuse, avoiding sensory triggers to memory of sound, sight and smell and becoming overly involved at work to

avoid thinking about the event. The veterans also avoided talking about the event for fear that others might not understand. Although similar in some ways to PTSD symptoms methods of treatment were not necessarily seen as the same and clinicians expressed concern about only being able to offer limited appointments when time and a compassion based approach was required to build therapeutic relationships (Williamson et al, 2019a).

Barriers and enablers to help seeking

There is concern that although more recent leavers are seeking help quicker than previous generations of ex service personnel (Murphy et al 2015), there are still large numbers with mental health issues that do not seek any formal support and do not utilise the support available. Cultural issues play an important role on society at large as well as serving and ex serving personnel and their families. The distinct contrast between the 'warring' identity (obedience, chain of command and dissociation) and the 'civilian' identity (self advocacy, autonomy and relationships) increases potential for mental health distress and relational problems (Smith and True, 2014).

Military discourse of being a hero and not showing any signs of weakness can deter help seeking as does stigma around mental health. Stigma is not the only barrier to help seeking. Initial barriers include ex service personnel actually recognising that there is a problem (Mellotte et al, 2017).

In Iverson et al's (2005b) study, individuals from lower ranks, who were divorced or separated, were at risk and many were not likely to seek help due to embarrassment and stigma. The fear of being labelled was a deterrent to

coming forward for help for those ex service personnel who were in employment. There was similar access to treatment issues with US veterans (Forbes et al, 2011; Maguen, 2012; Elbogen et al, 2013; Stecker et al, 2013).

Serving personnel have expressed concern that unit leaders will treat them differently, impacting on career opportunity and peers will consider them as weak. Internalised stigma or self stigma (Corrigan, 2005) results in feelings of shame, low self esteem and poor morale. There is substantial evidence of a negative relationship between stigma and help seeking within the military (Coleman et al, 2017). However Sharp et al (2015) take a different perspective claiming that there are has been no research which links stigma directly to utilisation of services.

Enablers to seeking treatment include being at a crisis point and the risk of not help seeking and social support from friends and family.
Barriers during treatment included practical issues such as waiting times (especially when being referred between services), limited sessions, transport, as well as poor therapeutic relationship with NHS health professionals without military specific knowledge. Treatment enablers included receiving a diagnosis, flexible health services and supportive professionals such as their GP or welfare officer and receiving treatment in an environment specifically for ex service personnel.

Partner support

There has been research looking at how female partners of male Israeli military veterans gave support and whether their partners post traumatic

stress symptoms and functional impairment was affected (Dekel et al, 2018a). Three styles of giving support were identified: active engagement (discussing issues with partner, expressing emotions and joint problem solving), protective buffering (hiding worries, concerns and even disagreements so as not to let their partner get stressed) and overprotection (underestimating partner's capabilities, restricting their activities or being overly attentive with assistance and effusive in their praise of the veteran's accomplishments). The most significant factor in the study was that only protective buffering made a significant impact on the veteran. Unfortunately this was a negative impact and there was also a correlation between those partners who carried out protective buffering were more likely to have higher stress response to their partners post traumatic stress, than those women who had low protective buffering. Surprisingly active engagement did not produce significantly better outcomes for partners or their veterans.

If partners are not educated and engaged in treatment and understanding of potential mental health impacts of service there is a risk that they will misinterpret symptoms in their partner (Renshaw and Caska, 2012; Meis et al, 2013). When looking at support for Vietnam veterans it was found that educating spouses about PTSD increased the support received by veterans and increased the likelihood of higher participation in therapy. Not only does this assist the partner to understand their veteran's behaviours as mental health related, but had the result of reducing their own levels of distress (Sherman et al, 2008).

Military partners

This section will consider the partner experience of living with a veteran with mental health issues and the mental health issues that partners themselves face.

Challenges faced by partners of ex service personnel have been reported as inequality in the relationship, loss of congruence with one's own identity, volatile environment and emotional distress and isolation (Murphy et al, 2017). These are echoed in the themes identified by Beks (2016) in a Canadian study of partners lived experience (all consuming effect of illness, walking on eggshells, ambiguous loss, alone, facing PTSD as a unit). Similarly Doncaster et al (2019) in a qualitative investigation into how partners of UK ex service personnel construct their experiences of living with combat related trauma identified five key themes (walking on eggshells, a wounded soldier or man behaving badly, negotiating multiple roles, heroes don't do dishes and the Army were his family).

Mental health difficulties

Murphy, Palmer and Busuttil (2016) conducted a study into the mental health needs and barriers to help seeking in a group of 100 partners supporting ex service personnel who had been diagnosed with PTSD. The results were concerning showing 45% meeting the criteria for alcohol problems, 39% for depression, 37% for generalised anxiety disorder and 17% with probable symptoms of PTSD.

Verey and Smith (2012) interviewed a mix of UK active serving personnel and veterans working in civilian roles. They identified that the importance of being in a group and having a shared experience was part of an effective transition process. They also identified the negative impacts that a husband's PTSD symptoms had on spouses and the difficulty that readjusting to family roles had on all family members.

Mansfield et al (2014), who approached the experience from the partners' perspective, identified that partners are often overlooked when considering veteran mental health in the US. Partners commented on themes of deteriorating relationships and resulting feelings of sadness and isolation. Partners also demonstrated a desire to be more involved in their partner's treatment both to provide insights to medical staff and also to gain information themselves. One participant stated, "The Vet can't get better if the family, especially spouse, still struggles with PTSD" (cited by Mansfield et al, 2014, p.494).

Secondary traumatisation

Trauma not only affects those directly exposed to it, but also those around them (Renshaw et al, 2011; 2014). Partners of ex service personnel with PTSD have been found to be at increased risk of experiencing symptoms that mirror those of PTSD (Ahmadi, et al, 2011)

Partners have been traumatised by hearing about the traumatic events their loved one experienced (Dirkzwager, et al, 2005) and what Figley (2015, p.2) described as 'compassion fatigue'. In a recent study of Israeli male veterans

of the 2006 Israel-Lebanon War (Dekel et al, 2018b), found partner empathy can become a 'double-edged sword as cognitive empathy (perspective taking) can play a positive role following the traumatic event experienced by their partner, whereas affective empathy (personal distress and empathic concern) can potentially have a negative impact on her levels of distress. The findings of this research also confirmed that similar to adverse childhood experiences in serving and ex serving personnel previous traumatic life events and years in education impacted on their posttraumatic stress symptoms alongside the levels of posttraumatic stress symptoms of their partner.

Caregiver burden

Caregiver burden has been found to be related to the severity of the ex service personnel's PTSD symptoms, the more severe the symptoms the greater the burden (Beckham et al, 1996). Caregiver burden is not fixed but increases over time, with the partner experiencing greater psychological distress and anxiety (Beckham et al, 1996). Calhoun et al (2002) built on this and added increased depression, hostility and obsessive-compulsive symptoms.

There is a significant burden of mental illness with caregivers of ex service personnel with PTSD (Murphy, Palmer and Busuttil, 2016). Those with generalised anxiety and depression were more likely to identify more barriers to help seeking and is similar to patterns in research of the military population discussed above.

In a review of US literature Verdeli et al (2011) suggested the provision of treatment specifically for military spouses suffering from depression. They flagged the increased workload and importance of the role of the spouse in maintaining family stability during their husband's deployment. They identified how they could contribute to reducing stress for their children and enhance their partner's mental wellbeing during deployment.

Cobos (2020) suggests, both from her personal experience and related academic research in the United States, that there is more undiagnosed, underdiagnosed or undertreated cases of physical, psychological and moral injury from combat deployed active service and recently retired military personnel than has been documented. This increases the caregiving challenges faced by spouses and partners.

Alcohol consumption

In a recent study that examined mental health outcomes and alcohol consumption for female partners of UK military personnel it was found that compared to women in the general population UK military partners were more likely to meet criteria for probable depression and hazardous drinking and more likely to report episodes of regular binge drinking (Gribble et al, 2019a). There was not significant difference in rates of PTSD symptoms between the two populations. This differs from a US study (Farmer et al, 2011), which reported that across clinical measures of depression, alcohol use, physical health needs and employment experiences veteran spouses were remarkably similar to their general population peers. This is in accord with a systematic review (Gribble et al, 2018) using 8 papers from the US and 1 Australian,

which concluded that there was limited evidence of the prevalence of hazardous alcohol consumption in the military spouse/partner population.

Intimate partner violence

Van Der Kolk (2014) suggested that solders returning home could frighten their families with rage and emotional absence. He noticed that the wives of men who suffer PTSD tended to become depressed themselves.
As the level of interpersonal violence perpetrated by the veteran increases so too does the burden of the caregiver (Calhoun et al, 2002)

Griffin and Morgan (1988) found that US military wives were more likely to be physically abused than civilian wives and more often requested that their husbands drink less, work less late and express more emotion. Thirty years later Monson, Fredman and Riggs (2012) continued on this theme with the implied link between PTSD symptoms (hyper arousal/ dysregulated anger) and issues within intimate relationships.

Family impact

For the partners, family members and friends of those ex service personnel who have come home different, changed by their military experience and mental health difficulties, there is a grieving process without clear end. Their loved one is still alive and physically present but has disappeared in mind or considered psychologically absent. This is what has been termed ambiguous loss (Boss, 2010). Financial difficulties resulting from loss of employment of the ex service personnel can impact the whole family. As does relocations

and change of schools for children. Family roles have to be reassigned to reintegrate the often absent parent back into the family.

The emotional numbing associated with combat related PTSD in ex service personnel may lead to difficulties in maintaining intimate relationships not only with partners but also their children (Meis et al, 2013). Families report often having to adjust their behaviours in order to avoid triggering the post traumatic stress symptoms of the ex service personnel (Mansfield, et al, 2014).

The couple experience

The third area is the couple experience of living with mental health issues after leaving the military. This section demonstrates the lack of research that is available that includes both partners as equal contributors in the research. The main focus of research relating to couples and the military seems to be on the design and efficacy of therapy solutions and psycho-educational programmes rather than exploring the lived experience of couples and considering what help might give them the best support. It is the aim of this study to gain deeper understanding of the lived experience and address part of the gap in the literature. The research will provide mental health practitioners and support services with insights and learning to improve support for care of veterans and their partners.

Couple Interventions

The US has been leading on support for couples both during and after military service, recognising that the potentially traumatic nature of combat not only impacts veterans but also their families (Monson et al, 2009). Couple

interventions have been shown to reduce PTSD symptoms and improve relationship outcomes (Kugler et al, 2019). Couple Therapy has also been shown to reduce the cost and level of service utilisation in the US (Madsen et al, 2017) This started from the base of marital satisfaction surveys and the impacts that deployment could have on family life and on morale of serving personnel. Examples of some of the couple interventions developed in the US are as follows: Cognitive based Couples Therapy (Monson et al, 2004, p. 341) where the 'behavioural and cognitive interventions are aimed at the dyad and at simultaneously improving PTSD symptoms and relationship discord. Partners reported more satisfaction with the therapy but the veterans did acknowledged some improvements in anxiety and depression and nothing for their PTSD symptoms. Emotion Focused Therapy (Wiebe and Johnson, 2016; Blow et al, 2015) based on building a secure attachment bond in the couple relationship to increase emotional accessibility, responsiveness and engagement. Internal Family Systems Therapy (Lucero et al, 2018) approaches the individual as though internally they are a family system with different parts taking on roles (manager, exile, self) with the aim being to lead with a grounded self and deal with internal conflicts as would be done in family therapy by acknowledging and valuing each part. This process can transition from working with an individual to the couple and also include the children at a later stage.

Coming from a background in emotionally focused couple therapy and the power of positive attachment figures, Johnson (2008, p. 9) stated that 'couple

interventions can make a crucial, and to date almost unrecognised, contribution in the treatment of traumatic stress'.

Another example of a US programme supporting military couples with training interventions for example is in building resilience (Gottman et al, 2011). Field combat stress clinics identified spousal conflict as the major contributing factor to soldier suicide and suicidal ideation. In response a training intervention in family skills was developed as part of a Soldier Fitness Program, which the US Army piloted. The priority seemed to be on reducing the distress of the soldier (and negative impact on soldier effectiveness in the field) with the partner as secondary.

In the UK the Royal British Legion and Combat Stress have recently piloted The Partner Together Programme in 9 different locations (Murphy, Spencer-Harper and Turgoose, 2019). The programme built on psycho educational programmes from the US, such as the SAFE programme, which is a family intervention for serious mental health created within the Veterans Affairs system (Sherman, 2008) and made cultural adaptations for the UK. Initial findings have been positive with participants mostly and clinicians observed reductions in secondary posttraumatic stress symptoms and symptoms of common mental health disorders.

Allen et al (2010) explored the impact on active duty US Army couples of current PTSD symptoms in relation to marital satisfaction. They found that satisfaction was influenced by communication, confidence in relationship,

positive bonding and the parenting alliance. If these were addressed PTSD became less of an indicator of marital satisfaction. Erbes et al (2011) focused on National Guard soldiers recently returned from combat duty in Iraq. Knobloch and Theiss (2011) surveyed mostly active service personnel from across all branches of the US military, who had returned home from deployment in the last 6 months. Canfield (2014) considered similar issues in relation to supportive Social Work interventions for military families.

One of the few studies that includes both partners in the couple dyad is Gerlock et al (2014) where it was found that US veterans returning with deployment related PTSD brought issues to their relationships such as drug and or alcohol abuse, psychological and physical aggression, physical impairment, in addition to their PTSD symptoms. The findings were used to develop a dyadic relationship model aimed to help clinicians work with couples on their capacity to communicate and resolve conflict.

Nelson et al (2002) considered the importance of looking at the distinction in couples of whether they are single or dual trauma couples. A single trauma couple being where only one partner has experienced trauma and a dual trauma couple being where both partners have a history of trauma. This links to the work on secondary traumatisation already discussed and demonstrates the importance of considering the whole history of a couple when supporting their mental health needs. By researching the lived experience of couples this study can contribute more insight into the whole story by sharing the unique experience of the couples.

The research mentioned above has mostly been focused on either the ex serving personnel or their partner. 15 years ago Sherman et al (2005) were discussing the adverse affects of PTSD on couple relationships and how inclusion of partners in recovery could be significant and it is disappointing that these issues of lack of inclusion continue to inform programme design with partners not being included in their partners treatment unless as part of couples therapy.

Gaps in the field

In Camacho and Atwood's (2007) review of the journal 'Armed Forces and Society' there were no articles considering the couple experience.
As mentioned previously Borah and Fina (2017) identified only one other Australian study (Runge et al, 2014) that documented the experiences of military spouses.

Since then there has been progress in this area of research. However Spencer-Harper, Murphy and Turgoose (2019) conclude that their study is 'the first in the UK to qualitatively evaluate the lived experience of partners living alongside veterans with mental health difficulties who attended a structured group support programme'. A niche group but indicative of the limited research in this area.

Couples that are less stressed and more successful tend to speak in terms of 'we' and had set boundaries, utilised self-care and discussed specific coping strategies (Gerlock et al, 2014). The concept of 'we' has also been found to

be a useful in framing a couple's relationship as a united front (Sones et al, 2015; Greenman and Johnson, 2012).

Burrell et al (2006) surveyed spouses of active serving US Army personnel regarding impact on wellbeing. The response rate was 13 per cent and the team was concerned that their findings were not generalizable. They recognised that spouses impacted negatively by the military lifestyle were less likely to respond and that their distribution of questionnaires was reliant on units doing this effectively. However they did not consider that their questions did not capture the essence of the experience of the wives or that the approach of testing hypotheses might limit the engagement with participants. Qualitative research can add valuable insights and engage participants at a more meaningful and relevant level providing them the flexibility to express their own lived experience.

Loved ones have been recognised as having an important role in helping those dealing with trauma (e.g. Van der Kolk, 2014; Johnson, 2008). US veterans seeking care from VA PTSD clinics would like increased partner and family involvement in their treatment (Meis, et al., 2013). This supports findings in the UK where partners of ex service personnel on the pilot of The Together Programme indicated their desire for partner involvement and dedicated couple time to be included in the programme (Murphy, Spencer-Harper and Turgoose, 2019).

In conducting this review I am convinced that my research will have a contribution to make to the field, both in addressing a gap in the literature and in adding the voices of couples themselves to improve understanding of this under-researched area.

Methodology

Philosophical approach

In my practice as an Integrative psychotherapist and counselling psychologist one of the primary ways my clients communicate is by sharing their life stories with me. I understand human beings as existing in relation to others and that making meaning is an essential part of this. Therefore we work collaboratively to make meaning of whatever issues they are facing and create new understanding and insight that may lead to change. Constructing new narratives of their experience and updating old narratives through re-telling can be both a sign of change and part of the change process itself (McLeod, 2006; Schafer, 1992). Building a therapeutic alliance (Horvath and Symmonds, 1991; Bordin, 1979) is a key part of this work. So too is the exploration, interpretation and reflection of multiple realities: the client's, my own and others with whom the client interacts.

This research was based on the same philosophical approach as my professional practice. The epistemological principles supporting my research are postmodernist, social constructionist (Gergen, 2015), where knowledge is co-created and is situated within the context of time, place, social, political, economic and cultural dynamics (Polkinghorne, 1992; Findlay, 2006; Willig, 2013). I aimed to conduct a qualitative piece of research, which developed understanding (Barker et al, 2002) in a more particular way.

I believe that the output of this research is not knowledge production in a positivist sense of a quantitative project looking to generalize research

outcomes and find a universal truth. In this context I consider knowledge to be particular to the human condition and in service of understanding a social reality. I am conducting this research through a lens that does not support the concept of a universal, objective reality that can be fully known. I consider there to be multiple realities that are socially constructed. Knowledge that originates within different contexts or social constructs may usefully be able to sit alongside each other. However there will be times when their principles and practices are unable to be congruent and the application of knowledge from different paradigms is not cohesive.

Gergen (2001) suggests that the process of taking the local and making it universal has an oppressive feel to it and stifles dialogue. This resonated with the way I found it difficult to engage with some of the quantitative research discussed in the literature review. The 'knowledge' was unhelpful as it presented data without sufficient exploration around the complexities of the why and the how of the personal stories behind the statistics.

The search for understanding, 'verstehen as epistemological principle', (Flick, 2014, p 90) has raised the question of whether it is 'ever valid to speak for others who are unlike me or who are less privileged than me' (Alcoff, 1991, p.7). As a civilian researcher, with no experience of war, it is not possible to completely put myself in the shoes of a military veteran or their partner (Caddick et al, 2017). However Geertz (1975) adapted the concept "experience near" and "experience distant" from Kohut (1971) to address this concern. He recognised that in creating knowledge and understanding about

an experience the narrator was experience near, and the researcher was experience distant. Empathic understanding could be achieved through accepting a coexistence of these experiences with one not preferred over the other. This addresses the potentially hierarchical, power dynamics that can be framed when researchers are seen as expert.

The considerations of subjectivity and intersubjectivity (Aron, 2000; Benjamin, 2018) that form part of my private practice extend into this research project. I value the intimacy of working directly with research participants and their narration of experiences (Sarbin, 1986). I agree with Finlay and Gough's (2003) assertion that subjectivity in research is more an opportunity than a problem.

I adopt feminist principles (Flick, 2014) and their egalitarian approach to knowledge generation and meaning making and was conscious throughout the research that my choices of and responses to the narratives presented were influenced by my subjective experience. As McLeod stated 'the intentions and experiences of the inquirer, the quality of his or her engagement in the task of constructing knowledge, become central to the process of the investigation' (McLeod, 2006, p.142).

Throughout the research process I reflected on the power dynamics of the role of a female researcher, particularly within a military culture (Fenell, 2008), the gender issues within the couple relationship and between myself as the research progresses.

As a practitioner-researcher I want to broaden my perspective and gain understanding that can support my work with clients. I want my research to do the same and hope that it is engaging and stimulates dialogue. With this in mind I embarked on my choice of methodology.

Choice of methodology

Initially I was drawn to Grounded Theory (Charmaz, 2012) approaching it from a constructionist perspective. My intention, as Willig (2001) suggests, was to ground my observations in the contexts that generated them. I was attracted to Willig's (2001) own observation that Grounded Theory itself is on a journey out of the post positivist paradigm into constructionism. However, as discussed in the Introduction, when I moved from a project that was about interviewing 10 veterans to one focusing on the couple experience the structure of Grounded Theory and the process of 'saturation' no longer seemed appropriate as I was not trying to generalise the couples' experiences or make universal claims.

I also considered a phenomenological study 'describing the lived experience for several individuals about a concept or the phenomenon' (Cresswell, 1998, p.51). Interpretative phenomenological analysis (IPA) was attractive, as it was not trying to generalise findings (Smith and Osborn, 2003). However I found this potentially reductionist in the way that the analysis of the transcribed interviews seems to deconstruct the text as part of the thematic analysis and in doing so lost the narrative as a whole. Therefore a narrative inquiry was

considered the best fit with my study's objectives of enabling the couple to tell their own stories.

Narrative inquiry

As a counselling psychologist and psychotherapist I have an interest in the personal narratives people use to make meaning of their experiences. Storytelling is used to make sense of human life and create a narrative identity (Ricoeur, 1991). I conducted my research project from a narrative perspective, supporting my view that, as relational beings, our sense making is a communal activity, where, in the tradition of Wittgenstein's (1953) language games, our language is made meaningful from its use in action (Gergen, 2001). Hearing narrators share their stories was not unlike listening to my clients, albeit that we have a different relationship in these circumstances. It felt like a natural expansion of my professional role to engage in a narrative inquiry.

The breadth of approaches and descriptions of narrative research is considerable (Squire, 2013). There is no one way, which is both liberating and anxiety provoking for a first time researcher.

Frank's (2010) capacities of a story (Trouble, Character, Point of View, Suspense, Interpretative openness, Out of control, Inherent morality, Resonance, Symbiotic, Shape-shifting, Truth telling and Imagination) provided support for me in reflecting on the couple narratives with the dual aspects of these capacities. For example, the idea of stories not only being about humans dealing with troubles but having the capacity to trouble humans

increased my confidence to acknowledge the social justice aspect of my research. Point of View enabled me to consider the perspective that the narrators were coming from but also recognise that a persuasive narrative may engage an audience and assign validity to a point of view that is not wholly merited. This alerted me to the concept of narrative entrapment, which Grant (2017) described as a narrative that is 'superimposed' on an individual. It does not align with the individual's sense of self and influences people to respond to the narrative label that has been imposed leaving the individual trapped into having to conform to relate, or as McLeod (2006) describes where an individual's life experiences are not aligned with the dominant narrative which is presented by the social and cultural moment in time and can be oppressive. This makes it difficult for individuals to express themselves and have a voice, as those committed to a dominant narrative may not be open or willing to listen or hear alternative narratives. Individuals trapped in a misaligned dominant narrative can find that others respond to the narrative label (Grant and Zeeman, 2012) that has been imposed on them rather than the individual themselves. I have not selected all Frank's (2010) capacities in making meaning of this research. Much like the capacity of stories to be open to multiple interpretations, understanding and uses, Frank (2010) suggests that his list is not definitive and not all capacities need to be present in every story. He encourages others to add their own interpretation of what capacities to include.

Although like both Frank (2010) and Reissman (2008) I end up using the terms narrative and story interchangeably I believe it is worthwhile to articulate how I understand and use these terms in a research context. For me all stories are narratives but not all narratives are stories. Stories tend to be constructed with a beginning, middle and end and have some form of active protagonist and have a dramatic resolution.

In socio-narratology the concept of stories being both about some sort of 'trouble' whilst also having the power to make trouble (Frank, 2010) evolved for me throughout the research process. This aligned the engaging with the stories of marginalised individuals and groups, who were experiencing challenges, with creating an opportunity through dissemination of research findings to instigate some form of change.

Wong and Breheny (2018) define the story as 'the account of the events the speaker tells, while a narrative refers to the wider accounts of social life that are drawn upon to tell a story' (Wong and Breheny, 2018, p. 246). However narratives can be understood at a Meta level, e.g. a dominant narrative that has a broad societal traction as well as at a local level. In this project I consider that the action of analysing a story transforms the story into narrative at a local level. The story is what the participants tell and the narrative is what is examined.

The storytelling acts as a container for a moment in time. However as soon as the story is told to an audience it is 'out of control' (Frank, 2010, p. 35) and is open to interpretation by others, demonstrating its shape shifting potential.

An integrative narrative framework

In choosing narrative inquiry I realised that much like in my clinical practice, where I was required to develop an integrative framework, I needed to develop a research framework, as I did not intend to follow any one model of a narrative inquiry. Instead the framework I developed integrated aspects from across the narrative field, but is heavily influenced by my counselling psychology and psychotherapy background.

I tried to maintain a balance of roles and styles of engagement depending on the situation, similar to Chase's (2005, pp. 666-667) authoritative, supportive and interactive voices that a narrative researcher might use depending on their approach to the research and the narrators.

I adopted an experience-centred approach as described by Patterson (2013) and accept Squire's (2013, p. 48) definition that 'personal narrative includes all meaningful stories of personal experience that people produce'.

I broadly followed the narrative inquiry approach called 'dialogic/performance analysis' (Reissman, 2008, p.105). The process Reissman described is 'a broad and varied interpretive approach to oral narrative' incorporating elements of thematic and structural analysis. This provided me with a frame that holds 'a type of latent flexibility' that enabled me to tap into the

‘serendipity, contradictions and surprises in everyday life’ that opened up avenues to ‘richer and more powerful’ explanations (Janesick, 2004, p.108). I chose to include large parts of the narrator’s own words intact, rather than the whole being broken only into a collection of themes (Reissman,1990).

The idea that stories need to be shared to be updated and in so doing our identities are also updated (Etherington, 2003, p.180) maintains the sense of continuity and continuing that I believe emerges out of understanding an experience. My research is situated in a moment in time and will always be open to different interpretations and revisions. As suggested by Andrews (2013, p.205) there is no ‘last word’.

Narrative inquiry as retrospective meaning making, verbal action, socially situated and an interactive performance (Chase, 2005, pp.656-657) also contributes to my design thinking. The three-dimensional inquiry space of Clandinin and Connelly (2000), including the backward and forward notion of temporality brings the aspect of a future creating narrative that I also want to include.

With this research framework in mind there are several benefits in choosing narrative inquiry, particularly as a counselling psychologist and psychotherapist. The flexible design allowed me to engage in a collaborative way with participants, prioritising their experience of events. This helped in establishing a strong bond with the couples and minimised potentially oppressive power dynamics of researcher and participant, as the couples

were the experts of their own life. It also meant that there was no repeat of the relationship that the couples had with institutions such as the military and the medical community on occasion, where they had not felt heard.

This encouraged the participants to open up and share narratives containing rich descriptions. In this way narratives can reveal temporal, contextual and emotional qualities of people's lives and relationships (Caddick and Smith, 2017). When the focus is not on collecting sets of objective data, but rather understanding the couples' subjective responses to life events, it reflects my own relational experience with clients in my professional practice.

Not only does the story telling aspects of narrative inquiry closely align to my own professional practice but the relational approach was respectful of the participants' life stories and histories. From my perspective as a practitioner researcher embracing the particularity and complexity of the human experience makes the findings from this type of research more relatable, practical and applicable.

However there are also limitations of the approach that were considered. For example the narratives are very personal and raise ethical concerns regarding how these details are presented. As an experienced counselling psychologist and psychotherapist I was professionally well placed to support the vulnerability that participants might feel during their story telling, particularly in the case of people who have experienced trauma. Screening to ensure participants have the appropriate support measures in place after the

research process was required and signposting to additional support was provided.

The establishment and negotiation of roles in this type of research is complicated. There were times during the dialogues when there was a therapeutic feel to the sessions as I held a containing space for the couples. This was balanced with being a researcher and collaborator. There were choice points in how to present the narratives, what to include and whose words to use.

The remembering of stories is not necessarily a recounting of factual data. For researchers from a different research paradigm there may be concerns about the generalizability of the findings. However I support Smith's (2018) contention that generalizability needs to be considered from a different perspective and that the understanding acquired through narrative can be transferred usefully in certain circumstances.

Research Design

The design of this project was a series of three case studies, involving two sets of interviews with each of the three couples. Each couple were interviewed together on each occasion. The use of a case based approach allowed me to honour the participants' history as a couple without fragmenting or cherry picking data that did not recognise the breadth of their experience and diminish their identity. The case study approach ensured that individual agency and consciousness (Mischler, 1996) were not taken away by the

researcher and maintained a more equitable researcher/participant relationship.

The research design and process followed a number of key phases; **engaging** with the narrators (securing participants), **immersing** ourselves in their stories ('interview' sessions, recording and transcribing sessions), **developing understanding** (thematic analysis and identification of key narratives) and **reflexivity**. These created a bounded space that provided transparency of process and acted as a safe container for the narrators. However this was not a strictly linear process and applying reflexive research practices throughout the research allowed me to visit and revisit the narrative and reflect on my relationship to it. Therefore my findings are better described as understanding at a given point in time. This fluidity reflects the continual searching and 'inquiry reformulation' suggested by Clandinin and Connelly (2000, p.124).

Engaging with narrators

The process of engaging with the narrators began as I initiated the couple recruitment process and was maintained through selection, initial briefing, building our relationship within the dialogue sessions and concluding with the reflection on the research and their participation in it.

Sampling and recruitment

I initially searched for 3 – 5 couples that had the experience of leaving the UK military and living with a recognised mental health diagnosis. I was looking for

2 - 3 couples to form the core part of the research with some additional couples in case anyone chose to withdraw from the research project.

I developed recruitment flyers (Appendix 1) which I sent along with a Participant Information Sheet (Appendix 2) to several friends and colleagues, some of whom work with charitable organisations or have connections with the military. I spoke with these friends and colleagues both face to face and by telephone providing details of what I required from the narrators.

The main selection criteria were as follows:

- The narrators were required to be a current couple
- One person from the couple to have served in the UK military and no longer be serving
- The partner who is a former military personnel will have had a recognised mental health diagnosis. I stressed the sensitivity of the issues being discussed and made it clear that I would be unable to accept any couples that were currently in a particularly vulnerable state. In this context I understood vulnerability as meaning anyone in crisis i.e. under the care of a local mental health Crisis Team, with a high risk of harm to self or others, or current risk of suicide.
- Both partners in the couple needed to be willing to participate in the research.

Concurrent with reaching out to my network I displayed the recruitment flyers in a small number of local venues around the army garrison close to my home

base, where former military personnel and their partners were likely to frequent.

All of the couples came through my networking approach and so the very first part of the screening process involved me questioning the member of my network to clarify if the couple met my criteria. Following their expressions of interest I made contact by phone or email and arranged an initial session with each couple. I met with the local couple and held telephone discussions with the other two. I also had a number of email exchanges and telephone conversations with other potential couples but they were not progressed because one was still serving and about to retire and another veteran was married to someone still serving in the military and the partner did not want to participate. The main purpose of these discussions with potential couples was to assess suitability for research in terms of mental health risk assessment (including risk factors mentioned above and level of support each couple had in place), couple dynamic and balance of contribution from each partner. The session also allowed me to begin to build trust with the couples, introducing myself and providing information regarding the project and what they might expect from participating as narrators. At the end of the session if the couples were still interested in participating and I felt confident that they met the criteria and that we could work together they were provided with a Participant Information Sheet (Appendix 2). We then agreed dates for the first dialogue session.

Use of interviews

The 'interviews' in this project were replaced by a more conversational approach (Mishler, 1986). I facilitated a dialogue with the couples, where I utilized my therapeutic skills encouraging the participants to share their stories in their own way. I paid as much attention to the research relationship as I would to the therapeutic relationship. This required emotional attentiveness, engagement and reciprocity in the conversation (Reissman, 2008) I was focused on being present and really listening to what the couples wished to share. I participated on different occasions through my responses as a first hand witness to the story telling, as well as to facilitate dialogue, e.g. to include the other member of the couple dyad if I could see them having an embodied reaction to their partner's narration or if the balance of the narrative was overly one sided.

I planned two sessions with each couple, as I wanted both the couples and myself to have the opportunity to reflect on the first session. I was also not sure how much information I would get or if the couples would feel comfortable enough in the environment I was creating.

The dialogues took place face to face in hotel meeting rooms local to the couples, with the exception of Couple 1 who were happy to meet with me in my therapy rooms, which are in a discreet setting local them. The research locations were chosen to ensure personal safety for both the narrators and myself and took into account any sensitivity about being seen in a military

environment. Given that the veterans had a diagnosis of PTSD I also wanted to provide them with an emotionally safe space and the containment of the room was symbolic to me of holding a safe space for the veterans and their partners. In my initial contact with each couple they all communicated a strong desire to share their stories in the hope that it would help others not have to go through the same experiences as they had done. The room was part of me communicating to the couples that I wanted to hear their stories and took them seriously. It was a sign of respect that what they had to say was of value. As I was recording the sessions and was preparing for the possibility of the sessions being sensitive the room provided privacy and was free from interruption.

Narrator profiles

All of the ex service personnel that took part in the research had been members of The British Army. They had all been diagnosed with Post Traumatic Stress. Steve (Couple 1) was diagnosed 25 years after The Falklands War. James (Couple 2) and Mike (Couple 3), who had both served in Afghanistan, were both identified with Post Traumatic Stress whilst still serving in the Army and subsequently were medically discharged.

Table 1. Narrator profiles

Narrators	**Age range**	**Ethnicity & Gender**	**Relationship status**	**Military service**
Couple 1 Steve & Kirsty	55-60	M & F White – British	Married 40 years	8 years 1975-1983
Couple 2 James & Eimear	30-35	M White - British F White – Irish	Partners 4 years	7 years 2008-2015
Couple 3 Mike & Karen	45-50	M & F White – British	Partners 4 years	21 years 1994-2015

I was mindful that I was inquiring in the area of an intimate relationship, in the 'safe space, the secure base' that Etherington (2003, p.184) described of herself and other tellers of trauma experiences. I was ' sensitively attuned to each partner's internal frame of reference and experience and to the impact of this experience on the relationship' (Greenberg and Johnson, 2010, p.61). In addition I was conscious of the triangular relational dynamics as the work with the couples unfolded. I was alert to this from the initial contact, assessment and contracting with the couples. Paying attention to the 'cycles of interaction' (Greenberg and Johnson, 2010, p. 72) was a helpful guide as to how the couple might work with me by observing how each partner experienced the relationship and each other and how that might have impacted on how they both experienced me.

I used Adult Attachment (Holmes, 2009) to pay attention to maintaining boundaries, the power relationships within our triad, the roles that we each inhabited and our way of communicating. Using my research diary and reflective practice I monitored my relationship with the 'partnership' of the couple, which is the focus of my research, whilst holding the tensions of 'him' and 'her' alongside the 'them' (Clulow, 2009, p. 92).

Ensuring that I had appropriate consent at the beginning of the process was a part of the initial briefing. This was also built in as a check at the beginning of each round of dialogue. However, being guided by approaches to couples psychotherapy and reflecting on our experiences both within and between each dialogue helped me to be attuned to the need for on-going consent and checking in with my narrators to ensure our research contract was still intact. I remained open to the possibility of potential rupture and repair, maintaining my own 'consistency and responsiveness' (Clulow, 2009, p.148) and increasing my own personal supervision helped me create a safe space for our inquiry.

In the military community, regiment, rank, conflicts deployed to, and gender are all things that could identify individuals. Therefore issues of confidentiality were treated with sensitivity. The names of my couples were changed to maintain confidentiality and I chose not to identify the regiments or to overtly identify individual rank of the veterans involved.

Immersion in a storied world

The design focused on collection of narratives based around two 60 – 90 minute dialogue sessions. The sessions were taped and then I transcribed them fully, including pauses and laughter. I kept notes on heightened emotion and my felt sense in the room with the couples. The recordings and subsequent transcripts provided me with the opportunity to fully immerse myself in the stories and make repeated visits to moments and sections of the couples telling of their experiences. I also used them with the couples to build trust that I had no intention to misrepresent them.

The initial briefing agreed our way of working and addressed any concerns the couple had about the process, to ensure a safe environment for both partners and to establish trust.

Prior to each session the couple received a transcript of the previous session, both as an opportunity to reflect on the session, but also to ensure that each narrator was still happy to consent to participation in the research.

Although the formal sessions were at the core of this project other information was gathered along the way in the form of my own field notes and entries from my reflexive research diary (Etherington, 2004).

Dialogues

At the beginning of the first dialogue session with each couple I checked in with them allowing them the opportunity to raise any concerns and confirmed

their consent to participate. I obtained their signed Consent Forms (Appendix 3). I then reminded them of the purpose of the research and, as had previously been discussed, that the session would be taped and that they would receive transcripts of each session. After each dialogue the process of transcribing was a first level of reflection for me, allowing the stories to settle and becoming familiar with the characters, places and action that appeared in the narrative threads as I heard them. This is where my diary was useful as I often broke off to capture a thought and then turned my attention back to transcribing.

During the phase of collecting narrator's stories I had decided as part of my design that I would not ask too many questions in the initial dialogues unless for clarifications, to facilitate the narrators story telling if they were faltering, to ensure both partners had the opportunity to participate in the storytelling, or in response to unspoken communication such as body language. I was conscious that I wanted the couples to narrate their stories without the constraint or direction of following my line of enquiry. I did not want my questioning of the narrators to be a dominant interaction that becomes part of the story (Riesmann, 2008). I expected that in the second dialogues I would have the opportunity to co create interaction within the dialogue process and ask questions in areas that needed more attention.

The first dialogue for each couple was initiated by me reflecting back the area of research interest, asking the couple what comes to mind for them when I

ask what has their experience been like as a couple leaving the UK military and living with their mental health issues.

Each couple followed a complete arch in the first session providing a holistic picture of their journey thus far after leaving the military.

As the research progressed the second dialogues became slightly different for each couple as they had similar but unique experiences and certain issues had a different weight of priority. Couple 1 retold the same or similar stories. At the end of the first dialogue Couple 2 had identified an area that they wanted to talk about that they had not covered in the session and this formed part of the second dialogue. With Couple 3 we agreed jointly that they were happy with what they had shared at the first session and a second session was not necessary.

Towards the end of the project I contacted each couple to share summary findings as written up in the Discussion chapter and reflect jointly on our experience of the process as a whole. This was part of the co-creative process, making meaning together and providing transparency to narrators. I believe that having my work reviewed builds credibility in relation to the findings and adds authenticity to my approach ensuring the narrators find congruence in my retelling of their stories. This last engagement also included the debrief on the project for the narrators.

Developing understanding

Reissman's (2008) dialogic/performance analysis pays attention to the context and the performance by the narrator, which is situated in relation to who his/her audience is and how he/she wants to be seen. This approach is more experimental and underpins the approach I adopted. It builds on the conventions of both thematic and structural analysis and incorporates elements of both.

As each dialogue occurred I kept my research diary, which contained my different levels of reflections on the process and the sessions. These included how I was feeling about the couples, the impact the stories had on me, musings about the meaning of the stories and initial tentative interpretations, which were helpful in locating myself within the research process. I also used the diary as part of my own self-care as I often found it useful to get the thoughts, whatever they were, out of my head and stored on the page. At times it felt a bit like self-supervision.

Once I had the transcripts I systematically went through the first dialogue for each couple, underlining key phrases, paying attention to the substance of the stories, the function and performance by the narrators (Appendix 4).

I then lifted the key phrases and put them on post it notes (Appendix 5) and sorted them into themes (Appendix 6) by clustering repeating topics together and then consolidating into broader themes.

Thematic analysis can concentrate on the content of what is said and exclude other rich data that is available in terms of how things are said, the embodied impact of the narrative and also what is unsaid. By combining both thematic and structural along with performance analysis I will be sharing a complex but more complete expression of the couple experience, and my own.

This process was repeated for the second dialogues and any additional themes that emerged were integrated into those already gathered. During this process within each dialogue session I was able to identify vignettes that each narrator shared that not only contributed to the overall story but also represented and brought emphasis or attention to a key theme or aspect of the narrative being shared. For each couple I have presented their narratives by selecting several of the vignettes and weaving them together to maintain an overall integrity of the text and as a device to demonstrate the integration of different approaches that provided the framework of my inquiry. This is similar to what Clandinin and Connelly (2000) call the three-dimensional inquiry space. As the research progressed I considered the personal and the social aspects of the narrators experience, their thoughts and feelings as well as existential and environmental concerns. This would be the dimension of interaction for Clandinin and Connelly (2000). However I would more likely consider it as one of relationship. I understand experience in terms of past, present and future; a dimension of temporality that can provide continuity. The third dimension is that situated in place, which Clandinin and Connelly (2000)

identify as physical and topological, I would add the concept of place as context.

Following the thematic analysis I went back over the transcripts and my field notes and constructed the narratives that I present in the following chapter and identified multiple narratives that the participants constructed in their performance of their storytelling. I considered who the narrators were presenting themselves as, the impact this had on themselves and on me as their audience. I considered how this was influenced by the social and historical context the stories were performed in and in my own interaction with the narrators considering the influences on my response to and interpretation of the narratives.

Reflexivity

An integral part of my methodology was the concept of reflexivity, which has been identified as one of the 'key characteristics of postmodernism' (McLeod, 1997, p.21) alongside local knowledge taking the place of 'grand narratives'. Etherington described reflexivity as creating 'a dynamic process of interaction within *and* between ourselves and our participants, *and* the data that inform decisions, actions and interpretations at all stages of research' (Etherington, 2004, p. 36). This links to the relational aspect of my framework of inquiry as discussed above and the interaction space described by Clandinin and Connelly (2000). Reflexivity has encouraged me to be more mindful of context and look for deeper levels of connection with my narrators and their stories.

In the field of military studies Caddick et al (2017) explored being a civilian researcher in an ex military world and concluded that there are ‘a number of conditions under which dialogue is likely to flourish: a greater contextual understanding of veterans’ ‘issues’, a steer away from ‘pathologization’, greater transparency with regard to research ‘agendas’ and a broader commitment to reflexivity among military and veteran studies researchers’ (Caddick et al, 2017, pp.18-19). I have attempted to attend to each of these within this project. As I developed my researcher-practitioner identity I was able to integrate and expand my own reflective process as a practitioner providing greater transparency and ‘enhancing the validity of my inquiry’ (Bager-Charleson, 2010, p.127). I will discuss this more in the following section.

Credibility, Authenticity and Transparency

Qualitative research studies informed by a positivist epistemology focus on ‘discovery and verification of theories ‘ and use traditional evaluation criteria such as validity and reliability when evaluating their findings (Denzin and Lincoln, 1994, p.5).

It is the intent of this narrative inquiry to create a rich and thick description of experience (Ballinger, 2006) and so traditional evaluation criteria are not appropriate. When training for my professional qualification in Human Resource Management over 30 years ago I always remember the example of the hospital that measured its effectiveness by how quick the turnover was of

patients occupying beds. Unfortunately behind the quantitative data this did not distinguish between those who gave up the bed due to regaining health from those who left the bed to go to the mortuary. At the time the message was more to be careful about which measures you select but it has stuck with me over the years about how the human story can get missed by the focus on numbers.

I share the perspective that 'the reader will construct their own interpretations anyway…. I can only be authentic, transparent and construct something that has credibility in declaring my subjectivity' (Rooney, 2005, p.15). Therefore I do not want a situation where 'the use of external auditors or adversaries may function as validity rituals that serve little real purpose' (McLeod, 2007, p.188).

I asked two colleagues to read my Presentation of Narratives and provide their perspective on how the narratives impacted on them and any themes they saw emerging. This was an opportunity to reflect on aspects of the stories that others may have noticed and that I had not. It also allowed me to consider if I was presenting themes that I was drawn to in a way that would be generally recognisable. This was the beginning of a socialisation process for my findings.

The credibility of the research comes from the iterative process of reviewing with the narrators to ensure that meaning making is contextualised and linked to the 'co-constructed' texts (Salmon and Reissman, 2013, p.199). Ricouer (1991, p.80) describes 'reconfiguration by narrative' where his writing is

judged by how his readers can relate to it as though it were a ‘sort of magnifying glass’ using narrative as one aspect amongst social, political and cultural references that inform the creation of self-knowledge and identity.

Through my own record keeping of each stage of the research process and field texts, the research process has been transparent. My research diary assisted with reflexivity, demonstrating an ability to view the data from different perspectives whilst recognising that I am located within the research as a collaborative partner with the narrators (Etherington, 2004). In addition to the final write up of the research I have included an excerpt from my journal (Appendix 7). I also participated in a dialogue with a fellow research colleague as part of a reflexive process to help me reflect on the narrative I was developing in relation to the research. This took place prior to the dialogues with my narrators and helped me in a number of ways. It reminded me of what it was like to be interviewed, and the role of the interviewer to hold a safe space. I was surprised by the direction my narrative took and this led to a discussion about how directive I would be or not in the couple dialogues. I felt self conscious in the dialogue and realised that I had been holding a lot of emotion about conducting the research. The colleague dialogue allowed me to ground myself in advance of working more closely with the couples.

Ethical considerations

This research was conducted in accordance with The Codes of Ethics and Professional Practice of the Metanoia Institute and the Code of Ethics and Conduct (2021) of the British Psychological Society and their supplementary

Code of Human Research Ethics, including any guidelines regarding online working issued during the Coronavirus Pandemic 2020.

As mentioned earlier when considering the narrators, sharing life stories is particularly sensitive. Retelling traumatic events and focusing on the couple relationship could become intrusive for narrators and provoke unexpected, disturbing and emotional responses (Josselson, 1996). Therefore being aware of this and conducting the initial assessment, including risk, was done to protect the welfare of the couple. It was not the intention to engage currently vulnerable narrators and although Couple 3 appeared to be close to this threshold I adapted the research approach to ensure that it was manageable for the couple. For example, we agreed after the first dialogue that there was no need to meet with them for a second dialogue. During the dialogue session we kept the door open initially as the veteran had anxiety about being in spaces with obstructed exits. When a cleaner started vacuuming in the hallway the veteran felt comfortable enough to get up and close the door himself. At one point we paused the session to allow the veteran to go outside for a smoke and reground himself after an emotional account of a colleagues death.

The couples were informed of their right to withdraw at any time during the research project. This was done at the initial briefing, as consent was obtained and at the beginning of each of the dialogue sessions. They were also informed that any taped material collected would be kept in a secure storage area.

Care of narrators

As Adams (2008, p.179) commented that, ‘working with ethics involves realising that we do not know how others will respond to and/or interpret our work’. He highlighted the dangers for participants of disassembling life texts. On the other hand Rosenthal (2003) advocated that this process could have a curative effect on narrators in certain circumstances. Either way concepts such as ‘do no harm’ (Ellis, 2004, p.149) caution researchers regarding relational ethics (Ellis et al, 2011). Adams (2008, p.185) expanded this concept indicating that in personal narratives ‘we will always implicate intimate others’ and that this requires participants and researchers to recognise the difficulty for characters in the story to remain anonymous. As a result this requires a regular renegotiation of ‘interpersonal bonds and intimate conversations’.

As part of engagement and establishing trust and rapport I made sure that the narrators were aware that I had their mental health and wellbeing throughout the process as a priority. I assured narrators that I was not asking for them to recount the traumatic experiences that led to their mental health issues. I was also mindful that talking about such experiences can be a trigger and so I contracted that if they did decide to share such information or if either they or I had a concern the session could be stopped at any time. The example in the previous section shows this care in action.

As the research process was iterative and there were several points at which I was in contact with the couples I checked for any concerns that they may

have had. I used this to renegotiate my own relationship with them and give support or signpost them to appropriate support when needed.

As part of narrator briefing there was a discussion regarding the things they may wish to consider before participating in the research, e.g. confidentiality, impact on their relationship or interactions between them that they may or may not have wished to disclose to me. As we went through the research process part of our dialogues included reflections on these things and so I had informed the narrators of this and found them open to this process.

Self Care

As a practitioner I attend to my own self-care when working with clients. I do this mostly through the use of regular supervision and peer support. I increased this during the research process. I also have activities, which provide time away from listening to client stories of trauma or the embodied response to them. In the research process I was aware of the possibility of 'vicarious traumatisation' (Etherington, 2007, p. 86). The process of reflection helped me be more aware of when I may have been impacted and allowed me to ground myself again. However most of my emotional response to the narrators and their experience was to be profoundly touched by their own couple relationship and the healing contained within that in the face of challenging mental health issues. I had considered returning to personal therapy if needed, but did not feel it was required. My research diary became a place where I could capture thoughts unfiltered and regain equilibrium if needed. I had imagined that some of my own issues may be evoked in the

process, similar to Josselson (1996, p.70) being worried and feeling responsible about what impact the research is having on narrators. She suggested that our discomfort at times, with the work, acts as a counterbalance ensuring that we do not go too far, protecting both our narrators and ourselves. I found this useful and some key decision points were influenced where I found a tension between the role of researcher and that of psychotherapist. This gave me grounding ethically not to open research doors where I felt therapeutically there was rawness, resistance or lack of awareness. I resolved this as a researcher by offering some of these themes in the debrief as areas that narrators may wish to explore further in the appropriate supportive environment. This allowed me to be congruent with my own values regarding the transparency of the process.

'…To study personal narrative is to value the mundane, everyday, private informal and often conversational uses of language by diverse and ordinary people. In so doing we also listen on the margins of society and give voice to muted groups' Langellier (1989, p.272).

The presentation of the couple narratives follows in the next chapter.

Presentation of couple narratives

Steve and Kirsty's story

Introduction

Kirsty is 60 years old and Steve is 61. They are both white and Scottish. They met at a Youth Club when they were teenagers living on the outskirts of Glasgow. Kirsty is a Catholic. She has 3 older sisters and 1 older brother. Kirsty's dad died of cancer when she was 28 and her mum died 11 years later. Kirsty describes her relationship with her parents as '*special*' because she was the youngest and got more individual time with her mum especially as her elder siblings left home. Steve is a Protestant. He is an only child, who was raised by his grandmother only seeing his parents at weekends. In his early teenage years he started getting into trouble and his father then said he needed to come back to live with his parents. Steve had financial security from his parents but lacked emotional support. His father died when Steve was 33. His mother, who by the time Steve left to join the army, was an alcoholic, died last year at the age of 83. Steve describes the reason he joined the army as being totally sold by the adverts which promised a life of excitement doing sports and travelling the world. He did not see that there were jobs offering better opportunities in his hometown.

They started dating at 16 and 17 respectively, by which time Steve had been in the Army for 1 to 2 years, having signed up as a '*boy soldier'* straight out of school at age 16. A 'mixed marriage' between the two religions was not a common occurrence in that part of Scotland in the early 1980s. However both families were supportive and after the wedding the couple set up home in

army quarters in London and have lived in England ever since. They have been married for 40 years.

Kirsty has worked for the same large retail company most of her married life and has worked up to a management position at one of the large local branches, close to where the couple now live in the North East of England.

Steve is a Falklands veteran who had resigned from the military a year after returning home from The Falklands in 1983.
S: I got wounded in The Falklands but I kept it pretty low key. I didn't want it affecting my job and I was still young and daft in them days and thinking I am invincible.

He joined the prison service and had a successful career for 24 years. However during a return trip to the Falkland Islands to mark the 25th anniversary of the conflict a number of people commented on Steve's mental health. He was referred to a specialist treatment centre for ex service personnel and received a diagnosis of Post Traumatic Stress. At that point Steve's mental health deteriorated and he was medically retired from the prison service and he has not worked since.

The couple have one son, William, who is 25 years old and lives xx hours away with his girlfriend. William left home to go to University and then got a job and has a close relationship with both his parents.

However, even prior to his diagnosis Kirsty and Steve describe his return from the Falklands in 1982:

K: I knew like when he first came home it was completely different. He was the nightmares, the shouting.

S: There were signs there early doors (K: yeah) that I was no right. Wetting the bed, drinking, screaming during the night, things like that. She was 20, 21, I was 21, 22 we didnae know anything about anything, so we just plodded on and I was never going to go to barracks and say, oh by the way I'm…

The couple's experience of living with serious mental health issues is a thread that runs through most of their married life.

The aftermath of the Falklands

On returning home from The Falklands Steve describes one of the difficulties of transitioning from a combat zone back to a non combat situation and the challenge he faced in reconciling this with the rationale for the conflict with what was going on in sport.

S: When I came back and these devils that we have been told that we must fight because they invaded the Falklands, these Argentines and how despicable and horrible and ye know, build you up to war, you come back, you're back about 3 days and you look at the television two of them are playing football for Tottenham Hotspur and you think, I don't have a problem with that, but if they were that bad, why are they, you know, why was it so

important to go over there and have a fight if ye like (I: yeah) that is difficult, but this is how I changed.

Some attempt was made by the military to check on the after affects of being involved in combat. Steve describes a surprise experience on one of his routine visits to the doctor during the period he was on light duties following his injury in The Falklands.

S: He takes me into this room, phwhoa, and I looked and there was a table of about 5 or 6 people. And I couldn't even tell you what rank they were because some of them were navy, and the army ones had more stuff on them than I could work out and there was a woman there, which I found, what is she doing there? Anyway they were psychiatrists, psychologists, and they were doing the thing and I remembered that they asked me, em they said that, em there is confirmed kills, people have confirmed that they have seen you kill somebody or whatever. Em and some of my men got killed and they wanted to know if I had any issues. No, no fine.
I: Did you think you had any issues, or
S: No, no. But I lied because he went, are you drinking a lot? No, yes. I was. Eh, are you experiencing trauma? I didn't even know what trauma meant. I went no. Nightmares, no.
K: He was only 22, he wasnae like, it wasnae like, you know what I mean?
S: Are you wetting the bed? Are you screaming? No. And then, and I will say exactly what was said to me, 'when you killed somebody how did you feel?' I don't know, I just …

'Did you get excited?' Excited.

'Did you get an erection?' What a fucking question is that (K laughs) I went no. And it was them trying to find out, because there had been in the 6 month, there had been guys killing themselves, there had been guys killing other guys and they, and they feared a Vietnam type backlash ……And this was them starting to, but it was pathetic. I mean it was really they, they were struggling you know….. And I would not tell the truth, not tell the truth about anything that I've, because I seen it all, see them all as a weakness. So I did and it was only then that I started to think about maybe I am. Well I thought, I got away with that one because I lied, and I lied…And I never told them because it would affect my career. Or I thought. Or they would have said mental retired and you are out in the street. Now they would help you but they can only help you so much and you trying to get a job as a somebody who has been medical retired, it is a lot different.

Leaving the military

S: Yeah I remember you being and you were a wee bit nervous and upset with where we were at when I left.

K: The thing is you had security. You have a lovely wee flat that we loved, in Putney, em and all of a sudden we had nothing. We had a second hand suite, wedding presents and all that. It was all we really had, wasn't it. But we were happy enough. We didn't need anything else. Anyway when we got to civvy street you thought my god they gave you pots and pans and everything, they gave you everything, a bed. You know.

S: It was a scarey reality check.

K: Yeah.

S: But it was very important, because my illness, my, em, mental illness and physical illness. I wouldn't let anyone know about them because I needed to succeed. In the army it was bravado to get promoted and had to hide it all. In there, if I came out I wouldn't get the prison service job. I got the prison service job, started on the Monday, hated it, because I was 'Johnny right at the end of the queue' type of thing.

After Steve's probationary period the prison governor offered him a permanent position at '*a big nasty prison'*.

S: It was close to where Kirsty worked and everything and I thought I can put up with that location wise. And I said I would be delighted sir the only thing is that I am homeless at the moment. He said leave that with me. I will get that sorted and we got a house (K: a flat) almost straight away, didn't we? Anyway because of the riot ye got this special thing, where everybody gets paid overtime. It is all done, there is a system there right. So I am on £300 a month from the army. My first weeks wages £196 cash in hand. Bang. Second week £196. Third week this overtime thing kicked in from the riot £270 a week. So that took a little bit of the worry away from you (K: yeah)

I: Sorry were you giving your pay packet?

K: oh aye. The day we got married I put my wages in and he put his wages in. And we have been like that since we got married (S: yeah, yeah) Never, like you know what I mean. That has never been an issue.

S: So the point I am saying is Kirsty wasnae used to getting that much.

K: No, what happened, let me talk, right, when we moved in to this prison quarter we always said that we always felt that we didnae want to be in this position ever again because we wanted a place of our own, right, so…
S: Because we thought we could always find work.
K: We could always find work but we couldnae find somewhere to stay, so Steve said…
S: And the prison service was the same as the army.
K: If you retired or you lost your job or whatever, do you know what I mean? So we saved that year right. Steve worked 7 days a week, 18 hours a day, made amazing money.

S: But what I didn't realise is I was hell bent on a purpose, was to get as much money as we could, work the two minute silence to get, you know, to get and we got that first house…

Although Steve and Kirsty both agreed that Steve's job helped with his mental health condition there were still issues impacting on their relationship.
S: …it supressed a lot of the mental thing because I had things to divert the mind, you know. Then I became a manager, blah, bla, bla. And all of that without, knowing about it, actually em was good, because it kept things under. But it was bad, because it almost blew, when it did blow up, it almost went ballistic.
I: Were you aware of, sort of at the time, that there was supressing going on, or something wasn't…?

K: Aye I was aware of a lot of things like, he would have mood swings. There is no two ways about it, em, the nightmares, like I dealt with all that and he would be (K clicks her fingers twice) sometimes walking on a knife's edge.

S: I got a complete shock I think it would have been about 5, 6 years after I came back and you told me one night you've always been like that. Whit? She says you were like that when you came back and I says naw I wisnae. She said, Steve, I was nearly… She didnae mean away. I was at my wits end. I didnae know. What am telling you now is because Kirsty told me that I didn't know I was screaming in the middle of the night. I knew I was bed wetting that was it. I sort of knew I was drinking a lot (K: no, no) but no that much, Cinzano.

K: It was like cheap French, German Leibfraumilch and shite, you know, and that was, that's what we drink. But even that we wernae big drinkers.

S: No we wernae, but I was certainly drinking, no for the lovely bouquet and I remember making a cocktail of martinis up wi Cinzano and it was horrible. I was daeing it just to block it oot, but we all wur, but we all didnae say to each other. I, I don't think we knew what we were daeing we just knew that if you had a drink it stops it.

25th anniversary and beyond

In 2007 Steve was invited to return to The Falklands as part of the 25 Anniversary celebrations and the trip was the start of an unravelling of Steve's mental health.

On the trip,

S: eh there has been nobody back that had been up XXX (names mountain) and they're having difficulty filling in the gaps in the story and would I mind spending some time with him. They were so nice, and so good I said absolutely I don't mind. So when the main body would go to certain things I was going a different way with XX (name) and a couple of other people. We were walking up Mt. XX, so they are taking me up to Mt XX and that is where things started to woosh, right back to they days and I thought oh. And then I got really angry with them very, very short into the thing we are walking up and I cant remember the exact words but something like we know yous went that way, to do this and do that and I am looking at it and it is quite eh, standing out features that I could work out and that we never went that way. We went that way and I am looking and that and I thought I don't want to make a fool of myself, so I double checked and I says no, no, I am sorry we went that way. And this other guy questioned me, no, no, no in XXX XXX book Excursion to Hell or something, he clearly shows the route and I just went 'Well I will tell you now, there was me, XX, XX and XX and I never fucking seen XXX at any part of the thing, so I don't know and they sort of looked at me and I said if you bare with me there will be two trenches over here somewhere and you can still see. And they started listening to me. This guy was the author and he wrote about me….. But he hammered me. He was relentless as a reporter asking me questions, asking me, asking me. In a nice way but he was relentless.

On returning home Steve had a breakdown.

K: The day he came back he phoned me from XX Station and he was crying his eyes out and he says come get me.

S: Really?

K: And he says, you need to come and get me, and that just wasnae Steve. Come and get me, I need you. Would you come and get me? Do you remember that? And I met you at XX Station and I got time off work and I met you. You were sobbing for I don't know how long.

S: I don't remember any of that.

As a result of the trip Steve was put in touch with XXXX XXXX (charity for ex-service personnel),

S: ..he took me down to XXXXX XXXXX, Audley Court and they made a few mistakes to be fair. They, em, they caused, caused a problem.

K: That is when it started to go downhill big style.

S: Because they opened the doors and things started to come out and, but they never…

K: Never finished it.

S: They never closed the doors correctly. My doctor went ballistic when they came back because of what they had done, em…

K: He would go for two weeks and they would start treatment..

S: Too late.

K: And send him away. Yeah, too late. They sent him home and he was in a right..

S: Yeah.

K: He was an absolute wreck, you know, like all this time.

Steve's GP transferred him to the NHS.

S: They had problems as well because they couldnae..

K: They couldnae deal with it, em..

S: The military side of things.

K: I suppose now, now they would deal with it a bit better, but then they didnae deal every day with it. They dealt with mental health. They didn't deal with the trauma. Do you know what I mean?

It is 14 years since Steve was diagnosed with PTSD and almost 40 years since The Falklands conflict.

S: there are bits where I think it is the fatigue of it.

K: Yeah.

S: It is not new and it mainly surrounds when I wake up in the morning because and I am no kidding and this is the one thing I cannot dae is sleep. When you are asleep you are subject to wherever your mind takes you. You cannot stop a nightmare happening or you cannot stop a bad thought or whatever. I am ok, I don't get them as much. I do get them. Flashbacks during the day and things like that, but I was getting fits of rage. I was actually em, being self destructive by I was going into, making situations more dangerous than they needed to be for me. I would fight. I would start a fight with anybody no problem. Because I wasnae caring.

K: We were in a situation, I hated going out anywhere with him, because you would never know what was going to flip him. Do you know what I mean?

S: Yeah.

K: and you were..

S: but that wasn't me..

K: Naw, naw. He would argue with you and he was very possessive, no possessive, protective against you. I went for God's sake.

S: I know, I know.

K: But that is good now.

S: And I hate to say this (pause) but it is true, I was let down by a couple of organisations (K: yeah), no deliberately, but they were trying. They made mistakes.

One of the issues was that the couple described experiencing a lack of continuity in organisations with the individuals working with Steve.

K: aye and even the National Health Service, that XX (name), he was the latest one. He promised him the world and I thought, you know, I love you. You are going to get to the bottom of this and he deserted him within months.

S: I was allocated..

K: I was so angry. I thought, fuck, another one down the drain.

S: I was allocated 13 weeks. That's the truth of it. When we approached 13 weeks it would have had to go to special appeal to get, because of resources. I get that. I would have loved to shout my head off but maybe I, maybe I did present myself better and maybe they did thought I was.

In 2014 Steve had a new psychiatrist and described arguing with him about his treatment. Steve then decided to come off his medication.

S: I don't tell anybody, stopped taking them, ended up do lally, because I just stopped. Actually absolutely bonkers, you know, I know better.

IK: Did you stop them because you felt, 'I feel fine I'm stopping them' or was there something else going on?

S: No, I stopped them because they werenae working.

K: Yeah that is right (murmered)

S: I stopped them because I am still feeling shit, I am still getting the nightmares and I'm still doing it and I'm not taking them because I have side effects, wan of the side effects is to put weight on and all this sort of stuff (K: Yeah, yeah) so I went to hell with it I am not doing it, because they are no, I don't, they are no and then eh, I was going to say days, but probably weeks (K: yeah) things unravelled completely because I end up not only with the problems that I had at the beginning, I end up with the withdrawal symptom type thing of the (K: He came off the medication). So I take the medication regularly, all the time.

K: Only because I leave it out for him.

I: But I was going to say, how does that work in terms of, you know, when he came off his medicine. How did you feel about that?

S: She didn't know.

K: I didn't know, he was throwing them down the…

I: But when you found out?

K: Well by that time it was too late. Things had spiralled out of control because he was taking fits. (S: shakes) No he got rushed into hospital a few times. Totally delirious, unconscious, shouting, screaming, nobody, nobody

could define what was wrong with him. And this went on, the fits were really really bad. That was the worst.

S: And how many times was that?

K: Aw so many times. But then it built up and built up until he tried to kill himself. That is where the point came that there was no return. Do you know what I mean? And I never saw that coming. I knew it was bad, it was really, really, really bad. It was like…

S: I will tell you something…

K: And I hid loads because I never spoke to my sisters, I never spoke to anybody.

I: Was that the going missing?

K: yeah that was all built in, this was years of going to XXXX XXXX (national charity), going to all the things, getting it wrong, then having to reverse, reverse all the treatment and start again.

The couple describe ways that Steve now copes with his mental health, including the constant redecorating of Steve's media room, which houses his record collection and state of the art entertainment system.

S: Do you know my room? That is a therapy.

K: I swear to God, Isabel, if we are getting visitors he goes hell for leather and everything is perfect, (S: perfect) they are no even out the door and I mean out the door, right and he barricades himself in. He puts thing so that he can't, he empties everything out, he pulls everything off the wall. You have no idea

S: She says, what are you doing now? I don't know. It is no right. It is just for something to dae. I wake up thinking right I need to get that done the day and

that done the day. I am getting to the end of that thinking I want to do that, put it in order.

K: But it is only this last year that I have realised that that is his way of coping.

S: It is my hobby.

K: Yeah, yeah. And if that his way of coping, right and other things like cooking. He is really good at cooking. That is another way of coping as well. You know what I mean? (S: yeah) He is able to.

S: So between these three things and then William, then it is starting to fill the void and if you don't catch the void quick enough and then it fills up with bad things, you spend all your time greeting or dealing with the bad things and then you are and it spirals, and it gets a grip of you and it is like a vine, it just keep round and round and round. And you wake up, and I used to wake up thinking I'm sick of this. I've had enough of this. I do not want to go on. It is scarey. You think you are going to die. You think well, I am no gonnae take a chance and die in a bad way, I am gonnae dae it myself. And the brain starts talking to you. It starts saying 'they are talking a load of rubbish. They are lying to you. Look I've come back when they said I wouldnae come back and listen it is no as bad as you think. Think of XX (name) one of the guys that is dead now. It is all right, he is happy and everything and that's when you start. It is the bad and the good angel. But at the moment I feel, I feel alright.

K: I am, this is the happiest that I have felt.

S: My moods are fine.

Although the couple agree that they are in a stable phase they disagree on how much they should talk about their emotions.

K: You didnae want to talk about it with me did ye?

S: That has been discussed quite a lot. I refused, her and William were in bubble wrap, cotton wool and I would not let them feel anything that I was feeling so my defence was to..

K: Shut them out.

S: No shut them out, keep them away from the bad stuff and I was adamant that that, that is the way, right or wrong, 'cause there is good and bad. I just didnae want them to worry and eh feel some of the rubbish I was feeling. You think it was contagious.

K: Doing that was probably the worst thing he could have done. Because he shut me out and William, but you only done it to protect us but that didnae. That is what made it worse because we couldnae air our feelings. We couldnae talk about it because it was a no go area.

The couple describe that things have settled again now. However as Steve describes some of his mental struggles it becomes apparent that the couple are still impacted by the experiences.

S: So that's the things I battle wi whether I am right, some days I think I am completely wrong for what I did. Sometimes I'm, I'm completely wrong. I'm either completely wrong because my guys got killed or I'm wrong because I killed they guys and I then battle with myself to say (pause) if, if he'd have run at me like that and I shot him, I could square that box off, no problem. There was wan, two it was debatable. I didnae give them the chance. The point what I'm saying after the first instance and people say to m,e but you were quite right to do that yeah, but it doesn't make ye feel better. Being quite right

doesn't make it right in your mind you know and that is the fundamental. Now what happens I wake up seeing their faces during the night. I wake up. She'll know better than me, she has to bring me back to the here and now because I am gone. My hands, I keep rubbing my hands……

K: My new tactic is he is always fighting right. He is always like holding his head and stuff. I just take his hand now and I put it down and I hold onto it for a couple of minutes and that seems to calm him down.

S: The other wan, the other wan I, I come round to the first thing I remember all the time is, is Kirsty. It is the first time I recognise, but she has been saying that for 3, 4 minutes, it's Kirsty, it's Kirsty, it's Kirsty (K: yeah) I don't know that, I just hear this voice. Sometimes I in my subconscious, oh fucking hell (laughs) but you know what I mean, oh fuckin hell, but no and I do …oh fuckin hell, I'm back, leave me alone (K laughs) and then it triggers another set of emotions because then you feel depressed, then you feel anxious, then you feel vulnerable, then you feel weak, then you feel all these things because of this happening and then you feel it's happening too much, I cannae take it. It is one of they things that's the rest of my life and that's, you're no able withoot the help of the, the various things de de de (K indistinct) that em you are no compartmentalise it and keep it. So my problem I keep saying to them I am pretty much experienced. I don't think there is any new nightmare I'll get from now on in, it's all a variation of the same.

Steve has XXX XXX, another specialist national charity, that he can tap into if needed, but the biggest thing is Steve's own regular gym activity, which he believes is supporting positive mental health.

The couple reflected on what had made their relationship work

K: We have always kind of stuck together really, through thick and thin.

The session ended with Kirsty simply stating,

‘We are still here.’

James and Eimear's story

Introduction

Eimear is 34 years old and James is 35 years old. They are both white. Eimear is Irish and the youngest of 4 sisters. Eimear describes her relationship with her parents as good. James is from the North West of England. He has one younger brother and describes his family as challenging. They met on holiday in Spain in 2016 and have been together as a couple for 5 years.

Eimear is college educated and has a professional qualification. She has good career prospects.

James describes wanting to get away from his local town as his reason for joining the army. James was 17 when he joined the military. He served several tours in Afghanistan before being medically discharged with PTSD. James has a son who is 6 years old from a short lived, sexual encounter with a local girl. James tries to see his son every other weekend and provides financial support. However his relationship with the mother is not amicable and James also described being pressured by his own mother to maintain the relationship.

James and Eimear are currently living together in Ireland. The couple's experience of living with mental health issues has been an integral part of their relationship from the day they met.

J: We met in Spain, didn't we?

E: mmhmm

J: Eh, I was open with Eimear from the start. Not about where I was or what I was doing, but I knew by this point that I was going to get discharged.

E: …em, I knew, James was very open with me from the get go and I knew, I saw the signs and the triggers very quickly. Em, even those first couple of days that you know we were on nights out, er, and things like that. I would very quickly pick up on loud bangs or his reaction when I suppose, like a chair moved, the loud bang of the stool that fell on the ground and I knew he was on edge all of the time and that kind of thing.

Leaving the military

James describes his transition out of the military being a long process. He was taken out of his Special Forces role and returned to his original regiment. He was then transferred into a Personal Recovery Unit (PRU) and received a diagnosis of PTSD in 2014.

J: They said it was to focus better on treatment, but really you were left in your room kind of thing. Em, I was told to go and see a CPN once a week. Now that, that to me is the worst thing you can do to a soldier because any free time you get in the barracks you are going to go drinking….So any problems are just spiralling because you are not dealing with the drink and things like that.

He was finally discharged from the military in August 2017. Around the same time, after a few months of having a long distance relationship, Eimear moved

from Ireland to the UK in September 2017 and she and James began living together. James had found work through an ex Sergeant Major who had reached out to him with an offer of contract project work and Eimear had also secured a job.

First Job

The backdrop to James and Eimear's relationship is punctuated by the 3 jobs that James has done after leaving the army.

E: we were on cloud nine I suppose initially and then James had started this new job that with the army, eh ex-army, em, but then I think things started to go a bit pear shaped for us. There were a lot of, I suppose I was homesick, I was away from any sort of, I wouldn't have spoken up about things to family and friends because I kind of didn't want to, you know, I suppose …

J: You didn't want to worry them.

E: I didn't want to worry them and I didn't, they wouldn't always necessarily understand either you know and I didn't want them to be forming or being judgemental or opinions or anything like that until they had got to know James for themselves and all that kind of a thing.

James had begun attending EMDR sessions, which had been arranged by the PRU.

So I got sent to a woman who is an ex-soldier, now she kind of, well she personally, she weren't for me because she would still speak to me like I was a soldier. Now they already had stripped me of all that, so I didn't want to be spoke to like a soldier at that point. You know and I kind of said to her, she

literally said I don't have no, I'll say it how it is, which I respected, then all of a sudden it was I was a this, I was a soldier, I was a that. I don't care what you was. You are there to help me with this treatment. Help me with that not your army career.

J: Yeah, so eh, we started of session one kind of thing it was just her talking at me about this kind of thing. So I was kind of a bit intimidated at this point, because at this point all my self-confidence was gone eh. She was like don't waste my time on this, so I kind of felt if I don't perform on this it was like, it was exactly like what a senior soldier would say to you kind of thing. Don't waste my time, so she said I'll go, it is going to be, again might work for other people, but for me it was terrifying me because I asked, I still hadn't yet spoke about the trauma. Everything was just trying to get me stable. I had never once spoke about in the year and a half, I never once spoke about it. The actual trauma. So all of a sudden it was don't let me down and off you go, kind of thing under this EMDR treatment which is totally new to you. So I started trying on the day one and eh, well day two, the second session and I just kept going into a bit of a shock kind of a thing, a bit of a eh, it was right obviously, you are not ready for this yet, kind of thing. I was like well give me a chance it is the second, the second session…, but from that I was getting straight in me car, driving 110 miles, 120 mile an hour just (makes a swoosh noise indicating speed) down the motorway straight to the nearest pub with my mates. 'Cause I just could not hack it and then that was leading to a bender.

J: I think at this point this was when Eimear first started seeing the benders (E: mmm). Eh, which I was obviously hiding because, things like that we were living apart in Ireland and the UK, so it was easy for me to say I was going out with mates every different night doing this, when I was just on a bender.

James was trying to get support but was being passed between organisations as his needs were too complex.

J: Talk XXX wont do anything, cant touch me, too much of a risk. No, you need to see a psychiatrist. This, this rumour I would say it was, of being military, you get the help quicker. I have never got a single bit of help quicker. You know that period in XXX I was waiting what, up to a year, bounced around. We can't help you get the treatment you need.

Eimear describes how difficult she found it to live with James while he was drinking with his friends and that triggering blackouts.

E: I couldn't deal with the blackouts. I couldn't deal with the, I couldn't deal with James. I didn't know what to do. I didn't know what the right thing to do was, what the wrong. Like some days were fine, some weeks were fine, but the minute something would go wrong, then that was it, I lost him again. And that is the way I would always describe it, that I lose him. It is like I lose him. It is like a totally different person and then what happens if James has a lot on his mind, or he is out with ex-army mates that were bringing up, they could be laughing, joking about a story or something like that but for James it is triggering away, it is starting to bubble in his mind and then next thing there is alcohol involved. I could be there with him, like, I could be drinking as well and

then he blacks out. But he is fully functional when he blacks out, which is obviously really, alarming em and I think as a partner that is very difficult to watch. em, because I think that I know now what it looks like and thankfully it hasn't happened in a few, I don't really know when the last one was at this stage, but that is a good thing. Em but, you know we could be sitting in a pub and having a great night and you know finally things are really looking up for us, next thing it could be a song a band could play, a loud bang in the pub, too many people in the pub, eh, a situation where James thinks something is going to kick off with another group of people who have nothing to do with us, but he is constantly on high alert and watching and then the next thing it is like a total change on his face and on his eyes, everything and it is like he doesn't even know who I am in front of him and he is flicking back to maybe, how I would describe it and I don't know if this is it or not. It is almost like maybe a bad previous relationship and I am whatever hurt that girl might have caused him. That's me sitting in front of him and he is saying things that don't even make sense. Em, I am trying straight away to sober up because I have to, but then it is like how do I, how do I get him into a taxi and get him back home behind closed doors where he can lie down and if he wants to go mad at home, he can do. I know, I think I know he would never hurt me physically or anything like that thank god, but it is, that is not even my concern. My concern is for him, em and then it could last a couple of minutes, it could be half an hour, then he would come out of it and he is extremely emotional and upset and we could be standing in the middle of the street you know. Em, there's been times when we were living together when we would come home from nights out and we could be gone to bed, asleep and next thing James would

have left the house, gone off up the road, just wandering up the road or whatever and like you are constantly on high alert as well. You are kind of, and this was I suppose, I just wasn't used to this and next thing it was all happening and you know, like you just kind of have to learn how to cope and learn how to go with it. But you can't talk to friends and family because straight away they would be like you should leave him. And they would, that's, they're only going to be thinking of me. Em, but,

I: What's it like for you to listen to that?

J: It is hard. It's hard.

Eimear described being homesick and reaching breaking point.

E: I had gone to visit my family…, when I came back on the Sunday I knew. So over time I have gotten to know, to spot the signs and James wasn't coming back to me. That Sunday when I was due to fly back, I wasn't getting a response to text messages. I could see he was online, he's avoiding my messages now, em he was due to pick me up from the airport that night and em, I think when I was at the airport or something you contacted me and I know the names of the people when he says I am drinking with X or I have gone for a few, but he would always play it down, but I'd know dis is not good and here we go now, eh and he sent his brother to pick me up from the airport that night and no sign of James. It was actually, you were going drinking with (J: my cousin) your cousin. Em so I went back to the flat on my own. I was devastated because I was like he is gone and you know like James would never be like that, do you know what I mean. He would always come and pick me up from the airport. I just felt so, you just feel so like, I suppose you have

the relationship side of it and you have, you keep constantly remembering this is not, he doesn't mean to do this. This is not James, but that is very hard, really, really hard, em . I am getting emotional now and I shouldn't (I: Yeah, I know. I am feeling the emotion as well, for both of you) em, so..
I: It is alright. Just take your time.
J: Yeah, this is the start of the absolute breakdown, in between… I suppose. Obviously this weren't just the one incident that led Eimear to the decision she made. She had had enough, I think.

However Eimear describes how she was not ready to walk away from the relationship.

E: Em, so we started to do the long distance again, (J: yeah. I had been, I had been) he had been very bad. (J: I'd let go from work at that point) Yeah.
J: 'Cause, it weren't actually nothing to do with being on a bender or anything like that (Eimear sniffs) The snow had fell bad, em and when it fell down, we weren't allowed to drive in the snow, because you needed your own car. So they kind of cancel all your appointments. Eimear's left again (sniff) so starts drinking.
E: I think though you had a few incidents where you hadn't shown up to work as well though. There was a few, they were putting it down for sick
J: No, no, not really. Not with them. It was because I was rearranging my own appointments. Me head was going bad because I was rearranging appointments, things like that.
E: To suit the Sunday night drinking or the eh, yeah

J: Well I had the Monday admin day and I just weren't doing any admin. Eh, I ended up phoning me boss and saying look I am really struggling at the moment. I am having a bad time. (sniff) I had kind of let them know, some of my work colleagues, what I was going through. I was very guarded about it, kind of a thing and, I would, because of the change of meds, he turned round to HR and said James XXXXXX is off this week. Cause he basically said to me, take the week mate, you know what I mean. Like my figures were better than anyone else's, kind of thing, so it was I know you are not going to pull the wool over our eyes (sniff) eh, so when he, HR had said why, why is he taking a week off. You know he has got PTSD and it was the first time he mentioned the blackouts, which we haven't mentioned yet, eh so they have gone, what, he blacks out. He's driving on the road, he is working on his own…

E: and going up ladders and stuff.

J: Yeah, yeah, going up ladders, so we will have to end his contract. Now I didn't know about this. All I knew was that my laptop had been turned off

E: So again.

J: I was trying to check e-mails and was thinking what is going on. Has the system crashed? So I phoned me colleagues and no one would answer the phone to me. No one would speak to me. And that, that, it was the repeat of the army. So I was just getting the paranoia. Everything was just getting coming in, sinking. Eimear had left. You know I was just heading for an absolute disaster then.

E: And no support, really, you know (sniff).

J: And so I was still waiting for this counselling and support.

Second Job

Through the same army connection James was about to start a job in a different part of the company he had been working in before. However this time it was not based in the UK and there was a lot of travel.

J: Yes, it was September for this job kind of thing. Now I had had about 3 weeks work on an install project off them, where and I think it was them kind of testing me to see if I was ok and whatever. I was on these meds and I was you know, super happy and hypo kind of a thing, which again was getting ready for the big dip. Em, but again, you know I was kind of lying to them saying everything was ok when it was far from it kind of thing. We were still going through the exact same thing.

Eimear describes the stresses of trying to maintain the relationship at this time.

E: So we were long distance now, so I had a total awareness of …what James was like now having lived together, to now being back in Ireland thinking about him doing all that stuff in XXXXXXX. And now it was turning that it was just over text messages. So that would be it I just wouldn't hear from James. He would go on a whatever day and that was it, it could be a day, it could, I suppose the longest was a week and a half through the summer and I actually thought I was going to lose my mind. I had, I couldn't talk to my parents at home about it because I was trying to paint this positive picture of James again to try and get things back on track and you know it was honest to god hands down the worst year of my life, like it was like I

couldn't, I didn't know what to support him, nothing I did was right. Like nothing I did was, not that it wasn't right, but that it wasn't enough.

E: I feel like I am over here living a relatively normal life and I have all this going on and I am like, why can't you just go out have a few drinks and have your time with your friends and come home (James sniffs) but that is where he can't stop. He doesn't know when to stop and then he is blacking out and then my biggest concern is that he is not there with people that spot this or even care, em or want to look after him. And then it just goes from one thing to another thing, to another, to another and for days until he finally comes out of it himself (J: mmm) and then he is a different person. And then that is another strain on the relationship because for me it is a trust thing as well. It is just so hard. It is very difficult you know and I can't talk about it to family and friends.

James described the job as having no structure or routine but being fantastic money.

J:…the pressure was starting to build in the job. Because of the no structure and a constant. Emma was constant we need to see each other, we need to see each other, we need to see each other. I had that pressure on me all the time. I had me mum massively pressurising me to see me son. You know, you need to come over and see him and I was like for fucks sake. I am trying to fucking deal with this. I am trying to deal with this. I am trying to hold this job. Lose this job, (sniff) I am not going to get another job. You see, now in my head no one is going to have me because of this PTSD and the severity of it.

At least I am back where they understand me. And again it weren't good, because they didn't understand it…so it was building and building and building….

After an incident on a business night out, where James blacked out, the company agreed to pay for him to see a psychologist privately. However due to business demands James was unable to attend regularly and stated that he began to feel that the offer of help had been an empty gesture.

E: 2019 there were still the benders and the different ups and downs and I suppose it will always kind like as James would be due to come to me and I'd be saying oh my god he is due to fly over, my parents, my family know he is coming. I have my friends know he is coming and I cant get in contact with him. Due to fly tomorrow, this is the kind of thing that still goes on like up to just before Christmas not knowing was he going to be on the flight tomorrow because there has been no contact from him and that is just the way it has been and that is probably the hardest. It is very hard, like. I don't even know maybe it sounds basic, but when you are living it like just this constant state of uncertainty. It is totally outside my control. I cant you know. If I am going over to him, I have control over that, even if he is on a bender, I can still make the flight and go over to his family home and put on a front here and cover it all up. But if he is due to come to me, what do I tell people if James doesn't show up. I have had that. I had that at the end of last year where I had to say, oh something came up with his son and he had to. You start, you go in to a spin of lies with it because you are putting on a front you know, em because I can't

be telling, I can't be letting people know because I know for a fact that they will say this is all a bit too much.

The Christening

Things reached crisis point when James travelled to the UK for the christening of a friend's son. After a hard week at work and a long journey James describes just wanting a meal and some chat.

J: And it was kind of, oh god this is going to be a two day bender for me. Because I know what, I am sat with two lads they have got PTSD. They are my mates and when we get together, we do drink.

On Monday morning, under pressure at work and frustrated with his colleagues James shouted aggressively on a conference call. Pressure continued to build as his friend, hung over and wanting to go back to bed, dropped him off at the wrong station making it impossible for James to catch the connecting trains to get to his work later that morning. James last memory is of getting on the train.

J: I woke up in a field eh nearly 24 hours later with a really good Samaritan, civilian kind of a fella, coming home from the pub. This fella found me in the field just speaking absolute gibberish.

E: But he had rang me so this was just like a normal Monday evening. I had come home from work. I was around my house doing normal things and thinking that James was on route back to XXXXX after the weekend and I knew something was up, but I said look ok leave it off, you know the next thing I get a phone call, but the thing is when James has a blackout, he slurs

when he is talking. He has kind of got a yeah. So he rang me and I was kind of like hello and you know, yeah I am in a field. So I am on the other side. I am like what James? Who are you with? Who are you with? And you are trying to like ok figure out what is going on. What am I going to do? How am I going to help him? You know and I cant like, but em he is like I am in a field, I am freezing with the cold. I am absolutely frozen and I don't know where I am Em, I'm scared. You know it is the anger then that builds up in me because I'm like you've put yourself in this, you've left yourself open to this potentially happening because of the boozing and the friends that you're you know with. I obviously didn't know the background at the time what had gone on at work and all that.

J: Yeah, yeah. I wish I had put myself. I'd only went to a christening, I still got to be able to do them things, you know, so that was not the time to be angry where me and Em fall out then. I was like let me get out of this situation before you pile on this, because Eimear can be very de,de,de,de,de

E: Because I am in a blind panic.

J: It is now gone from me boss, me project manager, me friend dropping me off to now Eimear giving me, make me even worse. Just wait. Don't drill it then. I think that is where we have a breakdown, so to speak. And then I end up in hospital again. So what did they do like NHS service kind of thing, give me one Diazipam and put me back on a train.

The second job ended similarly to the first and his contract was terminated

J: Exact same thing, no couldn't log in. So I knew I had been sacked again, by a laptop. Contacted Mick, I cant get into my Laptop. Oh, I don't know what..I

said Mick don't bullshit me mate. I said this is exactly what happened the last time. I don't know anything at all. Let me chase it up for you. Someone I am supposed to absolutely trust and then I got a call of this agency that I was kind of contracted to saying yeah, they have decided it is best to terminate the contract so that you can get the treatment that you need. It was just like, fuck.

E: So I suppose we had come so far in the line of rebuilding things and you know it was, it is hard to take like when we you are trying to plan a potential future, a house, a mortgage, this that and the other you know it is hard to take and I suppose he has lost another job and you'd be thinking Jesus God how are we ever going to be able to find a state of calm.

Move to Ireland

The couple began discussing how a move to Ireland might work. After his blackout and losing the job James became suicidal and was seen by NHS mental health services in his local area. He was re-diagnosed with complex PTSD.

Eimear reflected on the impact James mental health issues have on them as a couple.

E: It is never going to go away. You worry I suppose and I wish, and I don't want to get emotional again because you know, but I suppose I think of things like if we were to get married, in the morning coming up to a wedding would James be triggering? Would he be able for the day? Would he be able for the pressure of the day you know, because he would have been in such good form and so high and so delighted that then if he started drinking on the day of

the wedding would he be, blackout? Would he you know, would something like that happen or you know, it will always be a worry.

James is currently waiting for a decision on payment from the Armed Forces Compensation Scheme and depending on the outcome would give the couple some financial security. However they describe their experience as having been difficult.

J: I have had an absolute, humiliating nightmare with. You know Personal Income Payment that has absolutely degraded me like kind of thing

E: I think the thing is with these processes is that they are not designed considering they are processes designed to deal with people with PTSD they are not designed for, you know, they are not simple, they are complex. They are everything that would be winding a person up on a normal day. Not a mind, or highly strung or having a bad day or whatever.

However James secured a job in Ireland and moved in with Eimear at the beginning of the 2020.

J: I was waiting for Eimear at the end of the day, this is the other, this is a couple of days ago and there is no other place I'd rather be than that job. I just had a lovely feeling of going home, works going well, I'm with good people there and there is no danger. Even though I constantly feel that there is

E: And that'll always be with you really, you know (J: yes) even things like, even things like…..when we moved in to the new apartment and I was saying what side of the bed do you want because, before, like I was putting my stuff in the drawers or whatever. He was like I'll have the one nearest the door

because I have to be there. I should really be the one closest to the door and I was like what? And he was like just if anyone ever broke in I'd be the one to jump out first. You wouldn't get hurt, you know that kind of a thing and it is just things like that, I think, you will always be on (J: yeah) high alert and you know that kind of thing. I don't ever thing that's going.

The couple share their reflections on what makes them get through the issues they face,

E: We've been through an awful lot in a very short period of time, yeah that's for sure. Em, its been rocky. I would 100%, they say opposites attract. We are definitely very opposite (J: totally) in many ways but then we are very alike in other ways, you know. I am very OCD with things. I'd say that myself and we probably fall out in ways because we are similar in that do you know what I mean. We clash on things but then at the same time, I don't know I suppose I am a lot em, I am not a party, like I am basically the very opposite like I don't really know what brought us together really (giggles) or how we make it work, but what would you think James?

J: Love. Yeah, yeah, I love her to bits.

E: Em I suppose maybe the fact that I am a little calmer you know I think I probably, I dunno, I think he…

J: I disagree with that (laughter) I totally…

E: I mean calmer in the sense of I wouldn't live, em, I wouldn't have lived a life of partying or going off the rails, or I am very em you know. I don't know what I'm trying to say. Maybe we balance each other out a bit but I think it was from

day one really. Yeah it was love and I suppose you work through the crap and the hard times for that and I suppose and we do…..

I: Does that, does it get emotional for you thinking about you two as a couple?

J: Yeah, yeah. Massively, yeah. I think it is because of, 'cause I've caused a lot of damage as well and if it weren't for Eimear we wouldn't be together, because she has picked me up and kept us together kind of a thing. Where 'cause I was that low when we split. I think eh, I, I didn't have the strength to pull us back together, and things like that, but Em did. So that's why I get a bit upset.

Mike and Karen's story

Introduction

Mike and Karen have been a couple for 6 years. They have both been married before and have children living with their previous partners. Mike's marriage broke down after he returned from deployment. His mental health issues contributed to the breakdown of the relationship. Mike described waking up one night to find himself with his hands round his then wife's neck and he was trying to kill her. This incident persuaded Mike that he needed help and he went to see his company commander, who arranged for him to be seen by a doctor. Mike received a diagnosis of PTSD in February 2014.

He moved out of the family home and onto the army base. However the marriage ended when he discovered that his wife was having an affair.
It was after this that Mike and Karen met online and began their relationship through speaking on a chat room and then phone conversations.

Mike describes his mental health issues,
M: I had been denying it for a long, long time, em there had been quite a few horrific instances in my life to be honest, em, and I had just shut them off. I didn't want to deal with them or anything……. After I came back from one of my Afghan tours, I did start drinking very heavily, em everything like that. I was hiding, the blokes were covering for me as well, as they do, em.

The path to medical discharge

The couple had only been dating for 4 months when Mike had a serious breakdown. Following his return from what would be his last tour in Afghanistan Mike described being transferred out of the regiment to another role. He was away from home and his social life revolved around heavy drinking.

M: I was having quite a lot of violent issues at the time, em, I had been arrested on the train for beating someone up. I had also been arrested in Tesco's.
K: Escorted out. You weren't officially arrested. (laughs)
M: Well but I was arrested and then released without charge after I beat someone up.

Mike returned to the regiment and was attending Anger Management class and a regular mental health appointment.
M: I came in as Platoon Sergeant and even though I wasn't that rank. I was acting and they wanted to leap frog me, and they saw me as the vulnerable state that I was in and they jumped on that bandwagon. But things just snowballed and snowballed and I had had enough. I was just ready to end it all. I ended up in XXXX Mental Health Hospital.

K: I got a phone call from XXXX saying Mike has had a massive breakdown while he is in for his appointment today, could you possibly take him over to

XXXX where he got sectioned for his own safety for 14, 15 days I think he was in there.

M: I needed to get out of there, em but the army wouldn't release me into their care. They wasn't willing em so I was stuck there. So Karen, I don't know why but she….
K: Because I am stupid. (laughs)
M: she em she signed a waiver said she would be willing to be released in her care, em 'cause she knew it was just not doing me any good there at all.

Mike was then told to go home to recuperate by his boss, which was difficult for Mike
M: Em they basically says go home and I didn't have any contact with anybody for about 8 months. 7- 8 months.

Karen describes the lack of support during this period as 'ridiculous'. Mark could disappear for 12 hour '*off in his own headspace'* and Karen feared for his safety. This was the second breakdown that Karen experienced with Mike.
K: ….he generally had no concept of where he had been but at this point it was a couple of days later that the army welfare officer turned up and said you should have rung us. He is actually classed as a vulnerable person because of where he was sectioned and cause he was a risk to himself, not to other people, to himself. You should have called us first, and I went and you told me that when.

Karen described finding out that the Welfare Officer who was supposed to help Mike with the PTSD, depression and stress, had been signed off with similar issues.

K: The commanding officer at that time just went not my problem, we'll leave somebody else, because he had been shunted so many times they all went not my issue and we were pretty much left to our own to deal with everything and like I say, it was like hindsight six months after he had been released we found out what he should have been doing and none of it happened……..you know the army, the higher up very much went (makes hand washing gesture) and it was sort of like Karen has taken over the role.

K: And then we got called in for medical board, about a year or so after, it would be 4 years this month and em had to sit down. So we were kind of expecting the decision to be that of medical discharge because he had been off the best part of 11 months by this point. So we were kind of expecting it.
M: But it was still…I do, I didn't want to leave the army 'cause it has been my life for the best part of 21 years and I, it was, I enjoyed it. I was good at it and then they told me no mate, you're done.
K: Cant even, not even be a reserve for call up or anything. Just no.
M: I didn't know what to do with myself, so again I spiralled down hill again
K: And again there was no support then. There was just literally xxx (M: Yeah) on the occasional visit wasn't there.

Fresh start

The couple decided to move further north to be close to family and Mike's children, as his ex had moved to the northeast of England. Another reason for the move was that living in and around a large army base with firing ranges and a neighbouring air force base provided noise stimuli that could bring on panic attacks, increase stress levels and trigger blackouts in Mike.

K: …unfortunately XXXXXXXXX (the city they moved to), in hindsight not the best move. Very, very large numbers of foreign people, which is not in a racist capacity, but having seen the stuff that he had seen, is quite a big trigger. He became very reclusive.
M: And there was, the trouble with that is you have got things like Divali and that with all the fireworks, which caused me a lot of grief….

K: But I had kind of had a bit of a breakdown of my own, trying to keep Mike on the straight and narrow, keep him focused, keep him doing stuff, trying to work fulltime, running a house full time, having kids at either end of the country…..and I kind of neglected myself a lot and it was the realisation hit that I can either carry on spiralling down myself or I make the decision to basically get made redundant from the company I was working for and be there for Mike. That is what he needed to get him to appointments. He lost his driving licence. He had a bad crash up in Scotland.

Mike describes the accident that happened while he was doing a charity motorbike ride:

M: Yeah it was em I have had a lot of flashbacks and blackouts in the past with em with the incidents I have had, but me motorbike was always my safety blanket. Know what I mean? Put my stuff on and I can just clear the world out of me head, but on this occasion, I em, I just had a total blackout. Em, my cousin was on the bike behind me. He says I was going down this road, weren't speeding, em, I just ended up on the other side of the road and nearly cut this car in half, didn't I? (K: mhm) and they, everyone thought I was dead…

Mike could no longer drive:

M:…*the doctors all said now that is you done mate, kind of thing, which was one of the more difficult things to lose actually. My bike was my baby, weren't it. Yeah. And that just took another leg off me from underneath which was harder and harder.*

To get away from the noise in the city the couple described moving in to a cottage on the site of Mike's grandmother's business. This was agreed by all the family to be a positive move as Mike and Karen could help the elderly grandmother with the upkeep of the site, but also provide company and care for a frail relative.

Karen describes the benefits of the project for Mike:

K: He was able to work, he was working under his own steam he was doing occasional interaction with customers on the touring. So he was slowly getting better with dealing with people in public eye but could quite easily go and hide in the house if it was too much. It was the best of both. He was sort of like his

own boss, loads of jobs to do because it was quite neglected lots of physical work. Like I said Mike was really coming on leaps and bounds and then it was just the social side of the interaction that we needed to get.

Family conflict

Mike and Karen describe how optimistic they were feeling that things were finally working out for them. They started to plan expansions to the business with the agreement of Mike's grandmother. However an acrimonious family dispute with Mike's uncle, resulted in the couple having to move out and losing what money they had invested in the project. This was a bitter blow for Mike.

M: Yes, so I again spiral down hill. I was, wanted to take me own life, but the local mental health team, crisis team got involved, didn't they?

K: Yeah, I called those because it was so, and this was not military, but it definitely didn't help with everything that he had already gone through and the large amounts of medication he was still on and everything like that.

Karen acknowledged at this time that the military were really helpful and managed to secure the couple temporary housing before they moved into their current home.

K: Mike's Welfare Officer who was an absolute fantastic chap and he happened to speak to the local council because we were going to get put in to a hostel, which would have been absolutely awful for Mike, shared entrances with people you know.

Layers of trauma

At this time Mike started having regular appointments with a national mental health charity specifically for ex service personnel

K: When we moved to XXXXXXXX we had to reapply to the NHS obviously because we had moved districts and there was a 22 month wait through the NHS for mental health assessment and that was with him being fast tracked for being ex-military and XXXX turned round and said let me speak to XXXX XXXX…….which I then think in hindsight has been a massive (M: yeah) benefit for you hasn't it

M: mmhmm

K: Hopefully you will be getting signed off soon. (Speaking very gently) He is back, he is allowed to apply for his licence once again, so that will start back in real life and he is allowed to, he has just applied to be em Instructor at the army cadets (M: yeah) so he can start back doing work

M: If, if voluntary work works for 6 months I can start part time work. Yeah. So I am way on my way to recovering, its just been shit getting there hadn't it

K: yeah.

I asked Mike what had been so helpful for him working with the mental health charity

M: It has been a progression of things. I had, I hadn't thought that the things that had happened to me in the past had done as much mess to my head as they had.

I: Is this pre military stuff as well as military?

M: Yeah, yeah. Em in the past before I joined the army I joined, well the week I was supposed to join the army I got stabbed, 13 times and my fiancé at the time she was killed em I think that is when I started not caring. I started just lock it away em I had quite a lot of big issues on tour. I got trapped in a burning building, em while I was and that started a lot of issues off. I also got blown up in Afghanistan. I had quite a lot of my company was either injured or killed and some among those were very personal to me.

K: XXXXXX XXXXX (the national charity), from my opinion, looking at how they have treated Mark, em, when he was with the NHS in XXXXXXXXX it was very much about dealing with his symptoms and how he is dealing day to day. How to deal with panic attacks, you know, those sort of things. Whereas XXXXXX XXXXX (the national charity) have gone right back.
M: When he was shot, I went forward and got him em as I was bringing him back and there was a large irrigation ditch em I jumped over. The blokes passed me him and I dropped him in this ditch and I fell on top of him and that caused me, (sharp breath in) sorry, that caused me a lot of upset for a very long time and I was just denying it weren't I, sorry (visible tears and upset)
K: Because he was blaming himself because to use Mike's phrase that he has used in the past, it is my fault, it is my fault and because at the time he could hear people calling for the medics, calling for the surgeon he assumed he was still alive at that point. But it is through the contact with XXXX XXXXX and the Welfare Officer, with the family that have been able to go through and say he was already gone. There was nothing that Mike could have done that would in any way shape or form that would have saved him and that, and that has

been for a long, long time, even when we were first met there would be times when Mike would get very, very down and he would be like and I have always been with Mike not, I am not asking questions. When you are ready you can talk to me. You have had enough people telling you everything and whatever. Your time in the army and that has caused you to be here, I don't know that and I'm not going to intrude on your memory but when you want to I am here to a certain extent it kind of, I was kind of helping him stay within himself because I wasn't asking him to I wasn't trying to extract the information because I was thinking it was better to leave well alone to a certain extent. So in hindsight, but it has needed the professionals to extract the right information and get it and help him get to where he is now. But like I say that one was major, major blocking point for him. Mike that was a lot of the nightmares (M: Yeah) the sleep terrors, you know Mike could regularly go on an hours sleep for six, seven days at a time. So you know, from a personal point of view our relationship started of really close and then after he had moved in and the medication started to wear off when we got to another point we work opposite sides of the day because he was scared to go to sleep because by going to sleep he had that would be when nightmares would happen and that would be when he would get the reminders trying to strangle the ex-wife, not wanting that to happen em and then I'd be up as he is trying to go to sleep and he is doing all that. We were almost like living opposite lives and just passing and that sort of thing. So that got difficult.

Plan for the future

At the time of my dialogues with the couples it had just been announced that the national charity had lost NHS funding and services were being cut. I asked Mike how he felt about losing this service.

M: eh, I don't know to be honest. It would be nicer if there was a safety blanket there for me. But like we said I am, have made leaps and bounds, am ready to start doing some voluntary work things like that myself, so it is almost that natural progression anyway where I would be cut back on their services and everything.

Karen took a similar position, but revealed her continuing concern about the situation.

K: So we are trying to look forward. There is the possibility of a relapse or whatever I don't think, he is never going to be better per se. He is never going to be the person that he was as such because he is a new person now who has dealt with that and got to that stage, but that sort of like let's not try to think too much worse case as it does have to go back to the NHS and back to 22 month wait. That is quite a scarey thought for me knowing, eh sorry sweetheart, knowing he has got so far and if we have a bad few days or one of the anniversaries it could just start the spiral and they are not there.That for me is quite worrying, is knowing where do we go then.

M: I don't think it has helped as well, I have been having a lot of issues with the Veterans and fund em (K: compensation) compensation. It's been a constant fuck around.

K: Massively.

Both Mike and Karen described their frustration with the process

M: Em, my issue is, if it was a physical injury like some of my lads who have been physically injured at the same time, there is your money lads, crack on. Thank you very much.

K: But because it is up here (points to head)

M: They just keep saying oh we'll

K: We will reassess you in a year. We will reassess you in a year. We are currently at the stage it was supposed to be due for reassessment and in October of last year they are still reassessing it…….Mike has said on more than one occasion if I had lost a leg we would be able to have a plan for the future as opposed to come back in 12 months, come back in 12 months.

M: …even when I spoke to them when I was being made homeless. I said look I am in a mess here and you owe me some money. Help me out, I am being made homeless. Em, well are you dying? No. Well that's the only reason we can do anything.

K: The only way we can jump your claim forward from your routine assessment date is if you are diagnosed terminally ill or if you have died. They will not, so even though all the paperwork says, if you are suffering extreme financial difficulties contact us, when you contact them there is nothing they can do.

Mike and Karen have different perspectives on the role of the military in support. Mike describes society and 'massive charities' to be at fault and not the military. He states that they say they are there to help everybody but questions what they can do to help him.

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M: …the areas they've got, but not everyone can get to those areas….now if I need help, they have got this big place in XXXXXXX, or whatever. But I cant get to XXXXXXX. Em and also there, it is very difficult to go get help from them, unless you are their poster people, like they have got all these photo shoots with people with their legs and new robotic legs and everything like that but…

K: You can have a physical fix, as if to make things better. If you have got a chap who has lost his leg you can put a ramp in, you can do, you know, you can sort out a mobility car, you can sort out rails and you know full on rehabilitation for that. You can't rehabilitate mental health to the same. There isn't something physical that is going to help them, that is going to make their life better. And as much as it seems to be saying an awful lot, PTSD we are there, we've got you support. In reality it is not there.

K: But it is like I say, the military aren't there for support as much as they say they will, they are just not.

M: I don't think it is the military. I am not blaming the military. I am blaming, it is society, especially these big massive charities who say they are there to help everybody. What can they do to help me? I get XXXXX (charity name) and everything like that. I get emails once a week or whatever. Oh come to

this event, Go-Karting here, Go-Karting there. I cant get to those places. Yeah, public transport. I am shit on public transport em and then it is at my own expense to get to these events. I can't afford to go. I have no money to do those things.

K: because our money is tied up there while somebody is making a decision if he really, really is mental enough to need a pay out, which has a massive knock on. Yeah, I mean if we could get that side of things sorted financially we could start doing more.

The couple describe the financial stressors that they face.

K: The only thing we are eligible for, I get carers allowance

M: Which stops us get housing allowance, housing benefit

K: yeah, so you then think, oh you've got carers allowance 60 pound a week, it's a help. It should help towards Mike being able to do these things but it doesn't, because what they gave me in carers allowance they took off me in housing benefit and we now get 50 pence a week housing benefit that is. It is nothing.

The couple described different emotional responses to the frustrations caused by the compensation scheme.

M: I have stopped caring about it now, cause it was another chip on my shoulder that was just dragging me down and the only way I can deal with it is don't think about it. Just not bother wi' it otherwise I just get pissed off

K: It winds me up. Because it does, I am there day in day out

M: When I ring up the Veterans, any progress, no well, ewewewew

K: Get back to us in 6 weeks (M: Yeah, whatever) get back to us in 6 weeks. Get back to us in 6 weeks.

M: It has got to the stage, whatever……...

K: Give us another 6 weeks, so we have gone from it being we will hear within the next week to give us another 6 weeks again, and that. It is just, it is not like we want a lot in life we just want a little bit of security and that does annoy me about the Veterans Association because we are one couple in the whole couple in the whole country and how many other people are in and to be told as we have been in the past, if you are really struggling contact us and we were really struggling. We were going to be on our arses. We were going to be on the street and nothing and that I think to be fair if I had been at work Mike probably would not have been here now. He would have been on his own too much dwelling in those thoughts when we were going through that really difficult time we had nothing, we had, you know if I had been trying to hold down a fulltime job, his guilt then takes over but that I am trying to do all of this stuff and he is at home and not able to and then where he should be able to go for help, doors closed and that was triggering as well to an extent. I think that's why I get personally annoyed, you know, ifs and buts and all that sort or stuff.

Couple dynamic

I: So what do you think it is about you two as a couple that's making you get through it and get through it together?

M: It's the stupidness off it, its just yeah…

K: Laughter (M: yeah)

M: I have always been an idiot and that got forgotten about. I just became a recluse and everything like that and the stupidity of things that we get up to. Yeah we are stuck in the house, everything like that we just make it, just try to make it entertaining now. We started playing, she plays the xbox with me and things like that and we have and we just take the piss out of each other.

K: You know what, we have so much shit and hard and actually that's that parcel and we're gonna have this parcel and we are just gonna be, just take as little serious as we possibly can.

M: Silly things like, because I can't go in to supermarkets that are busy and things like that. So we always go stupid o' clock at night and stuff. It's empty and we just mess about, don't we? Trying to have a little bit of fun there.

K: Yeah.

M: It's how I get by. It's working so why not carry on.

Karen described some things she has learned in how to live with Mike.

K: I know now, you know, if Mike is asleep, you don't wake him up. If you do you shout from the other side of the room. To get him to wake up, you don't go and interfere. Em, I know, like I said to you on the phone, as long as you are in and he can see the door. Triggers like that. If at the beginning of the meeting his leg shaking, his hands shaking, it's easing off. But if you are in another situation. If I see it start to happen, it is time to go. He could start off being at events, like with family or whatever and he is relaxed to start and then I will start seeing it under the table, then it's like let's move. Sometimes it

does go to almost like mothering instincts. You know, like you see with your kids and what not and you sort of pre manage a situation before it happens.

M: …There have been occasions where it is not, there's not been any build up either so I've just ended up at a shopping centre and I had a massive panic attack and then you start seeing people staring at you and it (I: makes it worse) yeah…

K: The only benefit we had that time is that he is tall. I said go, just go. He was in such a rush. I said keep your head down, focus on the door. Get out. I will catch you up.

M: I couldn't even walk could I?

K: By the time he got out, he's like collapsed down. There is me trying to pick him up. We got em, I got him home and that, 'cause I am literally watching his head as he is going out, and I am like, because I can't, I couldn't physically keep up with him trying to get out. So he got out. He's collapsed on the side and I am like let's go, we've got to get home and it had completely exhausted him. This massive panic attack, for want of a better word, and I am like, I've got to walk from here to there. He just couldn't physically walk and I am like I am going to have to bring the next door neighbour to get him to come and help me to lift Mike to get into the house and then he just slept for 12 hours because it was so physically exhausting. But there was no, he'd been fine, absolutely fine. It was one of those test your boundaries kind of day. He'd been doing fine and then just literally in the blink, nothing that he can physically see that caused a trigger or anything like that. It just went from OK to not, in the blink of an eye. It's sort of like, you know, last night he fell asleep on the sofa, absolutely fine. I had gone upstairs, I'm doing some crochet and

that, leave him in peace and quiet. And all I can hear is him screaming. So that is instant panic mode defence. Get downstairs, make sure he is ok. He is having a nightmare. No. He'd actually fallen asleep, his leg had gone to sleep and he had woken up and he was in physical pain. But that is the sort of thing that, nightmares and the panic and it is just trying to soothe him and calm him through when it is those.

M: I think one of the biggest things I have lost is the camaraderie with the blokes. Em, I have cut myself off from them and some of those I don't blame them. It is like they don't want the people who were good friends, we don't talk any more because there is still that stigma of mental health in the military. It is infectious. They don't want to deal with it because it will bring up things for them and you just lose contact with so many people.

M: It is like, you just feel what was it all worth for and everything like that. You just, I gave you everything I had and more and then I've got nothing.
K: So your Mum on a Facebook post or whatever, but it is so true 'You send 'em, you mend 'em'. And they are not there on the mending side of things yet. It's 21 years of being conditioned on how to live, 'cause it is every aspect of your life whilst you are in the army. It is conditioned. Even if it is just going to the pub with the lads there's, it's dealt with all in a set way and they all do it, and then because of the way Mike was discharged very quickly and without any support or back up, literally 21 years has just literally out from under his feet. It was like I don't know whether I can swim through the rest of this, it's like

M: Em, I didn't get the correct like rehabilitation to the trans, transgression into the civilian world and everything like that. Where they help you find jobs and everything like that. There was nothing and now I am like…
K: He was on a residential stay down there for mental health and things like that, but also to help him start. And I say start, that was the only thing that he had and he basically went through on a computer and had to fill out a questionnaire of what would be a good career for your future and it came back BT engineer or soldier. He's leaving the army. Why would you even have that as an option in there? Probably should have changed the programming in there somewhere.

M: I went for the interview there and my brain went down one route and I ripped the interview process apart. It was doing my tree in. It was, it was, it was a group part of an interview process. OK, so I think it was just part of a psycho evaluation, based on, it was basically right, you have had a plane crash. You got these things yeah, what all these civilians were going oh we should do, I'm like, right, everybody just fucking stop. You are pissing me off now. Right, survival you need this, this, this, this and this. Why do I need that? You need that to do that……I think the interviewer thought I was being over aggressive and I was just being logical…..and I scared off the potential employer.

K: Are you ready? (M: Yeah) Come on then, let's go and it is your turn to make lunch. Steak sandwiches.

M: Mmmm. That is another thing, I have to be supervised. I get, neglect, I forget what I am doing. I get distracted like even boiling a kettle. I boil the kettle three or four times if I make a cuppa.

K: So I bought a hob kettle so the whistle would get on his nerves 'cause the electric one….

I: He'd be like, what the heck is that noise?

K: Because the electric one would just click off and he would forget to make the cuppa. The hob one whistles.

M: Burning food. It is an absolute ball ache. So I have to get supervised. All the little things that should be easy.

Discussion

The purpose of this research was to gain greater understanding of the experience of couples living with trauma and distress after leaving the UK military. Each couple's set of circumstances was different and their approach to coping was varied. The detail from the joint narratives provides a useful empirical insight for counselling psychologists and psychotherapists working with members of this client group. To the best of my knowledge this is the first time in the UK that a narrative study has been conducted by a counselling psychologist with both partners in a couple together.

This chapter considers the three overarching themes that emerged from the couples retelling of their personal stories. First, I consider the findings associated with **military culture and identity** that relate to being discharged from the military on grounds of mental health, being part of a powerful military discourse, experiencing challenges to identity and the shame and stigma attached to mental health issues. Second I consider the findings from **living with the symptoms** of a PTSD diagnosis, including the duration and severity of the symptoms, the difficulties in accessing support and systemic constraints that interrupt continuity of support and treatment, how the couples found their own way of coping and the impact of traumatic symptomology on their relationship. The third narrative theme highlights the significant **partner impact** that occurs through secondary trauma, the role of caregiver and loss of self.

At the end of each of the three thematic discussions I introduce a section on Companion narratives, based on the metaphor used by Frank (2010). I have selected 6 companion narratives that are performed within the storytelling and, much like the themes, overlap and run concurrently in places. The first four could be categorised as narratives of power and the final two as contrasting aspects of relationship. This first narrative is the dominant **military** narrative including the hero, the tough guy and the military family. Second **them and us**, which is a splitting and isolating narrative. The **being let down** narrative, which explores institutional betrayals. The **medical model** narrative, another dominant narrative that shows relational power dynamics and hierarchies being performed and entrapping the couples at different points of time. The final two narratives are of a paradoxical nature. First the female partners narrative of **I am on my own** and then finally the resilient couple narrative, **the power of we**.

In the following chapter I will address the key clinical implications that were found in the narratives and in addition provide, through the lens of my own integrative framework, further implications for clinical practice and that support working with veterans, their partners and couples from this client group.

Military culture and identity

In this section I will consider the findings of the study under the four sub themes of:

- The power of the military discourse
- The impact of medical discharge
- The development of identity old and new
- Issues of stigma and shame.

The power of a military discourse

All three of the veterans in this research joined the military in their teenage years. They were socialised into military culture and adopted the military discourse that existed that men were strong and tough and able to maintain a positive attitude while facing adversity (Hockey,1986; Higate, 2003).

S: I got wounded in The Falklands but I kept it pretty low key. I didn't want it affecting my job and I was still young and daft in them days and thinking I am invincible.

The military discourse that bolsters the confidence and self-esteem of recruits can also create a sense of 'them and us' relating to military versus civilian life. These are represented as polarities and contribute to the fragmentation that some veterans and their partners get caught up in after leaving the military when their sense of identity is more fragile. I will discuss identity as a later sub theme. However identity issues can exacerbate how the couples coped with leaving the military and living with PTSD symptoms.

Karen: It's 21 years of being conditioned on how to live, 'cause it is every aspect of your life whilst you are in the army. It is conditioned. Even if it is just going to the pub with the lads there's, it's dealt with all in a set way and they all do it.

Both Karen, whose father had been in the Royal Air Force and Kirsty who was already in a relationship with Steve when he joined the military, had close hand experience of military culture. However Eimear who was unfamiliar with military culture before meeting James faced difficulties in trying to understand how best she could support James when he was struggling, while at the same time trying to resolve tensions that arose within their couple relationship from James behaviour around his ex-military friends and their nights out.

Adaptations in a cultural context

Military culture impacts on civilian life of the couples in other ways. Eimear noticed this in connection with James relationship with time.

E: Yeah, I would notice that a lot even in just, and it doesn't bother me, you know, but like any jobs James would do, everything is done at high speed.

J: No matter how many minutes late, no matter what the excuse was you would get a weekend you are getting punished. It just, it absolutely drives me mad being late for anything.

Alcohol plays a rite of passage in many an adolescent British male's life with legal drinking age at 18 in most venues. The military amplifies this with the

camaraderie of drinking together being good for team cohesion. Being able to hold ones drink ‘like a man’ is seen as a positive manly attribute and actively encouraged as a way of blowing off steam post operation.

M: After I came back from one of my Afghan tours, I did start drinking very heavily, em everything like that. I was hiding. The blokes were covering for me as well, as they do.

Alcohol then plays an additional role of dulling the senses and so not having to deal with emotions (Hockey, 2003).

All the veterans admitted to teenage issues of fighting, with Mike stating that his father gave him the option that if he did not join the army he would end up in prison. These aggressive outbursts before joining the military suggest a prior issue with affect dysregulation (Schore, 2003). Military training hones the skills of fighting and encourages targeted aggression.

Military culture can mask and normalise these adaptations. However they demonstrate the importance of taking into account the personal history and behaviour of those who have experienced trauma to provide context and identify risk factors (Herman, 2015).

Rank and status

The way that the military is structured focuses on rank and hierarchy with an institutional culture of following orders to the letter. For those leaving the military voluntarily and with good mental and physical health these qualities

can be attractive to employers. However for veterans with mental health issues they can add to the frustrations of their situation. Having been ‘the best’ in their military career it is very difficult to be considered, as what they and their military comrades (Corrigan, 2005) would identify, as ‘weak’. When faced with their perceived lack of high military standards in civilian organisations frustration and anger can build, such as was experienced by the couples in their engagement with the NHS. Not being able to secure or maintain employment due to ill health adds further frustration and damages self-respect.

The culture of hierarchy translates into care. The couples all talked about people whose case was less severe. Kirsty and Steve described them as ‘sympathy seekers’ as though there was a league table of who is more deserving. The couples shared their frustrations that sympathy seekers would give ‘genuine cases’ a bad reputation. And while there will be some people who try to play the system, I recognised this as splitting off (Gomez, 1997) the couples own fears that they had become or would be judged to have become sympathy seekers themselves. These concerns highlight both a dominant narrative in the military that mental health issues are considered a sign of weakness and the fear of narrative entrapment in a narrative of not being a genuine case. This adds another layer to the complexity of help seeking. The hierarchy extended to visible injury, which was considered by the couples as more acceptable than an invisible mental wound.

M: it is very difficult to go get help from them, unless you are their poster people, like they have got all these photo shoots with people with their legs and new robotic legs'.

Mike's perspective was that blackouts were not a good topic for an advert.

The impact of medical discharge

Hockey (1986) described fatigue, anxiety and disorientation of recruits on entry to the military. Service personnel medically discharged for PTS and mental health issues potentially follow a similar path to exit, but without appropriate reorientation back into civilian life. The process of discharge described by Mike and James compounded their trauma symptomology with feelings of rejection and isolation by the institution they considered family (Greenman and Johnson, 2012).

Job seeking

Although the military have generic programmes and processes to support the transition of individuals from the military, the participants in this research who were medically discharged experienced a disjointed exit process without specific support related to their individual needs.

J: you were left in your room kind of thing…..that to me is the worst thing you can do to a soldier because any free time you get in the barracks you are going to go drinking.

Neither James nor Mike was briefed appropriately nor had their expectations managed. Mike attended assessment centres and was not prepared for the types of activities that civilian companies put recruits through, such as a team exercise about what items you would include if you survived an air crash. This is designed to look at team and leadership behaviours, reasoning skills, ability to persuade and influence. However Mike, having survived combat in Afghanistan, was dismissive of the lack of survival competence of the civilian candidates and was unable to regulate his emotions resulting in a frustrated outburst at the assessment centre and loss of the job opportunity.

James described feeling bitter towards the army when he was assigned an employment coach, but there was no advice or guidance relating to his mental health condition whilst looking for jobs. James lost out on a job with the railway after disclosing his medication and came to the conclusion that his medical history was not going to help him secure a job.

The generic nature of job seeking skills within the army was underlined by Mike's experience of doing a computer based questionnaire to see what career he was best suited for and the choices were telephone engineer or soldier. Although Mike was laughing when he told this story I felt his hurt at the lack of sensitivity of this for someone who did not wish to leave the military. Being medically discharged took away a career that both Mike and James considered themselves good at and did not provide a pathway to any appropriate alternative career.

Employment

Steve recognised that some of the physical injuries he sustained would affect his operational effectiveness and this hastened Steve's decision to leave the military with a clean health record. He deliberately withheld his medical condition from the prison service to ensure he secured his first job on leaving the military. It took years for the couple to both recognise and seek help regarding Steve's posttraumatic stress, supporting Iverson et al's (2005b) contention that the fear of being labelled is a deterrent to coming forward.

Mike's experience of working in his grandmother's business gives an indication of how rehabilitation can be successful when the job is designed around the individual's issues rather than trying to bend the individual out of shape to fit the job.

Financial support

Following medical discharge for mental health reasons both Mike and James described their experience of Armed Forces Compensation Scheme (AFCS) as bureaucratic, not integrated, and was a great source of frustration and stress.

J: I have had an absolute humiliating nightmare with, you know, Personal Income Payment, that has absolutely degraded me …

E: I think the thing is with these processes is that they are not designed, considering they are processes designed to deal with people with PTSD, they are not designed for, you know, they are not simple, they are complex. They

are everything that would be winding a person up on a normal day. Not a mind, or highly strung or having a bad day or whatever.

The Royal British Legion and Poppy Scotland (2020) identified areas for improvement in a wide array of areas of the AFCS and the Department of Work and Pensions (DWP) benefits schemes confirming the experience that the narrators in this study shared. Having been told that they were not well enough to perform their duties by the military, there was a disconnect with then having to prove a level of disability to the compensation and benefit support services. As was found in the British Legion report the veterans' military medical records were not factored in, their assessments regarding their ability to work were not linked to the decision already taken by the military, the waiting time for decisions were continually extended and being awarded compensation often reduced other benefits negating the impact.

The armed forces can provide a safe container for individuals escaping troubled childhoods. Structure, discipline, rules and military values can present a challenge to individuals once they have left that context and are faced with civilian life. The certainty provided by the military environment does not equip ex service personnel for the uncertainty, ambiguity and nuance of civilian life and interpersonal relationships. Therefore at the end of service issues that have not been addressed are likely to resurface and may add to the complexity of mental health issues presented.

Struggles with identity

Each couple talked about identity either directly or indirectly in their narratives. Their roles as narrators took on different identities at different times.

For the ex service personnel they were each trying to reconcile their military identity (the structured and ordered life of a soldier, carrying out life or death missions, being in peak physical condition, having a clear purpose and shared experience with comrades) with that of their civilian life (unstructured at times chaotic and disorganised, different values and skill sets required, mental health issues and isolation) combined with Steve still holding on to the unfinished business of not being recognised appropriately for his military exploits and Mike and James dealing with the rejection they felt following their discharge. This supports the research by Smith and True (2014), which found that identity issues such as these increase the potential for mental health distress. All three men did not want to leave the military and had struggled with the idea that they were no longer capable of pursuing their chosen career. Mike described himself in terms of his 21 years in the army and on leaving stated that, '*I didn't know what to do with myself*'.

Kirsty described the loss of security she felt when Steve left the Army.

K: …all of a sudden we had nothing…..when we got to civvy street you thought…..they gave you everything.

Kirsty does not see herself as a civilian in the early years of her marriage. However there is a lack of support for military spouses whose partners are transitioning out of the military, highlighted by Keeling et al (2019). Kirsty's

experience required her to develop her own resources and increased the importance of her partnership with Steve as they described themselves as 'in it together'.

Development of self

The areas of military culture described above contribute to the sense of identity not just of the veterans but also to their partners. A sense of self is first developed as an infant and is developed by our life experiences (Wallin, 2007). Resilience and sensitivity to stress can have their origins in the developmental stages of a child's life, depending on the formative experiences that they have had (Felliti et al, 1998). Insecure attachment in childhood can lead to issues in later life. There is no one answer to this but as counselling psychologists we can draw on what we know from theory to consider how the life stories of veterans and their partners may be influencing how they are adapting to the situations they are facing as adults.

Secure base

In some way each of the three veterans although separated by age and period of service shared a path to joining the military that many young men experience. In the lower ranks of the army recruitment has historically been from young men of working class background, no further than secondary education and from areas of depravation (Iverson et al, 2007). They were already involved in fighting and other troublesome adolescent behaviour.

Their home life was not happy and may have provided the environment where insecure attachments were formed. The impact of these young men seeking a

secure base established a desire for the stability and structure that the army provided and that sense of belonging. The phrase 'the army family' is often used to capture how all encompassing military service is. The institution takes a parental role, setting standards and boundaries for recruits and rewarding the required behaviour adaptations.

As part of military training the creation of the bond of military identity is important for unit cohesion and discipline. However such a high value placed on physical and mental health leaves little room for illness and injury.

James describes recognising that his military identity is not always helpful.
J: I think a bit of it that does not want to leave it behind. I think the minute I forget it, I forget who I am, you know.

Steve described himself as '*Johnny end of the queue'* in his first job in the prison service and hated the loss of his military rank and status that he had earned during his military service. He was able to mitigate this by joining another organisation that was similarly hierarchically structured, had strict adherence to rules and valued strength and toughness.

Although Kirsty saw herself as part of the military family in the early years of her marriage she has worked for the same civilian company for over 20 years and progressed to a senior position. Maintaining her own separate professional identity was important to Kirsty, '*if I didn't have my job I would have killed him'*.

The lack of a secure base for Eimear when she was first supporting James contributed to her stress. She felt she could not talk to her parents and friends. She did not feel part of the group of wives and girlfriends who had been with James' other ex-army friends during their service and so part of an extended military family.

Shame and stigma

Shame

The challenge to military identity after being medically discharged can provoke a sense of shame. Having internalised an identity that rejects expressing softer emotions, applauds toughness both physical and mental, provides a clear role and value as an effective team member, being medically discharged takes all this away. Worse still is that the individual has been assessed by the organisation he has seen as a secure base and is found wanting. This can leave the individual feeling like they have failed; they have not been strong enough or mentally tough enough as the others who stayed with their troop. The process of being taken away from their squad and being separated adds to the sense of not being good enough to remain. There is a sense that this is something to be ashamed of.

Shaming that surrounds mental health stigma, military culture and fear of impact to employment also contribute to the difficulty in acknowledging the issue in the first place (Melotte et al, 2017). For example Steve indicated that with his bed-wetting *'I was never going to go to the barracks and say, oh by the way…'*. Therefore the culture prevented him from exploring this with colleagues and discovering that it would have been an issue that others

experienced. He describes using alcohol in the early days ‘to block it out’. The lack of a forum to discuss these issues impacted on how Steve and Kirsty managed their experience.

The shame is not only directed within the military. Veterans who have absorbed a strong masculine military identity now find themselves in the family unit without a job, mentally unfit (often physically unfit at the same time). They have lost the structure of military life and their self-image of warrior and protector is damaged. This can lead to a loss of confidence and self esteem.

Stigma

Hand in hand with shame is the stigma associated with mental health. This has been made clear in the military by the way mental toughness is framed. (I say this because I would argue that speaking up about mental health issues is a sign of strength. However that is counter to military culture.) Service personnel do not want to report mental health issues in case they lose the confidence of their leader or team (Corrigan, 2005). When mental health issues are raised the consequences are as the individuals feared. They are taken off active duty and sent away.

S: So there was a culture of weakness, a culture of don’t be so wet, don’t be pathetic blah, blah, blah, blah, blah and a culture of shame and a culture of I’m a tough guy and I just grinned and bared it and went on wi’ it no realising what was happening.

Mike and James who both lost their military careers as a result of being diagnosed with PTSD share Steve's representation of army culture. Mike described how being transparent about his vulnerabilities resulted in him being more isolated.

M: I think one of the big things I have lost is the camaraderie with blokes em I have cut myself off from them and some of those I don't blame them it is like they don't want the people who were good friends we don't talk any more because there is still that stigma of mental health in the military. It is infectious. They don't want to deal with it because it will bring up things for them and you just lose contact with so many people.

Both Steve and James described how being 'downgraded' due to health issues resulted in a reduction of pay. This provides a financial incentive for hiding fitness for duty issues.

In addition no longer 'being the best' was a self-esteem issue for James, and Steve also found his reduced physical capacity unacceptable and hid the extent of his physical injuries to the point of collapse in a physical fitness test. Serving personnel have a vested interest in under reporting mental health issues, which puts into question the usefulness of some of the quantitative data collected on the basis of self-report questionnaires.

James and Steve both discussed not informing potential employers about their mental health issues for fear that they would not be considered for the

job. James had the experience of failing the medical for the railway and two of his contract jobs being terminated as a consequence of mental health issues.

All three couples shared stories of not telling their families or friends the full extent of the mental health issues that they were facing. Eimear described being concerned that her friends and parents would tell her that she should walk away from the relationship and did not want people she loved to form a bad opinion of James.

Steve described not wanting to talk to Kirsty and their son about his mental health issues.

S: I don't know how to tell them. I don't want to tell them. I no, I'm no, I'm ashamed, I'm ashamed I'm ashamed of tellin, naw, I don't want them to know. I don't like what I would have to tell them. I don't want them to know.

Kirsty did not tell her sisters the extent of Steve's issues and it was not until he went missing and attempted suicide that she told her family what they had been dealing with for over 30 years since Steve's return from the Falklands

Companion narratives

Within the presentation of couple narratives there were many narratives performed that shifted with the context of the storytelling. I selected 6 that spoke to me and provided additional insight into the couple experience. I recognise that another reader may identify different narratives and I accept

that as the nature of narrative research. In the following section I introduce the first two of these selected companion narratives.

Military

There were many aspects of the **military** narrative alive in the stories. The couples presented themselves as proud members of the veteran community (Eimear being the only person who identified herself as civilian). This aligned with the dominant military narrative of military service defending civilian life and upholding values of honour and duty. This is what Frank (2010) would call a good companion. The narrative promoted a positive sense of self and included being hard workers and good at their jobs.

However, this narrative turned into a bad companion when the aspect of the military narrative that gives power and attention to masculine characteristics (Hockey, 2003) is applied depicting emotions and any signs of weakness as feminine and associated with failure. Trapped in this narrative the veterans become frustrated, angry, upset and it impacts on their self-confidence.

On being discharged from the military the couples experienced a sense of loss and abandonment from the military family, as they knew it. The military narrative is not universally accepted and the couples' expectations were not met with the level of help and support that are promised in policies like the Armed Forces Covenant. Due to the severity of his symptoms James was developing a narrative of being unemployable, where his skills and experience were not appreciated or understood.

The dominant masculine orientated military narrative does not accommodate complex traumatic stress or mental health, unless in a wounded hero narrative. But even that was understood by James and Mike to relate to those with visible injuries. Although there have been advances in gender equality this narrative is situated within the context of a patriarchal society.

As counselling psychologists and psychotherapists meeting a client for the first time part of the assessment process is to get a sense of the context that the client is situated within. The importance of military culture and identity for veterans and their partners is the influence that military culture has on their lives even after their service is over. Being curious about and recognising the narratives that clients may perform will deepen therapist understanding. The concept of cultural competence (France, 2018) for the helping professions offers the possibility of more meaningful engagement with this client group.

Them and us

The second narrative of **them and us** overlaps with the military narrative (e.g. military versus civilian, weak versus tough, male versus female).
It continues in how the couples identify themselves as different from the 'sympathy seekers' in relation to their experiences of the Armed Forces Compensation Scheme. This narrative continued in the couples' relationship with the NHS care that the veteran received.

The theme of splitting and polarisation that runs through the narratives, a sense of 'them and us' is replicated in structural and procedural aspects in both military and civilian approaches to supporting veterans and their

partners. I am advocating that as counselling psychologists we are in a position to recognise when these polarities exist and through our way of working offer a more integrated environment. However it is important to recognise the aspect of facing shared problems that can build couple resilience (Skerrett, 2015).

Living with the symptoms

In this section I will consider:

- Duration and severity of the symptoms
- Struggle to receive help
- Finding their own way of coping
- Impact of PTSD on the relationship

Duration and severity of the symptoms

Numerous pieces of research have looked at the mental health of veterans in the UK, including PTSD symptoms (Williamson et al, 2019b; Murphy et al, 2019; Murphy and Busuttil, 2015; Murphy et al, 2008) and this sits within the deeper understanding in the field of trauma (Herman, 2015; Van Der Kolk, 2014; Russell and Figley, 2013; Monson et al, 2012). There is a far smaller but growing amount of research that has focused on spouses and partners (Doncaster et al, 2019; Dekel et al, 2018b; Murphy et al, 2017; Beks, 2016). However what comes across strikingly from the accounts of the couples in this research is the complexity of recognising that you are living with a mental health issue. Lack of understanding of mental health and difficulty

distinguishing what is a mental health issue both contribute to the complexity. This is compounded by the length of time that veterans can be living with the symptoms.

It was 25 years after The Falklands War that Steve's PTSD was recognised and then diagnosed. It was exacerbated by the stress and upset that he experienced in the 25th anniversary trip to the Falklands. Steve still has nightmares, episodes of erratic behaviour and periods of depression, which means that he and Kirsty have been living with symptoms of PTSD for most of the 40 years of their marriage. Whereas for James and Mike the more recently discharged veterans it was 8 and 22 years respectively.

S: There is a little bit as well, of denial. And if you ask for help you are admitting there is a problem…There is certainly a bit of it that you are not accepting it, when you are not talking about it, asking, so there is a bit of coping by keeping it pushed away.

For those, like Steve, who are not diagnosed while on active service the path to diagnosis is varied. Several studies have explored barriers to help seeking (Melotte et al, 2017; Coleman et al, 2017; Sharp et al, 2015). The participants in Melotte's study gave a brief insight into practical barriers to treatment including waiting times, attitude of some health service professionals and poor experience of service that resulted in their disengagement. One of the initial barriers to help seeking described by Melotte, et al (2017) was the lack of recognition of a mental health condition by UK veterans. However Mellote

(2017) and her colleagues approach help seeking from the perspective of those who have successfully secured help and her participants were all receiving treatment. This misses the population who are finding difficulty securing treatment in the first place.

Where some veterans do not recognise that the symptoms they have would constitute a mental health issue, others recognise their symptoms but are hesitant to seek support due to the stigma attached to mental health issues that might impact on future employment prospects. They also withhold the severity of what they are dealing with to protect family and friends from upset (Coleman et al, 2017; Sharp et al, 2015). As discussed in the previous section the culture in the military of not wanting to appear weak or be judged poorly also prevents disclosure of mental health difficulties.

Struggle to receive help

Mike and James both endured waiting lists of up to 22 months and lost their places on this when they moved between regions. Support was provided by national charitable organisations but funding cuts meant that individual support was reduced. Mike had a positive experience of his support and was able to see the end of the service as a natural progression of his recovery. Whereas James recognised the potential good the support would bring but due to work commitments and reduced funding he lost his place on the residential programme he had wanted to attend.

Neither James nor Steve had good experiences of EMDR (Eye Movement Desensitisation and Reprocessing) either in relation to how it was administered or the timing of the treatment.

S: …they made a few mistakes to be fair. They, em, they caused a problem.
K: That is when it started to go downhill big style.
S: Because they opened the doors and things started to come out and, but they…
K: Never finished it.

Steve had been at a residential treatment centre for two weeks where he had been told he would begin EMDR. However early in the second week he still had not had any sessions scheduled. When Steve asked about it some sessions were scheduled but Steve's two weeks were over before he completed the course of treatment. He was sent home without any further support to process the impact of the EMDR sessions that he did have. This left Steve in a vulnerable state and Kirsty very angry as she had to deal with the emotional distress that Steve exhibited when he got home without any warning or guidance from the centre. In Kirsty's words, he was an 'absolute wreck'.

Steve and Kirsty's experience demonstrates the complexity of working in the area of trauma and distress. It would appear that other than delayed scheduling of treatment there were some issues in the area of treatment planning that opened up sensitive areas for Steve without success in

decreasing disturbance by reprocessing and working through to a process of closure and evaluation of the treatment.

James described his experience as ‘terrifying’. In the retelling of his EMDR experience there is little trust or rapport with the EMDR practitioner.
His recollection of her saying, ‘Don’t waste my time on this’ resulted in him feeling that he ‘had to perform’. James experienced insufficient empathy and there was not a strong enough therapeutic alliance to support James in preparation for the treatment. James had not spoken about his combat trauma to anyone since it had happened 18 months previously and may have been overwhelmed by a fear of reprocessing traumatic memories.

These two examples provide insight into the impact of not following or rushing appropriate protocols during key phases of an EMDR treatment process. In this case I am using the eight phases (history, preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation) described by Russell and Figley (pp. 16 - 20, 2013).

In each of the stories told by Steve, Mike and James about their pathway to treatment there is an element of carrying on until someone else makes a decision and intervenes. Patterns of delayed help seeking and waiting until a crisis point has been reached have been identified as one of the common ways ex service personnel seek help (Sharp et al, 2015). I consider another contributing factor that has not yet been explored is that the military mindset of following orders (Hockey, 1986) impacts on the sense of agency of those in

the lower ranks and inhibits a more proactive approach to help seeking behaviour.

There are a growing number of charities working with the veteran community offering support while providing an alternate activity such as surfing, the arts, horseback riding and other physical activities (Caddick and Smith, 2017; Douglas and Carless, 2015; Carless, 2014). However these are rarely inclusive of the partner and utilise the strength of the appeal to veterans to be back in a group of people who will understand their experience and replace some of the lost camaraderie that happened when they left the military.

These organisations can provide some respite to partners from their caregiver role. However Mike was frustrated at the lack of local opportunities to participate in this type of opportunity and raised concerns of cost. Without signposting to locally accessible organisations and encouragement to be less isolated Mike was unlikely to engage with this type of resource.

Finding their own ways of coping

Although there were many aspects of living with the symptoms of PTSD that were a shared experience for the couples I found the area of coping with nightmares and blackouts particularly poignant in the isolating nature of the experience for each person, even within the intimate space of their relationship.

Nightmares

The veteran is caught up in troubled sleep and their partner bares witness to the distress but is not recognised until the veteran is awake. The partner has to deal with this alone. There is no engagement in the present moment with their partner, only their reactions in the aftermath of the event can be deemed a couple experience. Kirsty highlighted this when she said for the first couple of years after Steve returned from the Falklands he was unaware of some of his screaming and fighting that happened when he was in the midst of a nightmare.

Steve and Mike both described nightmares or night terrors. In describing traumatic issues that they are challenged with, both Steve and Mike spoke of their sense of responsibility regarding making decisions that resulted in deaths of the soldiers under their command. Their sleeping patterns were irregular for fear of going to sleep and then experiencing a nightmare. This resulted in Mike delaying going to sleep to such an extent that he and Karen were sleeping at opposite ends of the day, which negatively impacted on their relationship.

Kirsty was woken up by Steve's screaming and regular bed-wetting. They did not speak of this to anyone else and accommodated these episodes as just the way things were. Kirsty put this down to being young newlyweds and not knowing any better. While Steve described this as something you would not discuss in barracks. Steve made efforts to hide both the physical and mental aspects of his Falklands experience as he wished to continue his career in the

Army. However he decided to resign rather than get to a point of medical discharge, as he was concerned of the impact this would have on his job seeking opportunities. Steve left the military and was successful in securing employment, although he did not disclose any of his health issues.

Similarly the couples appeared to have adapted to the nightmares, finding ways of coping. However these became intrusive in their relationship as the couple chose to avoid sleeping at the same time. Mike had the experience of waking up and realising he was strangling his ex-wife as part of a nightmare. Karen described learning to wake Mike up from his nightmares by standing on the other side of the room.

Kirsty described Steve as always fighting in his sleep and that she had found that holding one of his flailing arms was a way of providing a reassuring, grounding contact to help bring the veteran out of the nightmare.

Steve described both the guilt that he was burdened with for soldiers under his command being shot, as well as the transition in battle from killing to sparing the life of an enemy soldier. These thoughts impact on Steve's waking hours, '*I battle wi whether I am right, some days I think I am wrong for what I did*'. This supports the idea of moral injury (Shay, 2012). The difficulty that Steve describes is not fear for his life, but rather an existential crisis that is challenging his values and beliefs about war and his role in the taking of life and being responsible for the death of others. This features in his nightmares when he states 'I wake up seeing their faces during the night'.

The concept of moral injury has consequences for the diagnosis and treatment of PTSD as the predominant focus in the UK has been on supporting the patient process the consequences of the life threatening trauma and danger that they experienced or witnessed. However the moral injury to values, belief systems and sense of self has received little attention and requires a more compassion-based approach that is suited to longer term talking therapy. However in one of the only UK studies in this area Williamson et al (2019) found concern from clinicians that current resourcing and the philosophical approach that advocates a time limited appointment system is not adequate in supporting these cases.

Compassion is at the heart of Kirsty's description of her 'new tactic' of holding Steve's hand to bring him out of his nightmares and back into the here and now. The language used indicated that this was the most recent approach in a long history of attempts at providing comfort. This reminded me of the affect regulation (Schore, 2003) of a mother trying to find the best way of soothing her child. The communication between sleeping husband and wakeful wife portrayed to me the sense of an implicit knowing (BCPSG, 2010) for Steve that there was a calm and caring other to keep him secure.

Eimear herself described having recurring nightmares of looking for James and not being able to find him. An indication that vicarious trauma was being suffered. The couple having a joint experience of the symptoms taking over the relationship and difficulty of them separating out from each other's experience. MacDonell et al (2014) draw links to partner distress and the role

sleep plays in both maintaining mental health and in couple relationship processes.

The disturbed and chaotic experience of living with James was being replicated in the disturbance of Eimear's sleep. She described these as a reflection of her anxiety surrounding not being able to protect James. As each woman's story unfolds within the couple experience the concepts of both being traumatised by hearing of your partners trauma, watching the effects of trauma in your partner and of being traumatised yourself by the fear, panic, constant levels of high alert, threat of violence and emotional abuse are all present. In addition the likelihood that one or more of the women may have experienced a traumatic event in their own life prior to meeting their partner, making them more vulnerable to mental health issues, was not explored in the dialogues, although Eimear indicated that she had previously had therapy and Karen stated that she was on sleeping medication when she met Mike. Taking a full history of clients would ensure that all contributory factors are considered when working with this group. It is clear that there are significant adverse mental health impacts of living with a partner with PTSD (Murphy, Palmer and Busuttil, 2016) or as Dekel et al (2016) describes a likelihood of secondary traumatisation.

Blackouts

Similarly James and Eimear's experience of blackouts meant that James did not always remember what had happened, either if he was verbally abusive to Eimear or what he did in the gaps of time that could last several hours. The additional complication with James was that his alcohol consumption could

also account for some occasions of memory loss. However over time James had begun to associate high stress situations as a stimulus to his dissociative response. Alcohol was used to numb the senses, but exacerbated the situation.

Eimear described James as functional and that people might not necessarily know he was in an altered state. However the incident following the christening was an example of a complete gap of consciousness.

J: This fella found me in the field just speaking absolute gibberish.

James woke up in a field, frightened and feeling cold. He didn't know where he was and phoned Eimear. Eimear has the shock of a normal evening being turned upside down with that one phone call. She experiences concern for James and a sense of helplessness given she is too far away to help. Each partner suffers as a result of this type of dissociative episode. It adds tension into the relationship as the combination of work pressures, tiredness, alcohol and James choices when socialising with a particular set of friends all contribute to triggering his blackouts. This becomes not just a mental health issue but also an area of disagreement for the couple. This was not explicitly identified in the narratives but echoes findings about men being heroes or just behaving badly (Doncaster et al, 2018). Eimear identified her struggle to hold on to the perspective that James behaviour leading up to and during blackouts was part of his mental health condition.

Karen talked about the early days of her relationship with Mike, that he just went off to be by himself, or would turn up at colleagues houses who had shared similar experiences. This demonstrates the importance of support networks and a tendency for some veterans to prefer to talk or just be with people who have had similar experiences and so expect little explanation. It felt like there was a resignation that this was now just part of life.

The couple relationship was also tested by the lack of reliability and stability that comes from these intermittent blackouts, that is, not turning up to events and being unable to plan for the future respectively. Eimear describes James always apologising after the event and at the point she returned to Ireland this would have been what Gottman (2015) would call a failed repair attempt, one of the signs of a relationship in difficulty. However with James moving to Ireland the couple identified a way to overcome their difficulty. All the couples demonstrated working through challenges and making things work as best they could for themselves. Dealing with challenges successfully together over time is what Richardson (2002) described as a process of being able to reintegrate resilient outcomes. Repeating this process builds the capacity for resilience within the couple dyad.

Like with any skill couples need the opportunity to practice in order to increase their capacity for resilience (Neff and Brody, 2011). Although they were applying this to both partners I think in the context of this project this strengthens the argument of organisations providing care for veterans to

involve their partners as this provides an opportunity for the couple dyad to build resilience.

When Eimear describes the changes that happen to James during a blackout and how she loses him, she embodies the grief and ambiguous loss that Boss (2009) describes, where a partner is physically present but mentally absent. However this is not a passive interaction. Eimear describes being '*whatever hurt that girl might have caused*' and so becomes the recipient of unfair attributions from James failed past relationships. Although Eimear accepts cognitively that James does not mean to do this, she is clearly upset by the emotional injury.

Humour

Steve assumed the role of celebrity and comedian at times and Kirsty responded positively to his jokes. Mike also described himself as an idiot (in the fun loving sense) and Karen joined in playing at home and clowning around with Mike at the supermarket. I understood this as humour as a coping strategy, but also an avoidance of the traumatic symptomology they were living with. There was also a strong sense of teenage energy in the room during these moments of retelling their stories, which brought the possibility of developmental derailments to mind.

Impact of PTSD on relationship

In this section I consider other aspects of trauma and stress that have an impact on the couple relationship.

Anger and aggression

None of the partners described the veteran being violent towards them. However, they did describe the mood swings, and walking on eggshells that has been described by other partners (Doncaster, 2018). Mike described being arrested regarding his outbursts citing examples of fighting on a train and in a supermarket. He had been required by the Army to attend anger management classes at around the same time as he met Karen. The military trains individuals to harness their anger and aggression. It gives recruits the skills to kill another in hand to hand combat. There is a far greater danger in the risk of fights escalating into serious assaults. Getting involved in physical altercations with strangers, venting anger in the workplace and mood swings at home indicate a number of potential issues of unresolved emotions. Kirsty described 'dreading going out' in the early days of Steve's return from the Falklands, as he was quick to get into fights. She described him of being quick to rise. Initially Kirsty said he was jealous but corrected herself to say that this was Steve being overly protective of her.

Anger and aggression has been identified by ex service personnel as an issue and is likely to be more severe where there has been combat related trauma. None of the partners described intimate partner violence. However Kirsty described 'walking on a knife's edge' in dealing with Steve's mood swings and described hating going out socially with Steve as she never knew when his mood might 'flip'. Both Mike and Steve described an element of self destructive, not caring as dis-inhibitors towards their anger.

Potentially there is unresolved anger against the military for having been rejected (medically discharged), a self loathing for no longer being able to do what they once could do, physically and mentally, combined with the fear of having become what, whilst they were in active service, was ridiculed or seen as weak. Displaced anger regarding any of the issues previously mentioned and directed at partners, family members and third parties such as NHS. Mike described being a troubled youth and that he was offered a future in the army as an alternative to the likelihood that he would end up in prison. The recruiting pool of many soldiers comes from deprived working class backgrounds where violence and gang culture exist alongside limited employment opportunities. The military is seen as a way of escaping these environments with the potential to train individuals, provide structure and discipline and better outcomes. However this is not an either or. Just because some soldiers benefit from their time in military service does not mean that others are worse off.

Kirsty describes her own frustration at living with Steve's mood swings when their son was born, which would have been around 16 years after Steve returned from the Falklands. However she attributes the anger that she holds mostly to the lack of effective support she believes Steve experienced once he got his PTSD diagnosis. Karen describes being angry at the military compensation process and Eimear expressed her anger at James role in not being able to regulate his alcohol consumption and triggering blackouts as a consequence. As the women describe their stories anger is a healthy

reaction, but as a therapist I am considering how much they are holding and expressing anger that their partners feel unable to express in a regulated way.

James experienced mood swings and anger, but this was masked by the excessive use of alcohol and being in a social group including other ex service personnel with PTS issues.

Alcohol

Alcohol has been identified as a significant cultural part of military service (Hockey, 2003). However for these narrators post service alcohol consumption was much reduced either due to medical issues (damaged kidneys) or medication that was not compatible with alcohol. It is only recently that advertising for the military has shifted emphasis from showing recruits down the pub enjoying the camaraderie to a recent advert depicting drunken non military friends trying to encourage a potential recruit to join them in drinking and taking drugs. I still find this problematic as it still targets young people who may be exposed to this type of environment and as such have the same issues relating to adverse childhood experience as their predecessors.

While serving Mike and his colleagues recognised that alcohol was an instrument to blunt the impact of many of the stressors that they experienced. James the youngest narrator demonstrated the attitude that going out with the lads and getting drunk was still part of his social life. However he acknowledged that this was a trigger for his blackouts. He demonstrated a determination not to lose something else as a result of his experience. His partner was concerned about this behaviour, as at times of high stress this

became a repeating pattern that ended with a ‘bender’ followed by a ‘blackout’.

All three men discussed the role alcohol played in military social life and then more specifically how alcohol was the friend that each of them turned to when they wished to ‘block out’ the effects of combat trauma. Steve spoke about this as something that everyone did but did not talk about, whereas Mike’s friends actively covered for him when he had been drinking.

James was the youngest of the three men and appeared resistant to acknowledging the extent of the role alcohol played in exacerbating his condition. Eimear described struggling with reconciling that James’s behaviours were part of his mental health issues rather than just down to irresponsible behaviour and this tension ran through their dialogue when alcohol was mentioned.

For their female partners alcohol was not used as an escape. What was more interesting was the sense that the female role of carer lessened the likelihood of increased alcohol consumption as there was a sense of being on call and the need to be able to be in a sober state to provide support if any issues with their partner arose.

This supported the findings of the systematic review into hazardous alcohol consumption of spouses and partners of military personnel conducted by Gribble et al (2018). The experience of the women in my research also

aligned with the later study of Gribble et al (2019a) that compared military spouses and partners to women in the general population and found that the majority of military spouses/partners did not meet the criteria for alcohol misuse. However there was no evidence in my study of a higher tendency for hazardous alcohol consumption compared to women in the general population as stated by Gribble et al (2019a).

Kirsty described herself and Steve as not big drinkers. Karen was living with Mike who did not drink as he lost a kidney as part of his combat injuries. Eimear described being social and enjoyed going out for a drink. However, she was also aware that if anything happened to James she would have to 'sober up straight away' to take responsibility for caring for him. This would be an interesting aspect to consider in future research if the caring role acted as an inhibitor to excessive alcohol consumption.

Suicidal thoughts

Each of the veterans described having suicidal thoughts at some point after leaving the military. There is a general consensus that it is likely that suicidal ideation is worse than reported due to military culture and masculine stereotypes making people less willing to come forward (Iverson, 2005). The study revealed that in the Army the category of young males of lower rank had higher rates of suicide than the civilian population. As a result of the UK not tracking the veteran population in any way suicide rates within the veteran population are difficult to ascertain. However, reports in the media and data from the US suggest that veterans with mental health issues are potentially an at risk population.

For James and Mike these tended to be exacerbated by negative events in their lives, whereas with Steve the anniversary each year of being traumatised by the Falklands 25 anniversary trip appears to be a trigger. For each couple the impact is massive.

Karen described having made the decision of giving up work to be at home with Mike for fear he would not have survived if he had been left at home alone. This was after moving up north, which had already meant that Karen had given up her job down south. In their new location she had found employment and was working while Mike was recuperating from both his motorbike injuries and his mental health issues. However she choose to forego her own independence and work to look after her partner.

When James described being suicidal he linked that with the impact of the blackouts, losing his job and the period that Eimear had returned to Ireland. Eimear did not state any direct sense of responsibility in relation to James suicidal thoughts. However, her anxiety around wanting to protect James was evident.

E: *What if something serious happened to him and I hadn't said please James watch this or I feel like I couldn't live with myself then*.

Eimear's inability to tolerate the danger to James when he blacks out was mirroring James own lack of tolerance with living with his continued distress.

James also described how his medication (the antipsychotic risperidone) brought on the side effect of increased suicidal thoughts.

Kirsty and Steve's experience was different. Kirsty described her surprise and did not see the breakdown coming. There appeared to be no triggering event in terms of job loss, financial stress, etc. Although the consequences of Steve stopping his medication and the unexplained fits that Steve was experiencing were extremely stressful for the couple and Steve describes waking up '*thinking I'm sick of this, I've had enough of this. I don't want to go on'*. Clearly the uniqueness of each couples experience is part of what makes the experience of living with trauma and distress so challenging.

At times the couples experienced resignation that help was not going to come and that living with the symptoms was not going to significantly change. Suicidal thoughts were prompted in the veterans by just wanting their struggle with mental health to stop.

Intimacy

None of the couples in this study explicitly described the veterans symptoms as getting in the way of their sex life, which is often an issue for military couples (MacDonell et al, 2014). When in service deployments often break the couples attachment bonds and it can take time to re-establish intimate connection. Many of the PTSD symptoms have the tendency to push partners away from intimacy, in the face of aggression, mood swings, disturbed sleep. If the veteran has evoked maternal feelings in their partner, helpful in the caregiver role, this can be a barrier to healthy intimacy, which requires trust

and equality between adult ego states. However in other areas the couples adapted and normalised their own coping behaviours and so it is likely that they found ways around this. They may also have not yet felt comfortable enough to share those details with a researcher.

However I am conscious that although this is an area that other research has raised and so is worth therapists and counselling psychologists keeping in mind my participants were not clients seeking couples therapy and this may not have been mentioned because it was not a priority issue for each couple.

Although the veteran directly experiences the symptoms there is a joining of the experience for the couple that has a significant impact on the partner. I will discuss this in more detail in the section following the companion narratives below.

Companion narratives

Being let down

There is a **let down** narrative, which overlaps with the 'them and us' narrative. However in terms of experiencing living with the symptoms the isolation that comes with trauma is amplified by the sense that expectations of support do not match the experience that the couple has. Another way to consider this is a narrative of what Herman (2015) describes as institutional betrayal. The narrators in this project performed this narrative depending on their ego states at the time (Bromberg, 2011). Eimear criticised the design of the

compensation scheme from an adult ego state recognising that the administrative system was poorly designed for those suffering with traumatic stress. However James narrative was more that of a victim, and felt like a more vulnerable child ego state.

In this study, the hurt and frustration the couples feel at having to struggle so much to receive help was evident throughout the dialogues. The ex service personnel had a strong sense of being 'let down' after their service and their partners were angry and frustrated at witnessing the setbacks being faced.

Kirsty: …he was the latest one. He promised him the world and I thought, you know, I love you. You are going to get to the bottom of this and he deserted him within a few months.
Steve: I was allocated…
Kirsty: I was so angry. I thought, fuck, another one down the drain.

As counselling psychologists and psychotherapists it is incumbent on us to ensure that both as part of the initial contracting and assessment process we pay attention to the journey our clients have had to make prior to sitting in front of us. It is important that we are aware from the early stages of treatment the importance of continuity of support and have empathy for the path that our clients have taken. I think this is one of the advantages that a therapeutic approach can take in sitting with our client's experience.

Medical hierarchy/medical model

I am conscious that throughout this research there is a tension in relation to the master narrative (Grant, 2012) of the **medical model** in society. The couples talk about the PTSD diagnosis and I have represented it in this way. However I have also adopted trauma, complex trauma, traumatic stress as a more inclusive way of considering trauma and distress (Herman, 2015). The use of terminology such as 'symptom' can be said to privilege the medical model. As a counselling psychologist and psychotherapist I have concerns about diagnostic labels being potentially harmful and destructive. However I recognise that working within the NHS and other agencies the terminology and diagnostic model are what are in use.

There is a threat that dominant medical model narratives can create a hierarchical, expert driven narrative in a field that is full of subjective choices in relation to understanding how someone is feeling or experiencing trauma and distress. Boyle and Johnstone (2020) advocate an alternative path for practitioners with their Power, Threat, Meaning Framework (PTMF). The framework values the importance of context and a less disempowering approach to working with those experiencing trauma, which is an emerging approach in this area (Bonanno, 2021; Badenoch, 2018; Fisher, 2017; Herman, 2015).

The narratives of the couples depict a system that is not functioning well and is unable to provide appropriate support when needed.

Impact on partner

In this section the three sub themes that emerged from the narratives were:

- Secondary trauma
- Role of the carer
- Loss of self

One of the most impactful findings in this study is the extent to which as a couple the partner joins the veteran in a shared experience of trauma. In psychotherapy this can be experienced between client and therapist as transference (Aaron, 1996; Maroda, 2010) where unconsciously the client invites the therapist to share some of the experience that they are bringing to therapy. This might also be experienced as a parallel process feeling stuck with the work of a client and then realising that the client is presenting being stuck in their personal life, or feelings of anxiety about the work with a client who themselves are anxious.

Each of the women described being impacted by their partner's mental health issues. They all spoke of experiencing stress and their own mental fatigue.

Karen: I had, kind of had a bit of a breakdown of my own, trying to keep Mike on the straight and narrow…and I kind of neglected myself a lot.

Kirsty described living in a house which constantly has a building project underway, and she has only recently reframed the stress of seeing a room decorated and ripped apart over and over again to being part of Steve's

coping mechanism. Trauma limits the capacity for affect regulation and so Steve's behaviour could be seen as an enactment (Bromberg, 2011); an alternate way of expressing his emotions.

Eimear described the feeling of losing her own mind, particularly at the constant unexpected interruptions of James blackout behaviours into her 'normal' life. This particular situation between James and Eimear is a useful vehicle to explore the relational dynamics of the couple. Eimear loves James, but is struggling with how he is destabilising her mental health and her life. James blackouts are triggered by stress, but also by alcohol. I have discussed earlier the role alcohol has in the military and many studies have cited alcohol abuse as one of the more common issues impacting the mental health of veterans. This is a problem that the couple will need to successfully resolve for it not to become a bigger issue in the future. James does not yet seem able to accept responsibility for the consequences of his drinking.

J: I'd only went to a christening, I still got to be able to do them things.

Given the socialisation (Hockey, 1986) he received in the military, the acceptable behaviour of this group is to surrender to the banter and excessive drinking. This was a friendship group containing other ex service personnel, some of whom were also dealing with mental health issues.

Meanwhile Eimear has been moved from a quiet relaxing evening at home to '*blind panic'*. James has phoned her because he is confused and frightened,

immediately creating an overwhelming assault on Eimear's emotional and physical state, reinforcing her need to remain vigilant at all times to provide James with emotional support and the connection he requires in the moment.

Secondary trauma

The stress of living with the uncertainty of when a blackout might occur and then feeling the sense of responsibility to protect James from harm 'devastated' Eimear. Eimear's description of having witnessed James blackouts, being unsure how to help and having to take responsibility for his care clearly caused her, what Renshaw et al (2011) would classify as, psychological distress. Eimear did not attribute her distress to hearing James talk about his traumatic combat experiences. Eimear had only heard parts of James combat experience and had met him after his deployments were over. The tight definition of secondary traumatic stress used by Renshaw et al (2011), would require Eimear to take on the same PTSD symptomology that James experiences. However, other researchers have taken a broader definition of secondary traumatic stress (Dekel et al, 2016) that includes other distress symptoms such as low mood and anxiety. This recognises that living with a partner with post traumatic stress can itself be a potentially traumatic experience and lead to vicarious trauma. The experience was one of the most difficult aspects to deal with for Eimear, particularly since alcohol appeared to be a major trigger of these episodes, alongside increased stress levels. Eimear described her own inner conflict at believing James could choose to control his alcohol consumption and on the other hand recognising that his mental health issues were driving his alcohol consumption.

Eimear in particular spoke about being on constant alert and anxious that something bad was going to happen to James that she would need to be able to deal with. It could be said that this mirrored the feelings James experienced being in combat prior to engaging in action. Eimear described having nightmares usually with scenarios of not being able to find James when he needed help.

Apart from work and other life stresses James describes stress that comes from knowing that he is not in danger but feeling that he is and so remains in a state of constant high alert. However Eimear also describes being in a state of high alert, which aligns with perspectives on secondary traumatisation that the partner mirrors the veterans PTSD symptoms. However I do not think this is clear cut, as Eimear herself describes her state of high alert being linked to fear that James will be triggered and either need Eimear to be sober enough or be capable enough to take over full responsibility for James safety, rather than a transfer of anxiety surrounding a threat external to the couple. The concerning aspect of the relational dynamics is Eimear's acceptance that it is her responsibility to sober up and take responsibility for James, rather than James taking responsibility for reducing the likelihood of a blackout by stopping drinking. I was aware of feeling irritated in the room as this story was being told and recognised that I was being drawn in to a critical parental self state (Bromberg, 2011) in response to James.

In this study I was not able to make a distinction between the partners experience of living and caring for an unwell veteran being a traumatic

experience in and of itself versus the experience being an extension of the veterans symptoms being re-experienced by their partner, as has been the case in other research.

Role of the carer

Living with an ex service member with mental health issues can come at a heavy cost for their partners. The narratives show that partners can essentially become carers and have to give up their own lives. One area of high stress for the partner is in becoming a carer for their partner, whilst managing their own lives and navigating the impact this has on the relational dynamic. The study of Australian carers by Lawn and McMahon (2013) cautioned against objectifying the partner as carer, without recognising that they are husband, wife, partner where their relationship comes first and mental health issues second.

Women as mother figures

Eimear and Karen identified a maternal aspect to their relationship with their partner and each of the women described the desire to protect their partners from harm, which evoked for me a strong sense of a mother with their child.

This is an example of being aware of the particular ego states at play in the relational dynamics at any given point in time. Feelings of care and concern for a loved one, a wish that they avoid harm and pain, to share or ease the load are familiar aspects of a loving relational dynamic. However the evoking of maternal feelings is worth considering from the perspective of where the developmental need is originating. Soothing behaviours and ability to regulate

emotions helps the symptoms of the veteran's traumatic stress. When the veteran is overwhelmed themselves the ability of their partner to provide comfort and respite from challenging emotions can be understood in terms of McGilchrist's (2009) divided brain, with the partner providing the right brain empathy when the veteran is unable to regulate emotions themselves. Alternatively is the veteran adopting a child ego state to enlist support from their partner or is the partners need to nurture, provide love, make a difference prompt this behaviour? It may be in the course of a relationship that these ego states match sympathetically and each partner is able to give and receive what they need in that moment. However the stress comes when there is not a match. For example when a veteran in a child ego state frustrates a partner in an adult ego state.

Examples of this within this research can be seen in James's approach to drinking, which causes Eimear anxiety around it triggering blackout episodes. Kirsty takes responsibility for Steve's medication, as he cannot keep track. This may be a sign of lack of focus related to his stress. However it also raises a possible link to residual patterns of behaviour from military culture where every aspect of a recruit's life is orchestrated by the military. Having joined the military from school and in Mike's case having spent 21 years of his life in the military the training, discipline and institutional structure of recruits lives can lead to institutionalisation, learned helplessness and the need to replace the dependency on the institution with dependency on an other. When I consider the relational dynamics that can occur in this situation a co-dependent relationship presents as a possibility. In the couple narratives the

female partners have described ‘rescuing’ behaviour, feeling the need to take responsibility for actions that are the veterans, making excuses for unacceptable behaviour. However looking at the situation through the lens of co-dependency in some cases showing your love for your partner by enabling some of their dysfunctional behaviours unintentionally may enable this to continue and allow them to avoid seeking appropriate support and treatment. Both parties get trapped in a dysfunctional relational dynamic. Steve has been used to medical, dental, housing etc. all being dealt with by someone else. There is also the societal role of women as taking care of the softer skills of domestic life. I also think that this is not just a military issue and reflects on a patriarchal society view that women take care of softer issues, like medicine while men are doing more ‘important’ tasks. Anecdotally several of my married female friends stated that they too are the dispensers of their husbands medicine and fetch their prescriptions from the pharmacy whilst out doing other traditional female roles such as shopping and picking up the kids from school.

There is also a physical practicality involved that both Eimear and Karen describe and that is trying to move a large male body from a public setting to the safety of their home when they may be physically incapacitated or not be compliant to being manoeuvred, by a woman, without help, into a taxi or car.

Each of the women at times took on the responsibility for caring for their partner. For Eimear and Karen, they both described instances of being in public and having to support their partners through either a blackout or a

panic attack. However, the role of caregiver was much more pervasive than responding to intermittent events. Karen gave up her job to ensure that she was available to ensure that Mike got the proper level of care; particularly during the period he was having suicidal thoughts. She took on the role of driver to take him to all his medical and mental health appointments.

Kirsty has taken the responsibility of ensuring that Steve is taking his medication on a daily basis and knows more about the prescriptions that he is on than Steve himself does. Eimear describes her fear and anxiety when James is with people who don't 'spot' the signs of distress or 'care' as much as she does. This supports the findings of Beks (2016) regarding the all-consuming effects of the partner's illness in terms of sacrificing career, social networks and personal time. However it is also a demonstration of the partner using their strengths and resources in what has been described as the shock absorbing capacity of the 'we' (Skerrett, 2015, p.12). This 'we' capacity runs through the narratives of each couple.

There is a concern that some of these sacrifices that the partners have made are not just honouring the 'in sickness and in health' vow, but if taken to the extreme of always putting the other first in our adult relationships at the expense of our own health or well being then this indicates a co-dependent relationship. This can arise if there is a history of unmet childhood needs from emotionally unavailable parents in the partners past.

The role of caregiver and motivations behind it are complex and unique to each couple. Within couples this not fixed and can be different depending on the context and relational dynamic of the moment.

Loss of self

Karen giving up her job and Kirsty describing her job as a necessary antidote to the stresses of living with Steve's PTSD demonstrates the broad spectrum of responses to the situation. Military culture focuses on the team achieving their goal and individuals as part of a team achieving their goal through the support of others. Given what has already been said about the symptoms taking over the relationship, I find this reminiscent of the ability of the child to individuate from the parent as part of healthy development. The veteran's identity and concept of self is subsumed by combat ready military culture. This prioritises the team and the mission, requiring the utmost dedication and focus, to the exclusion of anything deemed peripheral. When this is translated into civilian life there is an imbalance in domestic life, which can engulf the partner to such an extent that they struggle to maintain their own identity.

Eimear struggled with her identity after she returned to Ireland. She described living in the city, being successful in her job and having a good social life before she met James and moved to England. On her return to Ireland she found herself living in her parents home, in a rural community, isolated from her friends and doing a job remotely that she was unlikely to return to.

E: I think for a period of time there it was totally just, I think I was having an out of body experience. It was like (I: mm) you know I was floating outside

what was, who I was really and you know it takes time to get back there again but, I'll get there.'

Each of the women described some way that they had modified their own behaviour for fear of exacerbating the stress on their partners. Kirsty described not wanting to '*upset the apple cart'* in relation to speaking out about all of her own frustrations and distress for fear that it would upset and anger Steve and alienate NHS and other support staff. Eimear talked about '*learning and still trying to figure out how to maybe approach certain situations*', including '*watch my tone of voice*'.

In other similar research this is described as a recurring theme of walking on eggshells (Doncaster et al, 2018; Beks, 2016; Outram et al, 2009). Paying attention to the social context is important here as it is easy to unintentionally repeat these types of patterns. Murphy et al (2019) who are developing training modified it for fear of upsetting the veteran. I accept that there are sensitivities and participant care to ensure. However this misses the opportunity to work with both partners on the emotional realm and strengthen the resilience within the couple dyad.

There is a parallel process of avoidance being enacted amongst researchers and programme designers, symbolic of the avoidance in posttraumatic stress symptoms and caregiver behaviour. Each individual in a dyad will have areas that they wish to discuss without the filter of their partners present but a key part of support and healing is to work with couples together. The concerns

around confidentiality and not wanting to upset the ex service personnel can be overcome by design and facilitation, rather than avoidance.

Further reflecting the prioritisation of the masculine the women all described just getting on with it and learning as they went along what worked best to support their partners. However their partners did not mirror this narrative back to them and I found myself formulating that this would somehow come from an external intervention. There was an implicit sense that the expectation was for the male needs to be accommodated first. Sherman et al (2008) found that educating partners about PTSD benefits the partner by reducing their own level of distress. The women in this study all agreed that some form of support, as a partner would have been useful. However the delivery of this type of programme would be time sensitive, as their belief was that once they had been living with the issues of trauma and distress for several months they had found their own way of coping and a structured programme would lose impact. As therapists working with couples and individuals the ability of clients to express their needs can often be found in their developmental experiences. Unmet needs in childhood can result in learned behaviour to expect less and add to feelings of low self-esteem. Entering a marriage or relationship in such a masculine oriented environment makes this an issue to keep in mind.

Companion narratives

I am on my own

The first of the companion narratives in this section demonstrated both the strength and resources that each of the women exhibited and also how at

times their own personal resources were depleted and their mental health suffered.

In the absence of consistent and timely support from external organisations the women described finding themselves dealing with their partners' issues **on their own** and taking responsibility for care (no one cares like me, I know the signs, I dealt with all that).

The narratives show the 'shock absorbing' nature of the partners in the relationship, taking the strain (quite literally) when their partners are overwhelmed by trauma and distress (Skerret, 2015). This supports the mutuality of regulation that is considered in the field of neuroscience to be a key component of couple resilience (Badenoch, 2018; Siegel, 2012).

The personal strength that each of the women showed, in dealing with both their partners' traumatic experiences and their own distress, is an aspect of posttraumatic growth (Tedeschi and Moore, et al 2020). The women applied learning from trauma and invested in their couple relationship. The importance of their future life together gave them purpose and part of that was in sharing their stories as part of this research process.

The power of we

The posttraumatic growth mentioned above and the resilience shown by the couples informed my final choice of the **power of we** narrative (We are still here, we have stuck together through thick and thin).

The couple dyads ability to jointly work through the stressful and traumatic circumstances they experienced and achieve a level of stability in their lives demonstrated them moving towards a condition of neural integration (Siegel, 2012). Combined with the ability to switch from a 'couple brain' to an individual brain (Badenoch, 2018) their responsiveness to each other contributed further to their couple resilience.

The mutual regulation of being able to spot the signs of the others state of arousal and the embodied expression of this in the research sessions demonstrated the power of the dyad. This can be applied to the couple dyad as well as the therapeutic dyad.

Clinical implications

The findings of this study show that there are a number of clinical implications for counselling psychology and psychotherapy practice to consider.

The strength of the couple relationship

The study confirmed the importance and value of a secure and loving relationship. Living with post traumatic stress can negatively impact on couple satisfaction but if a couple can work together and remain resilient then the partner plays an important intimate and stabilising role in the relationship and should be integrated into veteran treatment plans:

- Partners have more details of symptoms as dissociation does not allow veterans full conscious awareness of the impact of their symptoms.
- Partners are aware of triggers and have often learned to read physical/embodied signs before veterans are aware themselves.
- Due to the depth of dissociation veterans require insights from their partners to fill the gaps and help them back to consciousness.
- Partners provide a compassionate, emotion focused and nurturing relationship.

The contrast to the above points is that when there is an imbalance or unhealthy co-dependency the couple is dysfunctional and mental health and wellbeing deteriorates.

Becoming culturally competent

Most therapists today receive some training in anti discriminatory practices and have awareness around cultural issues of race, class and gender. Military

culture is in some respects similar in that the therapist may find themselves coming from a different cultural perspective and experience from their client. Maintaining a curiosity about difference will assist therapists to hear their client's stories within the cultural framework that the client has come from. This will allow the therapist to hold a more empathic and non-judgemental perspective when confronted by their client's attitudes, including their potential dismissal of civilian society, desensitisation to violence and attitudes to alcohol and other adaptive behaviours.

Tailored approach to individuals and couples will ensure better outcomes in long run

One of the benefits of qualitative research is the ability to take a deep exploration of a small sample. This philosophy aligns itself with less generalisation and one size fits all and more with what individual needs are. I believe it would be worth exploring some form of system where complex cases transitioning from the military receive a more tailored approach. I think such a system would be able to be designed that would result in:

- Less call on services over the long run
- More likelihood of success through transition
- Ability to focus resources on most difficult cases
- Provide partners and family with tools to manage at home.

Part of the tailored approach could also include the assignment of caseworkers. At present veterans with mental health issues have no single point of contact and are handed off from one organisation to another. Often support comes from the charitable sector. However cases that are too

complex get passed from organisation to organisation. Specialised charities are struggling with funding making long term support difficult to maintain.

I have 7 further clinical implications from the perspective of my own integrative framework from the themes and sub themes explored in the discussion section.

1. Confused identity

Whether the couples had met prior to joining the military or after each individual had moments of confusion regarding their identity. In some respects this is to be expected as we progress through life stages and gain different experiences.

Partners of former military personnel have to juggle multiple roles and can lose their sense of self in the chaos. This reduces their capacity to sustain internal conflict (Bromberg, 2011) contributing to their mental health distress.

The Armed Forces requires such a strong military identity and group cohesion, which provides a certainty and sense of belonging that is very attractive to many of the young men that sign up. On being discharged from the military this distinctive identity is challenged and veterans can feel rejected, triggering childhood wounds. Working with clients to rebuild a stable and coherent sense of self will enable clients to bolster weakened psychic structures that lead to anxiety, depression and trauma (Gabbard, 2014).

2. Establishing a therapeutic relationship

Be aware of the journey that your clients may have had before they arrive at your consulting room. The narratives revealed a history of unmet relational needs stemming from childhood through to rejection from the military and being let down by support services. The importance of the therapeutic relationship and the effectiveness of therapeutic work are determined by the quality of the relationship that can be established (Wampold et al, 1997) There is an opportunity to provide an experience of a trusting relationship that may help to model new ways of being for the client.

Contracting clearly at the beginning of the relationship is particularly important with this client group who have experienced being let down by support services. In the military emphasis is on strict adherence to rules, hyper masculinity is encouraged and discipline is maintained through threat of punishments. These traits may influence how veterans approach therapy. Managing expectations and understanding the motivation of clients (Horvath and Symmonds, 1991) will enable potential ruptures and repairs (Safran, 1993) to be worked through and contained.

3. Taking a full assessment history

Taking a holistic approach to client assessment provides a much clearer picture of the client's situation. Ascertaining if there is a military history in the family is one aspect, but it is also important to identify whether there have been adverse childhood circumstances, which may indicate developmental issues. Experiences of trauma before the military or post military is equally

relevant, for both the partner and the veteran. These are indicators of complexity of traumatic symptomology and levels of resilience.

Transition issues have been shown to contribute to psychosocial stressors such as financial security, employment, housing and lack of support networks and understanding this landscape will help inform the therapist.

4. Exploring attachment

The experience of non-voluntary discharge from the military can feel like a relational rupture, which seemingly has no opportunity for repair. It may be a repetition of a historic insecure attachment or rejection. Therefore issues of insecure attachment are likely to be present working with this client group. The couple relationship can provide a secure base (Bowlby, 1979) for each individual. However the challenges that come from living with traumatic symptomology can destabilise this. By working with couples co-jointly or as individuals understanding their part in the relationship can help them develop a stronger attachment bond. Understanding your own attachment style as a therapist and being aware of how you approach relationship will allow you to reflect on your approach to clients.

Given the earlier point about identity I find Aaron's (2009) description of multiple self-states useful. He encourages an awareness of which client self is being disclosed at any particular time and which of the therapists multiple selves is responding.

5. Modelling regulation

There is an opportunity for therapists to model the regulation of an empathic response to clients who may have had little experience of this. However military clients still immersed in that culture may find this uncomfortable and being able to work with what is tolerable for the client (Siegel, 1999) may require time and patience. An added complication is that paying attention to affect regulation (Schore, 2003) and attunement (Stern, 2004) may be considered soft for clients influenced by a military discourse of ‘manliness’.

6. Issues of loss

There are so many strands of loss running through the narratives of this client group; loss of self, loss of the partner they met before trauma occurred, loss of home, financial security, social network provided as part of the military family. There is the loss of friends and colleagues through combat fatality and suicide as well as loss of physical and mental capacities. This group presents a challenging and complex picture of loss. These are exacerbated by poor transition and post service experience. The concept of ambiguous loss (Boss, 2010) is applicable to the spouse/partner who has lost their partner not through death but being unavailable as a result of mental health issues. In another mirroring experience the veteran who has not reconciled with being discharged from the military has the experience of having lost their place in the military. The military as they experienced it as active serving personnel is no longer available to them.

7. Compassion fatigue

Working with clients who have experience of trauma either directly or indirectly can take a toll on the therapist. Self-care and appropriate supervision are important to have in place to be able to look after yourself and to create and contain a safe space for clients.

Clients who are partners of those with trauma symptoms may not be aware that they are experiencing a form of secondary traumatisation themselves. As a therapist being able to help a client understand their experience may make a significant positive impact on the life of a carer.

Additional practical observations

The following observations emerged in the process of discussions with the couples and themes repeated in their narratives. Although outside the scope of this research my own years of experience in 'organisation effectiveness' identified these areas as worthy of further research and review of the existing practices.

Improve process of compensation

The experience of claiming compensation for the two veterans who were medically discharged from the military as a result of their mental health issues highlighted a sort of 'Catch 22' situation. There is a conflict between not being well enough to serve but not unwell enough to merit compensation. They were told that they were not 'fit' to continue serving, yet they were repeatedly required to wait a further 6 months to be assessed to determine if they were showing any improvements in their situation. Psychologically this impacted

upon both men by intensifying their feelings of rejection and betrayal. Practically it made it difficult to move on and financially plan. There seems to be a disconnect between the military medical/psychological diagnosis and the administrative compensation process.

The design of compensation process does not take into account the mental state of those trying to navigate their way through form filling, including facing requests for post military medical histories and dealing with impersonal bureaucratic contacts. For veterans with mental health issues, experiencing lack of continuity of care and the cognitive impairments brought on by stress the process can be degrading, and dehumanising.

Improve pathways to civilian employment

When a soldier is being medically discharged from service attending a job seeking skills workshop geared towards those transitioning from military service after time served or redundancy but otherwise fit indicates a one size fits all approach to transition from military to civilian life. It does not take into account the difficulty that someone with symptoms of PTSD or taking strong medication will face in roles that require driving, machine operation, lone working. The practicalities of living outside the military with a traumatic stress diagnosis are not addressed and so leave the veterans ill prepared for that aspect of transition to civilian life. The veterans are likely to experience the rejection of employers, compounding the feelings of rejection already circulating in the field.

Reflections

Throughout the research process I used reflexivity to keep in mind the context within which the research was carried out and how that influenced the outcomes of the research. I also kept notes on my reflections of what was going on for me as I engaged with research process, the participants and their stories. As a result of conducting this research I learned some new skills that I have already started to apply to my clinical practice and have experienced both personal learning and growth. I will share some of the key elements of each of these in the sections to follow.

Research process

I had limited knowledge of narrative research practices at the beginning of this process. My comfort zone would have been something like Grounded Theory, but I recognise that when I am stressed I defend against my anxiety with a need for certainty. On reflection this may have influenced my choice of recording conversations and using transcripts. At the beginning of the process this gave me a check and balance on myself to accurately capture what was said and go back and immerse myself in the couple dialogues. However as the process unfolded and I settled myself into adopting a narrative approach I had the positive experience of opening my self up to multiple possibilities and as a result was able to engage with my participants in a deep and meaningful way. At the same time I provided them with a safe and contained space to share their stories.

Now that I am at the end of the process I have realised that there are a number of areas I would do differently. I would probably take bolder creative choices and experiment more with the presentation of the findings. In my anxiety about ensuring that the project was a good experience for the participants I made choices that caused me design problems later. At the point that I recruited the couples my description of how I intended to engage and how I would present the output meant that as I became more confident as the research process progressed I did not feel able, and did not think it ethical, to deviate from what I considered to be the contracting process that I agreed with participants at the beginning.

Therefore the Discussion became integrated with the Findings, which is acceptable within narrative research. However the choice of presenting such large chunks of the narrative also left me with issues of balance between the Presentation of Narratives and Discussion sections. I recognise that there was a sense of protection towards the couples from me, delaying the exposure of their narratives to others interpretation, and in the first instance that being me. I do believe that the narratives of the couples are compelling and informative, particularly for those without experience of working in and around a military context.

I intuitively made choices that worked for me and my participants which on further reflection and as the project progressed I came to realise were either borne out by other researchers experiences or as I grew in confidence are decisions that I am happy to stand by. I think the exciting part of the doctoral

process for me is that at some stage there is a stepping off point when you find yourself in new territory.

From a research perspective the ‘surprise’ for me was in how strong the woman’s stories came through. How they were central characters to the action. I felt initially guilty at realising that the more interesting and original parts of the project were findings that featured the women or that they contributed to as part of the couple. I felt guilty that the veterans were not on this occasion front and centre. In reflecting on my reactions to this I considered it from a narrative perspective and realised how caught up I was in a dominant patriarchal narrative. Even though I had considered myself a feminist I realised that narratives can be at play unconsciously. As I will reflect on later this had a profound affect on me in relation to how I thought I could use narrative understanding in my clinical practice and in how I view experiences within my personal life.

I was also conscious that at the same time as I was acknowledging the women in the project James was experiencing disappointment and frustration at the idea that military get priority treatment in NHS never having been his experience. This again confirmed to me that two competing realities could exist in the same time and place, an important concept when working with clients’ inner and external conflicts.

In paying attention to presenting the couple narratives I became more aware as a practitioner of anti oppressive practice in terms of the power dynamics

that are in play and potentially the position of privilege I put myself in if I am representing a group that I do not belong to. However I was reassured by the quality of the research community that the participants and I created together and their permission for me to travel on their path for a period of time.

Clinical practice

This project reenergised my clinical practice and reminded me of what I enjoy about being a relational therapist. The learning from the research made me more conscious of the narratives that both my self and my clients are situated in. I have been most conscious of this in listening to some of my women clients expressing themselves and trying to manage boundaries in their own personal lives. I was more aware when they were entrapped in a dominant masculine narrative that states that it is not polite or that they are oversensitive by voicing discomfort regarding offensive male behaviour. This is an example of how a dominant narrative can silence a narrative that challenges its position and is more congruent for the individual. I also experience a similar situation with male clients where they find it difficult or feel 'weak and ashamed' when discussing the emotions behind issues that they bring to therapy, such as eating disorders.

There are continuing parallels in that the healing potential of the couple dyad is also applicable to the therapeutic dyad. The importance of being heard (Badenoch, 2018), and the deepening that comes from it, reinforced my approach of being present in the moment with clients.

During the research I began an online continuing personal development course on Emotion Focused Therapy for Couples developed by Sue Johnson. Prior to the research project I did not work with couples, but I am now offering this service in my private practice.

This research process has given me the confidence to consider actively pursuing a practitioner researcher role going forward, developing the themes in this research further and following other areas of interest within my practice. Although I am conscious that for the purposes of self care that will not be straight away. I may not always have managed my self care well during the doctoral process but intuitively I realise that I saw fewer clients, as I was conscious that my emotional availability was compromised at times by the rigours of the doctoral process.

Personal learning

I shared my Beirut story at beginning of the project and if I wrote it now it would be retold differently as a result of the experiences I had during the research process. I would not write it from an observer position. At the time I was experimenting with the idea of creating a fictional version, but on further reflection at that time, the detached nature was just my defended position against the world.

Since I started training on the doctoral programme I have felt my transition from more cognitive rationale to more holistic embodied sense of my self and my surroundings. The concept McGilchrist (2009) articulated regarding seeing the world and the self from the perspective of the left and right brain really

engaged me and helped me consider how I maintain balance. During this process I have been more open to understanding and considering the attempts to achieve and maintain balance that my participants were demonstrating and their efforts helped me understand myself better.

I believe I underestimated the impact that hearing trauma stories and sitting in the room with participants would have had on me. Part of the empathic and trusting relationship that I developed with the couples made me more emotionally impacted. I felt this in a particularly embodied sense. During the research process at various points I felt physically and mentally exhausted. I felt a tight chest, I picked up issues of a sore back, and headaches and I fell and injured my knee. In some respect I initially put this down to the stress of the study process, but on reflection I recognise that I was attuning to my participants and in a parallel process their struggle became my embodied struggle.

As a counselling psychologist and psychotherapist I would be paying attention to whether I was over identifying with a client, but in the research process I became immersed in my participants struggle. This also linked back to a significant imprinted belief from my childhood, which I thought I understood but gained fresh insight through this reflexive process. My parents instilled in me the importance of ‘getting things right’ and educational achievement. This resulted in a sense of never quite feeling good enough. However I realised that a previously unknown aspect of this was my embodied experience that for study to be worthwhile it came with feelings of anxiety and distress. At

some level this was being enacted during this project. Therefore the secondary impact of hearing trauma stories and the experience from my childhood further underlined the importance of self care in this process. In hindsight I would build that into my research approach in a much more considered way than I actually did.

I am also conscious that some behaviours experienced by those with trauma and distress were mirrored by myself, such as becoming isolated and not seeking help at the earliest opportunity. Ensuring that you find the appropriate supervisory relationship and support is important and supplement that with whatever other support networks you may require. I gained a great deal of practical support from colleagues who were going through the doctoral process and we became a peer support group for each other.

A final thought on this process, which I have found difficult to bring to a conclusion, is managing the tension between the cognitive understanding that this research captures a moment in time, with the emotional attachment to the participants and their stories. Each time I engaged with the thesis I could see areas I would like to change or different directions to develop. I have had to become very pragmatic in the end and finalise this submission with the promise to myself that I can continue with the stories and subject matter through different channels. These will include dissemination of the findings through papers and journals but also include some creative projects.

Conclusion

When I think of Lord Ashcroft's final report (2017) and the array of small independent charities that exist supporting veterans and their families in all sorts of ways I can see how difficult it is to shape a national policy that addresses the marginal elements of a large veteran group. However I take heart from reframing that scenario to where a small focused effort locally may be able to make a significant impact.

Sharing a model of military cultural competence for therapists will enable localised support to become more informed in the absence of a national effort. I have been critical of the military's preparation of serving personnel being discharged for mental health reasons and realise that I have an opportunity to develop something for this population, which I could pilot in my own local area.

The narratives emerging from this research are powerful and moving and provide valuable details of the experience of living with traumatic symptomology. There are many more stories out there and they deserve to be heard.

In speaking with a colleague about this research we had a conversation about the therapists role in nurturing hope and I have extended that to the researcher. I end with this quote as I find it both beautiful and hopeful and it captures the connection I feel with my narrators.

*'When we write of experiences we connect with humanity – deeply felt experiences shared with others through narrative form are probably the closest we can come to knowing what it is to be human' (*Etherington, 2000, p296).

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Appendices

Appendix 1 Recruitment Flyer

Are you a couple that have experience of leaving the UK military and then living with a recognised mental health diagnosis?

If so I would like to discuss your possible participation in a qualitative research study that I am carrying out.

I am looking to work separately and in confidence with 3 different couples to hear about their experiences. I will meet with each couple on 2 occasions at an agreed location that is geographically convenient for them. This will include a final debrief session for each couple at the end of the project.

Each session will last around 60-90 minutes. The project would involve meeting with me on 2 occasions at a time suitable for you both.

If you are interested or wish to find out more information contact Isabel Kay on 07866 527 176 or Isabel.kay@metanoia.ac.uk

****Please note that there will be a pre-selection telephone interview for you to ask any questions and for me to check that couples meet the research requirements in terms of experience and appropriateness of inclusion in this type of study.**

Appendix 2 Participant Information Sheet

PARTICIPANT INFORMATION SHEET (PIS)

Study title:

A narrative inquiry into the couple experience of leaving the UK military and living with a recognised mental health diagnosis.

Invitation

You are being invited to take part in a research study. Before you decide if you wish to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The aim of this research is to give voice to the couple experience of living with a recognised mental health diagnosis after leaving the UK military. By gaining deeper understanding of the experience of the couple, mental health practitioners and support services can utilise insights and learning to improve areas such as the transition process and on-going identification of needs and support, both within the military and in civilian services responsible for the care of veterans and their families.

The duration of the study will be over a twelve month period. However the involvement of the couples will be mostly focused on a 2 to 3 month period during which time the researcher will meet the participants on 2 occasions for a 60-90 minute dialogue session.

The study is a qualitative research project. The completed study will be submitted to Metanoia Institute and Middlesex University as a Doctoral Research Project.

Why have I been chosen?

You and your partner successfully meet the criteria for participants in this research project. That is, as a couple you have had the experience of leaving the UK military and living with a recognised mental health diagnosis. One of the couple will have served in the UK military and the other is likely to be a civilian (although may also have served in the military). The veteran will have

had a recognised mental health diagnosis associated with their military service.

The study will involve 3 couples in total. The identity of participants is confidential and will be protected by use of alternative names and amendments to some personal details. The couples will not meet each other as part of the research. Confidentiality will be maintained at all times. The sessions will be recorded and transcribed and held in a secure and confidential location.

Do I have to take part?

It is up to you to decide whether or not to take part. However both partners in the couple must be prepared to take part to be included in the study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not impact on your partner's continued inclusion in the study.

What will happen to me if I take part?

Your involvement will be the same as your partners. Each couple will participate in 2 dialogue sessions with the researcher and share their experiences. These sessions will be between 60-90 minutes long and will be recorded so that the researcher can transcribe them as part of the research process. Before the next session you will receive a copy of the transcript of the previous session for information and to allow you to reflect on what was said.

It is likely that your involvement will be for a period of 2 to 3 months. The research study will take 12 months in total because not all couples will start their sessions at the same time. Also the process of writing up the research will continue for several months beyond the information gathering stage.

The researcher will locate a suitable meeting room near to your location and will book that for the session to ensure the dialogue can take place in a confidential setting and at a time that works for you both.

You will be expected to share your experiences of leaving the UK military and living with a recognised mental health diagnosis. You will be asked to consider what this was like as a couple.

This is a narrative inquiry, which requires the collection of narratives from participants (narrators) through dialogue with a researcher.

The research will consist of two 60-90 minute dialogues and reflection on them. At each dialogue participant consent will be reconfirmed:

Dialogue 1: Agree our way of working and address any concerns about the process, ensuring a safe environment for both partners and to establish a relationship of trust between us all. Couple jointly sharing their experiences of transition.

Dialogue 2/Final Debrief: Couple continue jointly sharing their experiences and reflections. Review meaning making thus far to ensure it is contextualised and linked to the texts of the previous sessions. A final debrief of the research project will be conducted including a reflection on the experience of the process and to ensure that participants have a clear understanding of the outcomes of the research. If required participants will be given or directed towards any appropriate further support.

These dialogue sessions will take place over a 6 -12 week period.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What do I have to do?

If you participate in the research study you will be required to attend the 2 dialogue sessions. In preparation for the dialogues you will be required to read the transcript of the previous session. During the dialogues you will be required to be open to the research process and be prepared to reflect on both your own experiences and on your participation in the dialogues.
In total this is estimated to be about 6-8 hours of your time over a 2-3 month period.

What are the possible disadvantages and risks of taking part?

The retelling of traumatic events and the focus on the couple relationship may feel intrusive and provoke unexpected, disturbing and emotional responses.

The ethos of this research is to ‘do no harm’. Therefore it would not be appropriate for individuals who are deemed to be ‘currently vulnerable’ to participate in this study. Should a participant become vulnerable during the study the researcher will assist the participant to find appropriate support (see section below on Participant Support Resources).

What are the possible benefits of taking part?

I hope that participating in the study will help you. However, this cannot be guaranteed. The information I get from this study may help to improve the experience of other couples who are dealing with similar circumstances in future.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with General Data Protection Regulations (GDPR) effective in the UK from 25 May 2018.

What will happen to the results of the research study?

The results of the research will be written up as part of a doctoral research project. Completed research projects are published electronically on the Middlesex University website.

The results are likely to be published by March 2022. I will provide participants with confirmation of when and where they can obtain a copy of the published results.

The research may provide the basis of papers presented at conferences and articles submitted for publication in health professional journals. You will not be identified in any report or publication.

Who has reviewed the study?

The Metanoia Research Ethics Committee reviewed the study.

Thank you for taking the time to read this information sheet and being prepared to take part in the study.

Contact for further information

Your main point of contact for information is the researcher (information below).

Researcher: Isabel Kay

07866 527 176
Isabel.kay@metanoia.ac.uk

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13 North Common Road,
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Participant Support Resources

ssafa the Armed Forces charity
SSAFA works to ensure that the needs of the Armed Forces, veterans and their families are met in an appropriate and timely way.
www.ssafa.org.uk
0800 731 4880

Veterans' Gateway
The first point of contact for veterans seeking support. VG puts veterans and their families in touch with the organisations best placed to help with the information, advice and support they need – from healthcare and housing to employability, finances, personal relationships and more.
www.veteransgateway.org.uk
0808 802 1212

Combat Stress
24-hour helpline
0800 138 1619
contactus@combatstress.org.uk
www.combatstress.org.uk

The Royal British Legion
Helpline 8am-8pm all week
0808 802 8080
www.britishlegion.org.uk/branches

Big White Wall
A safe online community of people who are anxious, down or not coping who support and help each other by sharing what's troubling them, guided by trained professionals.
Available 24/7, completely anonymous. Free to all UK serving personnel, veterans and their families.
www.bigwhitewall.com

Phoenix House (Recovery Centre)
Richmond Road
Catterick Garrison
North Yorkshire
DL9 3AW
01748 834 148
catterricksupporthub@helpforheroes.org.uk

***Local Counsellors & Psychotherapists*:**

UK Council for Psychotherapy (UKCP)
Find a Registered Therapist
www.psychotherapy.org.uk

Counselling Directory
Find an accredited counsellor or psychotherapist
www.counselling-directory.org.uk

Mind
A charity that aims to make sure that no one has to face a mental health problem on his or her own.
www.mind.org.uk

Darlington Mind
St Hilda's House
Borough Road
Darlington
DL1 1SQ
9am-5pm
01325 283 169

Relate
A charity providing relationship support including counselling for couples, families, young people and individuals, sex therapy, mediation and training courses.
www.relate.org.uk

***Other organisations*:**

Campaign Against Living Miserably (CALM) for men
A movement against male suicide, the single biggest killer of men under 45 in the UK.
www.thecalmzone.net
0800 58 58 58

Action on Addiction
Provides residential and day treatment for addictions to drugs, alcohol, gambling and other behaviours.
www.actiononaddiction.org.uk

Addaction
Works with adults and young people, in community settings, in prisons, in residential rehab and through outreach.
www.addaction.org.uk

***Activities*:**

Search/Google ‘yoga near me’ to find a class

Download a mindfulness app, listen to a guided meditation and/or practice techniques found on line

parkrun UK
parkrun is a series of 5k runs held on Saturday mornings in areas of open space around the UK. They are open to all, free, and safe and easy to take part in.
www.parkrun.org.uk

***24 hour emergency support*:**

Samaritans
For everyone
24 hours a day, 365 days a year.
The number is FREE to call
116 123

Call your GP (**111** out of hours)/ Mental Health Crisis Team/ Go to A&E

Appendix 3 Consent Form

CONSENT FORM

Participant Identification Number:

Title of Project**: A narrative inquiry into the couple experience of leaving the UK military and living with a recognised mental health diagnosis.**

Name of Researcher**: Isabel Kay**

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

3. I understand that my interview will be taped and subsequently transcribed. ☐

4. I agree to take part in the above study. ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

Name of participant (PRINT): _____

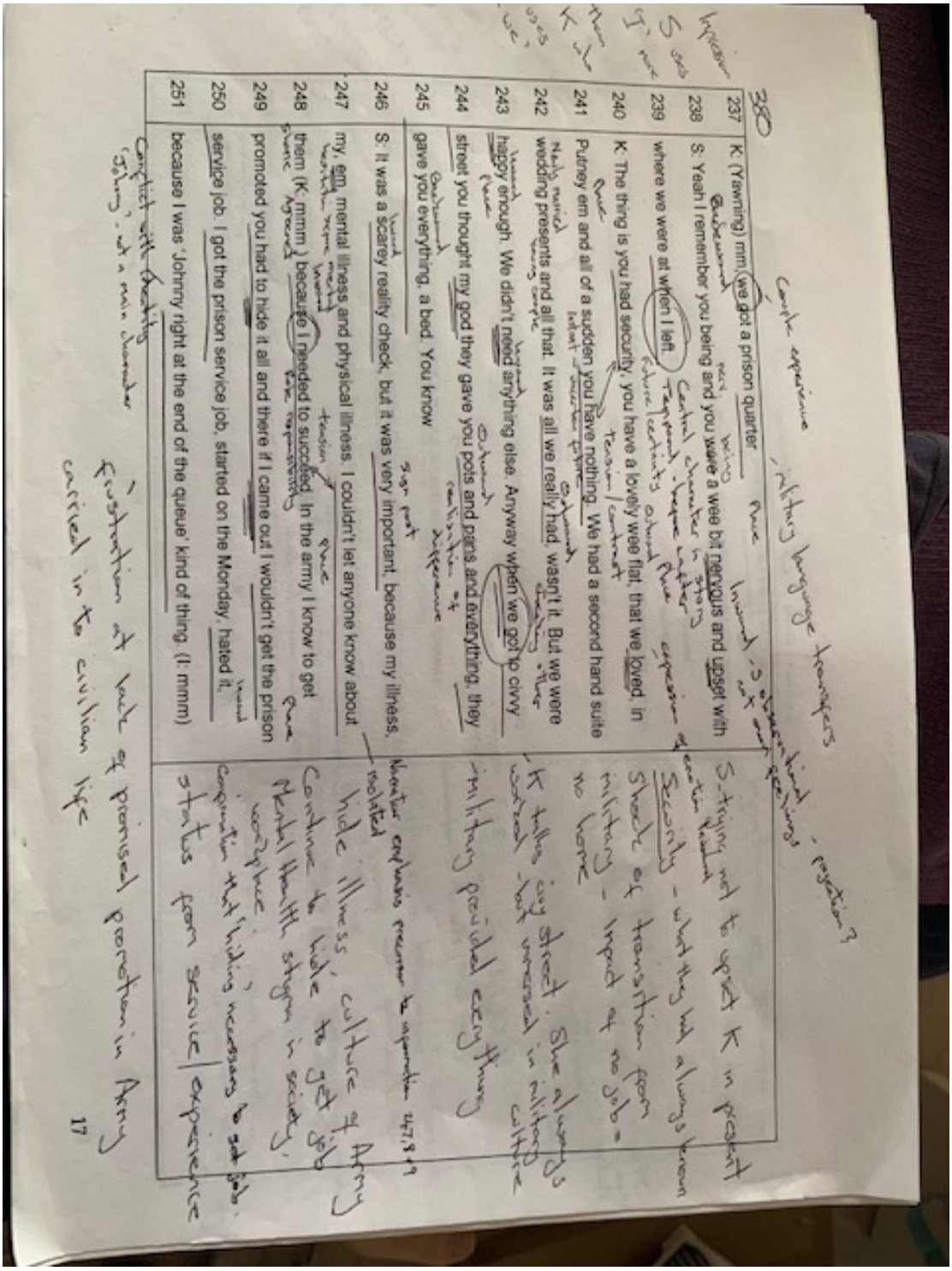
Date _____ Signature _____

Researcher: _____

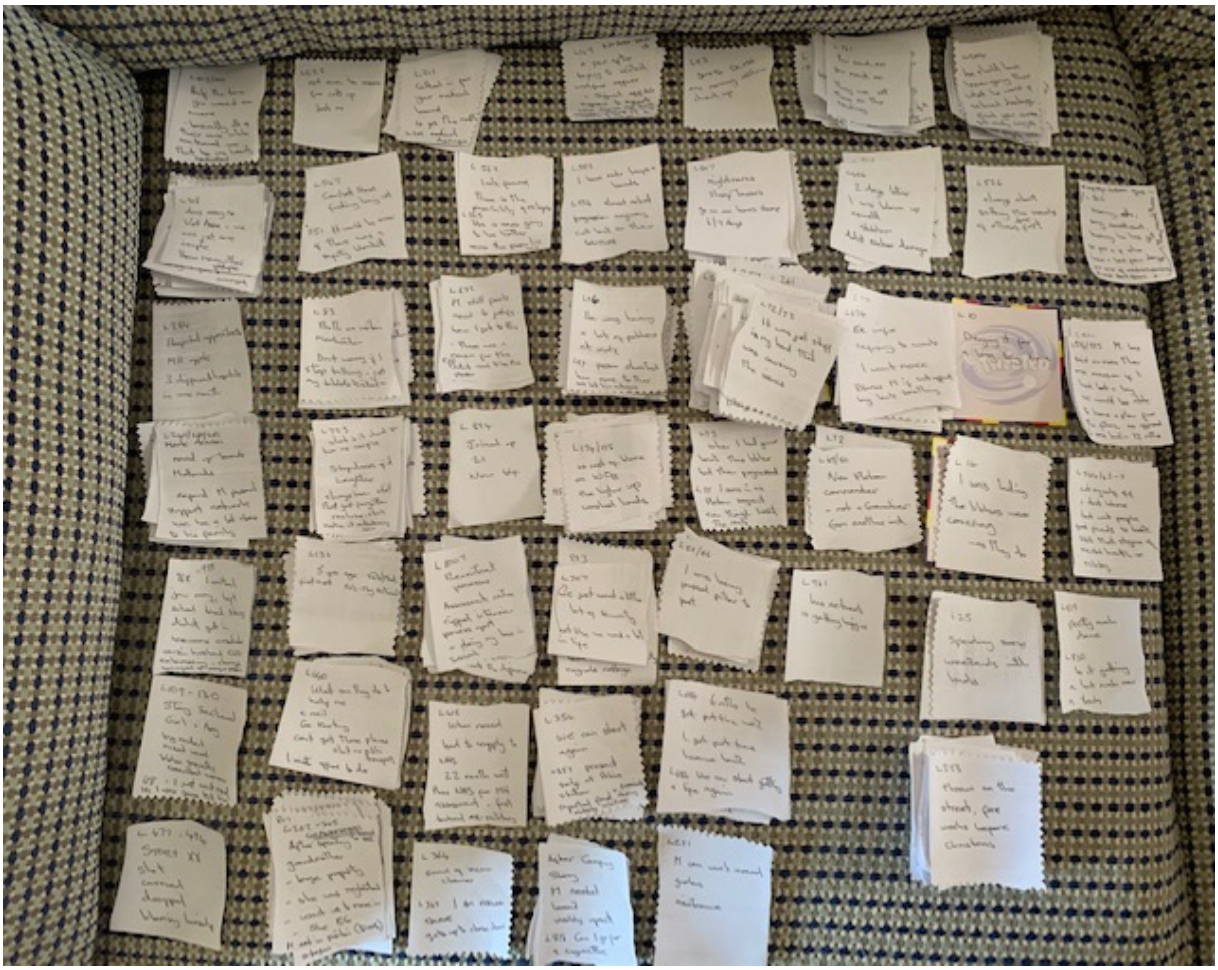
Date _____ Signature _____

1 copy for participant; 1 copy for researcher

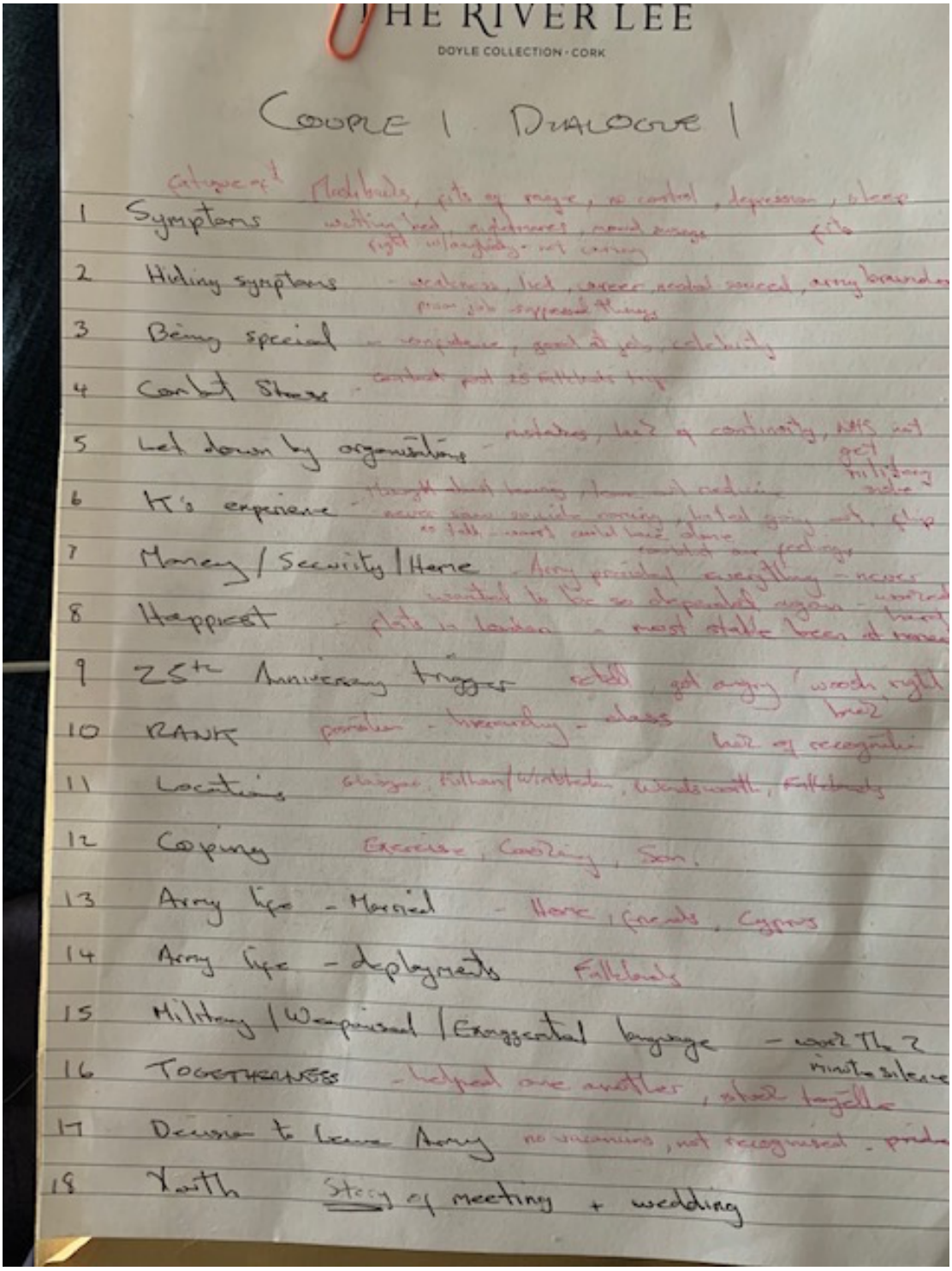
Appendix 4 Excerpt from Dialogue transcript



Appendix 5 Coding; post it process



Appendix 6 Initial themes



xx

Appendix 7 Excerpt from Research Journal

24 April 2020

I am conscious that from the outset I firmly decided to seek narrators through my own personal network. The rationale for this I thought was clear; that I was concerned about reaching too wide an audience with adverts and having to reject couples if I got too many. Given the fact that it took me over 12 months to secure all three couples I have questioned myself about my resistance to go directly to many of the UK charitable organisations that would be associated with veterans. I do think that I had concern about numbers but realise that there were a number of personal preferences that influenced my choices. I think the first being the time it took me to get out in front of my research. I lacked confidence to meet with unknown third parties. The second was my desire not to be associated with any particular organisation. I realise that is an attempt at maintaining a neutrality, which is in conflict with my belief that we are all impacted by our own subjectivity. I am also aware of a parallel process that may be playing out with regard to my narrators and the pride, disappointment and fear of rejection that I was experiencing linked with asking for help.