Veteran Families with PTSD: An Insider's Perspective

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Notice 1

Abstract

Research on the impact of military related posttraumatic stress disorder (PTSD) on veterans' families has grown over the years, particularly given the increase in conflicts through the Middle East, and almost continuous international operations since 1990 (Bryant et al., 2019). Correspondingly, there is a growing body of evidence highlighting the intergenerational transference of mental illness, relational difficulties, and family conflict within this population. Research involving contemporary veterans (those who served in conflicts post-Vietnam), predominantly utilises cause-effect quantitative research methods to find correlations between the impact of PTSD and offspring mental health. An area that continues to be less well investigated, is the parenting, co-parenting/partner and youth experiences within these families. Studies that have taken a qualitative approach to exploring the experiences of veteran families and PTSD, have done so from the single perspective of veteran, partner or child, with only some incorporating a dual perspective. To date, there are no known qualitative studies that assume a triangulated approach, to include participants' perspectives from all three family stakeholders.

The aim of this thesis was to broaden the knowledge of how veteran families experience parental, military-related PTSD, including perspectives from veteran parents, partners and youth. There were three components to this thesis: a systematic literature review that synthesised the current qualitative research on parental military-related PTSD and families; a qualitative study phase that utilised in-depth interviews with the three distinct stakeholders regarding their family experiences: (i) the veteran parent with PTSD, (ii) partners and co-parents and (iii) the youth; and finally synthesis of the data collected from all studies conducted, generating themes for the 'whole' family as well as differences between groups regarding family experiences.

The systematic review searched six databases, yielding 11 studies with 114 participants across studies. Thematic content analysis was used to make sense of the themes found across the literature, and are reported in Chapter Two. The review is the first of four publications included in this thesis. Findings from the review were used to inform the three independent phenomenological studies that sought to identify the perspectives of veterans, partners and youth, regarding their experiences of parental military-related PTSD. Data collected from semi-structured interviews were analysed using a combination of thematic content analysis (Paper 2) and Interpretive Phenomenological Analysis (IPA; Papers 3 & 4). Across the three studies there were 27 participants, including: 11 veteran parents, eight partners of veterans and eight youths ranging in age between 12 and 17. Findings from the veteran parent, partner and youth studies reported in publications, included in Chapters 4, 5 and 6 respectively. Based on these findings, the family experience of parental PTSD within veteran families identified the shared and unique themes among the family members with two important convergence of themes: first, strong family alliances exist within these veteran family despite dysfunction and second, a seemingly contradictory sense of disconnection exists, with each member expressing this concept differently. The thesis concludes by outlining the implications for interventions, resources and service delivery as informed by the findings of this thesis as a whole. The limitations of the thesis and potential future research projects are also noted.

Thesis including published works declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes four original papers, three published in peer reviewed journals and one manuscript in Chapter 6 that is currently In Press, accepted for publication. The core theme of the thesis is the family experience of living with military-related posttraumatic stress disorder, from the perspective of all three stakeholders: the veteran parent with PTSD, the partner parent, and the youth. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the Faculty of Education under the supervision of Professor Andrea Reupert, and Professor Darryl Maybery (Until 2019). Assoc Prof Sandra Steward joined the supervision team in 2019.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research. In the case of Chapters Two, Four and Five and Six my contribution to the work is outlined in Table 0.1.

Table 0.1

Contribution of Authors to Publications Included in Thesis

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co author(s) is a Monash student?
2	Military Posttraumatic stress disorder: A qualitative systematic review of the experience of families, parents and children.	Published	**80%** Candidate contributed to the concept, design, development of research protocol, data collection, analysis, writing and editing of manuscript, submission of manuscript.	10% **Prof Andrea Reupert** contributed to the concept, design, data screening and analysis, editing of manuscript. 10% **Prof Darryl Maybery** contributed to concept, design, data screening and analysis, editing of manuscript.	No No
4	Parenting with Posttraumatic Stress Disorder: A Veteran's experience	Published	**80%.** Candidate contributed to the concept, design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, submission of manuscript.	10% **Prof Andrea Reupert** contributed to concept, design, development of research materials, analysis, manuscript preparation. 10% **Prof Darryl Maybery** contributed to concept, design, development of research materials, manuscript editing.	No No
5	Partners of Veterans with PTSD: Parenting and Family Experiences	Published	**85%.** Candidate contributed to concept, design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, submission of manuscript.	10% **Prof Andrea Reupert** contributed to concept, design, development of research materials, analysis, manuscript preparation. 5% **Prof Darryl Maybery** contributed to concept, design, development of research materials, manuscript editing.	No No
6	"Don't talk about that stuff": Experiences of Australian Youth Living with a Veteran Parent with PTSD	Accepted	**90%.** Candidate contributed to concept, design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, submission of manuscript.	10% **Prof Andrea Reupert** contributed to concept, design, development of research materials, analysis, manuscript preparation.	No

I have not renumbered sections of published papers in order to generate a consistent presentation within the thesis. Approval to conduct the research reported here was sought and granted by Department of Veteran Affairs Human Research Ethics Committee (DVA HREC), and Monash University Human Research Ethics Committee (MUHREC), documentation for which is found in Appendix A.

Student signature: Date: **2nd March 2021**

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author, I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: **Date: 2nd March 2021**

Publications During Enrolment

*McGaw, V. E., Reupert, A., & Maybery, D. (2018). Parenting with posttraumatic stress disorder: A veteran's perspective. *Traumatology, 24*(4), 255-262. Doi:http://dx.doi.org/10.1037/trm0000154

*McGaw, V. E., Reupert, A. E., & Maybery, D. (2019). Military posttraumatic stress disorder: A qualitative systematic review of the experience of families, parents and children. *Journal of Child and Family Studies, 28*, 2942–2952. Doi:10.1007/s10826-019-01469-7

*McGaw, V. E., Reupert, A. E., & Maybery, D. (2020). Partners of veterans with PTSD: Parenting and family experiences. *Families in Society*. Doi:https://doi.org/10.1177/1044389420905753

*McGaw, V. E., & Reupert, A. E. (2021, In Press). *"Don't talk about that stuff": Experiences of Australian youth living with a veteran parent with posttraumatic stress disorder*.Traumatology, DOI: 10.1037/trm0000317

Reupert, A., Gladstone, B., Hine, R., Yates, S., **McGaw, V.**, Charles, G., Drost, L., & Foster, K. (2020). Stigma in relation to families living with parental mental illness: An integrative review. *International Journal of Mental Health Nursing.* Doi: https://doi.org/10.1111/inm.12820

Hinton, M., Metcalf, O., Varker, T., **McGaw, V. E.**, Watson, L., Fredrickson, J., Johnston, L., Forbes, D., Phelps, A., Kartal, D., Dell, L., Bryant, R., McFarlane, A. C., Hopwood, M., & O'Donnell, M. (2020). *In their own words: A qualitative study of the experiences, expectations and perceptions that underpin decisions regarding PTSD treatment amongst help seeking veterans.* Manuscript submitted for publication.

* Denotes publications/manuscripts pertaining to this thesis

Acknowledgements

What a journey this has been! When I began the candidature in 2013, I struggled to see myself at this point, and yet, here I am. This has not been a journey alone, and would not have been possible without the unwavering support I have had from many sectors, first and foremost my family.

To my husband Geoff, without your belief in me, I would have considered giving it all away on many occasions. You enabled me to study long days, to run away from the family and retreat into my computer, days at a time... over and over again. You have held the fort, you have cared for our children, you have supported my growth as a researcher, seeing the benefit in conference attendances, networking events and professional development. I am so truly grateful to have you by my side in this, and I promise the next learning venture is yours ;)

To my children, Zac and Isabelle, thank you for your patience and understanding. I know I have gone away to study – or stayed home on many family outings so I could 'write' – what you may not have known was those outings were Dad giving me space to write and meet a deadline. Thank you for the hugs, shoulder rubs and the 'backing away slowly' when you saw that 'you better be dying if you are thinking of interrupting me' look in my eye, as I was mid-sentence. I truly hope that despite the moments I have missed with you over the years, that the ones where I was present were quality, and were enough. I hope one day you see me as a role model for hard work, persistence (or perhaps perseverance), and also empowerment to reach for what you want! I heard a saying once by Richard Bach, and it has stuck with me: "Argue your limitations, and sure enough, they're yours".

So instead of 'I can't do this', I hope my efforts help you as an adult take a breath and say, 'maybe I can!'.

To my supervisors, Andrea Reupert and Darryl Maybery, I cannot thank you enough! The two of you are a perfect pair, providing such rich guidance and support throughout the process. I almost felt like you were my researcher parents, allowing me moments to feel defeated when I had a setback (15 months of rejected ethics proposals!), but then picking me up, setting me on my feet and saying, "We believe in you, just keep going". Thank you for the productive feedback and editing of everything I have written. Thank you for being available, for the timely response to my emails, texts and phone calls. Thank you for encouraging me to attend conferences, collaborate on a book, to resubmit to different journals. Thank you for the time. Honestly, I am not sure you sleep Andrea! I hope our connection does not end at the conclusion of this thesis. I would also like to thank Sandy Stewart, who stepped in to be a secondary supervisor when the University decided Darryl had to withdraw as my supervisor. Thank you for coming in at the 11th hour, after my gnashing of teeth and roaring of terrible roars did not budge the University's unjust removal of Darryl from my supervisory team.

Now to my colleagues, both professional and academic, for all your support through the years. Doing this PhD by distance has been hard, and having people such as the Prato colleagues (too many individuals to mention by name) to feel as if I am part of something has been so rewarding. Attending all the research days has helped keep me tied into the university. Also, to all the PhD students who went before me, and let me read their various documents, so I could 'get my head around' what was expected...it was so invaluable, and I will more than happily pass on the love with students to come after me. Thank you, Nat Hanily, thank you Nicole Detering, Julie Salter and Marie Simpson for being my ‘girls’ through this! Thank you for the dinners out, the encouragement and understanding (thank you for the tissues and the laughs). Thank you for consultative support around this very important area.

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To all the people who participated in this research, who openly shared their stories with me, allowed me to look in at their family life and help me understand what it is like to walk in their shoes. Thank you for educating me – my practice has changed because of you. Thank you.

Lastly, thank you to the veteran and his family who inspired me to do this project, my muse so to speak. I am so grateful you took a chance trusting me, taking steps that were incredibly hard, staying alive, letting me get to know you and your family. You have left an indelible mark in my life and I thank you. I know your privacy is important to you, so let’s just say ‘you know who you are’.

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Preface

A Positioning Statement: Bracketing My Story, Understanding the Beginning.

I became passionately interested in veteran families living with and parenting children in the presence of PTSD, through my clients at work. I am ex-military and while no longer in uniform, I continue to work within the Australian Defence Force, providing psychological treatment to Service personnel. PTSD is one of the primary disorders among my clients, many of whom are parents, struggling with the challenges of managing mental health in the context of raising children. One client in particular influenced this research. Symptoms of PTSD, particularly hyperarousal symptoms impacted his ability to work, sleep or use public transport. He described everyday parenting challenges such as teaching his daughter to ride a bike, because every street, path or park was potentially threatening. His emotional dysregulation was problematic in the family and at home, yet he was doing everything he could, to raise his daughter well and keep her safe. This client shaped my desire to learn more about families like his, as I felt like there was more I should have been able to offer, however I did not understand as a clinician, what it was like to live in his family. By his account, he seemed so... parental, quite the opposite to how veteran parents were often portrayed in media, film and in clinical research.

As a clinician working extensively with veterans, and a researcher in the field, I am very cognisant of the risk of personal bias entering the data, because of my intimate knowledge of veteran parents in a clinical setting. To bracket my experiences and minimise existing bias, my approach to the research is purposefully not grounded in pre-existing theories or suppositions. I also engaged in a number of processes to reduce researcher bias, that I discuss throughout this thesis. Essentially, I wanted to ‘ask the experts’ about what it is like living in their shoes, then provide the space for those responses to be whatever they may be. Beyond the Thematic Analysis used early in the research, Interpretive Phenomenological Analysis (IPA) allowed me as a researcher, to interpret how my participants made sense of their own experiences. In true double hermeneutic style, I too then began to make sense of my own experiences, and at the same time was able to observe my reaction/meaning-making to the themes found in the participants’ own meaning-making. I discovered through this process that the lived experiences of these families were not familiar just because I was a psychologist working within the Military, they were familiar, because they were my story too.

I grew up a child of a parent with a mental illness. Having a mother with depression and anxiety, along with two stepfathers with depression and significant emotional dysregulation, has shaped the person I am, the choices I make and the profession to which I am drawn. When I started this thesis, I had not considered my childhood experiences in the context of the lens through which I view life, or how I might interpret and influence my research around posttraumatic stress disorder in families. It was the journey of exploring the intergenerational intricacies around PTSD, that I began to also join the dots for myself. Because I am not only the child of a parent with a mental illness. My mother (as did I) also experienced the trauma of losing my brother Tao at birth, then my sister Isobel’s death at two months old. I was four and six years old respectively. That my mother was emotionally unavailable is understandable and likely inevitable as she too is the daughter of a veteran with trauma-related mental health and personality vulnerabilities.

My maternal grandfather was a cartographer in the Australian Army during World War II. Sent to New Guinea, he accompanied the scouts, often in highly dangerous situations mapping the land and witnessing horrific events. My Grandfather was a scary, cantankerous person, unpredictable in his anger. While undiagnosed, he likely met criteria for PTSD, though he would never speak about the war, nor how it affected him. His counterpart was my grandmother, the one truly incredible, stable constant in my childhood. She made up for my unapproachable grandfather. She smoothed the waters with my mother, she made sure I knew I was lovable and special. She was a buffer, and I now know why she was 'smoothing things over' and 'settling everyone down'. My grandmother Leslie hated conflict, she did not like to see people upset, nor did she want to talk about feelings, or 'make a fuss'. My grandmother was the daughter of a veteran with a mental illness, PTSD in particular.

My maternal great-grandfather Fred was a veteran of the first World War, a stretcher bearer for the 5th Australian Division and involved in what is now known as the Battle of Fromelles, where over 5500 Australian soldiers became casualties in a single 24-hour period. His medical records show that he was infirmed within a month of this event for 'shell shock'. After a few weeks respite Fred was sent back to the front line twice more, before being removed permanently for 'frayed nerves'. He was medically returned to Australia, with a new wife, my great-grandmother Gemima, whom he met while recovering in a British Forces hospital.

Fred had PTSD. He was unable to work consistently, would have 'bad headaches', sometimes drink too much, had trouble being in crowds, had frightening night terrors and dreams, and was emotionally reserved. Despite all this, Fred and

Gemima loved each-other and maintained a strong connected bond through all the difficult aspects of living with someone with PTSD. They raised three children, with my Grandmother Leslie being instrumental in helping me piece this together, speaking at length about her experiences growing up. She was fiercely close to her father, and her stories protected his image.

As I walked through this journey of exploring current day veteran families and their experiences, I found the same themes in my own history and the stories of my ancestors. My great-grandfather was a veteran parent with PTSD. My grandmother was a child of a parent with PTSD. She married a veteran exposed to war trauma, who was also the child of a parent with mental health issues. My mother was the child of a veteran with trauma related issues. I, and my sister Melody are the daughters of parents with mental illnesses and trauma. We are now both parents. Where I have made it to my middling years essentially mentally well (I think), Melody has battled depression and suicidality all her life. Her children are growing up with a parent with mental illness. And so, the cycle goes on.

Like my grandmother, I have a strong drive to ease the burden of others, to ‘smooth things over’. I do this by continually upskilling, to be the ‘very best clinician’ I can. As a researcher, I strive to authentically represent these people and their experiences. The difficulty I have faced because of my intrinsic interest and motivation to be authentic, has been letting go of data as ‘not relevant to the research question’. Not relevant. Such a fatal term and implies ‘not important’. Yet for me, it is ALL important, because for each and every participant, it is. I see my own background as a clinician, and family history of intergenerational military (and civilian) trauma is a primary source of this internal conflict around ‘relevant’ data. So, for the sake of a ‘finished’ thesis, I have had to manage my internal conflict, and accept that I have done my best.

Chapter 1. An Introduction to the Thesis

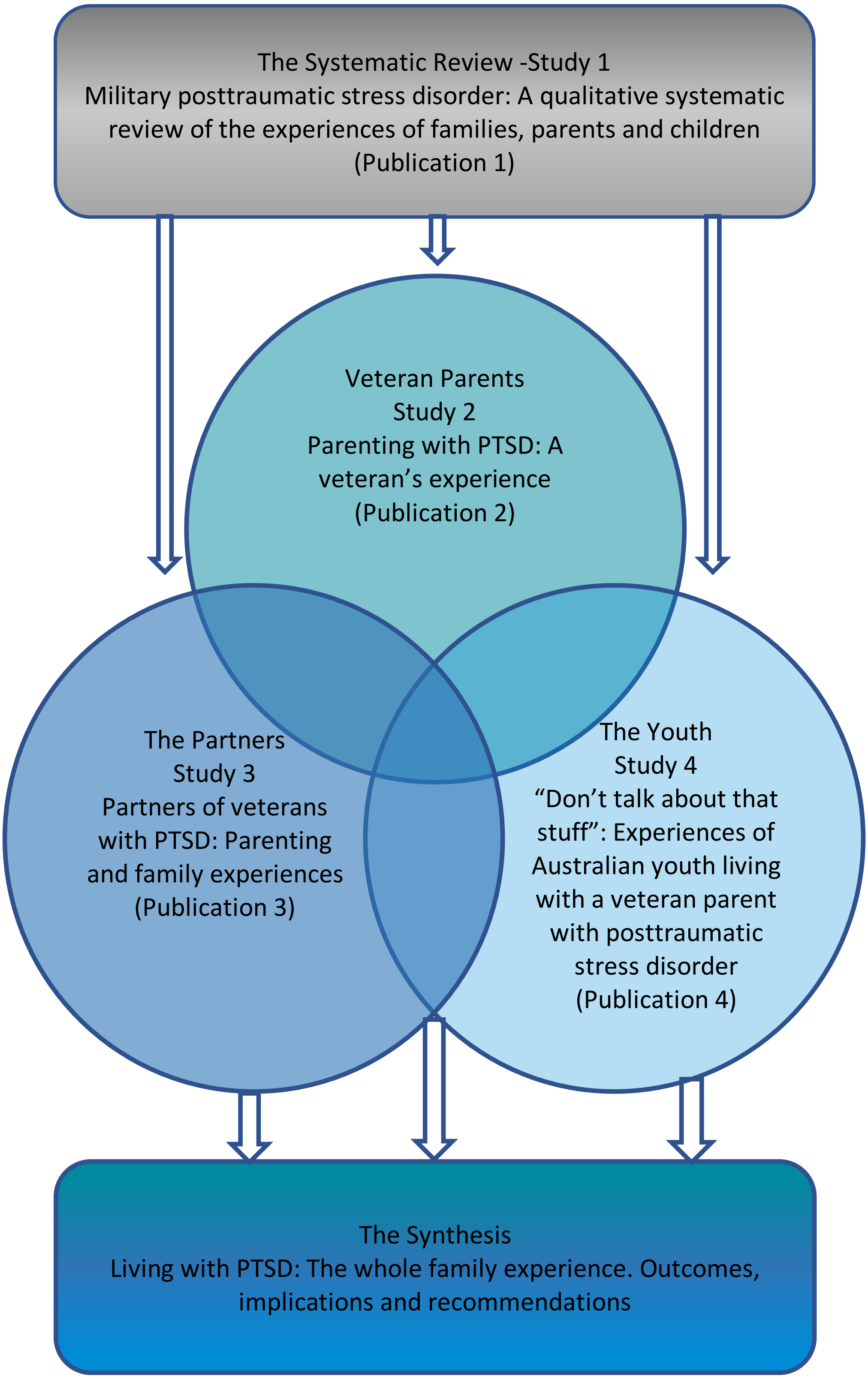
In Australia, there is a significant increase in veterans identifying as experiencing PTSD post-deployment and upon exit of the Australian Defence Force (Bryant et al., 2019). Though there is a lack of statistics around Australian military and veteran families, a projected 39% of Australian households are also families with at least one dependent child (Australian Bureau of Statistics, 2019). Drawing from international research, these figures are likely to be higher for serving members, as it is a predominantly a young population (18 – 55 years) most likely to be raising families (Creech et al., 2014). Furthermore, of veterans with PTSD, an estimated 63% are in families raising children (Teten et al., 2010). The overlap of these statistics indicate there is a significant number of children within households where a military or veteran parent has a mental illness, with PTSD being among the most prevalent mental illness. Since the Vietnam War, Australian soldiers are experiencing the longest sustained engagement in peacekeeping and warlike operations, and the number of families raising children in the presence of PTSD continues to grow. Where research regarding veterans has recognised the complexity of PTSD and the impact within families, there has been very little qualitative exploration to understand the perspectives and experiences of those at the heart of this phenomenon. This thesis explores the phenomena of Australian veteran families living with PTSD, through the lens of the veteran, the partner and the child.

1.1. Thesis Structure

This thesis is a ‘thesis with publication’, hence it is structured slightly differently to a traditional thesis. While it continues to have framing chapters and detailed methodology, the core chapters incorporate material that has been written for, and submitted to, peer reviewed journals for publication. Given the nature of published articles to be read independently, there is some unavoidable repetition with regards inclusion of background literature and research framing each paper, however care has been taken to minimise repetition as much as is feasible. Each of the studies, while unique, are ultimately woven together as integral parts of a single cohesive thesis. The included publications adhere to Monash University’s policies regarding theses with publications by retaining journal specific formatting and layout. As such, there are some minor differences in formatting across chapters, including additional page numbers. Figure 1.1 displays the overall structure of the thesis, with the publications identified.

Figure 1.1

Thesis with publications: Overall project structure



The Preface placed before Chapter 1 provides a positioning statement outlining the context within which this research was conducted. As a phenomenological qualitative thesis it was necessary to acknowledge the presence of the author throughout the research, along with steps taken to ensure authenticity of the participant perspectives remained. Chapter 1 (this chapter) provides an introduction, background and rationale for the study as well as an overview of the dissertation. Chapter 2 reviews the qualitative literature on families living with military related PTSD by way of a systematic review and incorporates the first of the publications included in this thesis (McGaw et al., 2019). The chapter also includes an extended methodology for the systematic review. A key aim of this review was to synthesise existing qualitative research on the topic, as it is typically difficult to search and identify qualitative studies in database searches. The findings of the review guided and influenced the subsequent qualitative studies that form the basis of this thesis.

Chapter 3 provides a detailed methodology of the three qualitative studies representing the core purpose of the research project. The perspectives of veteran parents are represented in Study 2 (Chapter 4), being the second publication included in the thesis (McGaw et al., 2018). Chapter 5 presents the perspectives of partners, by way of the third publication (McGaw et al., 2020), and those of the youths are presented in Chapter 6 (article submitted for publication).

Chapter 7 then discusses the themes found across studies reported in the preceding three chapters, with themes discussed in the context of the veteran family experience of living with PTSD. Strengths, limitations and implications arising from this thesis are the focus of Chapter 8, with a Postface finally reflecting on the research process as a whole, and concludes the thesis by way of a bracketing reflexivity comment.

1.2. Parent and Family Terms Defined

The title 'parent' is intended to be inclusive of stepparents, separated parents or parents/co-parents not residing under the same roof and who continue active (daily/weekly) participation in the 'family'. It was also acknowledged that the parental role may be filled by a grandparent, foster parent, or other family relative, who would also be included in this study as long as they met the inclusion criteria described for one of the parent groups and was in a primary care giving role. In the case of the participants included in the present study, all were biological parents to at least one child under 18 years.

For the purposes of this study, the term 'family' was harder to establish, primarily because of the diverse range of definitions, models and theories around the configuration of families presented in the research at large (Schadler, 2016). Given the purpose of the study however, it was felt that at a minimum the term 'family' required at least one adult in a care relationship for a person 18 years or younger.

The application of the term 'family' differs dependent on the research question/s, the researchers' own backgrounds and biases and the cultural milieu in which the research is set. For example, recognising the multiple variations of family structures a person might experience, Widmer and Jallinoja (2008) in their individual interviews asked participants to "please describe who is in your family?". This same self-determined definition of family was employed in the current study, then to expand, participants were asked "who (if anyone) is part of your extended family?".

The purpose of a self-determined definition of 'family' such as employed by Widmer and Jallinoja (2008), and now in this current research, allowed participants to acknowledge their own 'family' regardless of gender, number of parental figures, presence of biological connection or direct maternal/paternal association.

Families as defined by participants in this overall project included: single parent; two parents; multigenerational parent (Grandparent also living in the home); Uncles/Aunts; one child; multiple children/siblings; stepchildren/siblings; one veteran parent; and two veteran parents.

Within the discussion, 'family' refers to the combined experiences of participants included in the studies presented in Chapters 4, 5 and 6, there was no specific expectation of gender or biological connection for any role within the family, though the specific demographics of each participant group are identified within the respective chapters. The family unit was considered to include the veteran parent, the youth and the partner or caregiver, traditionally considered the other parent.

1.3. Parental Mental Illness, Families and Children

Though often treated in isolation, parental mental illness affects more than the individual experiencing the condition; it impacts upon the whole family especially children who live with the symptoms and behaviours of the parent's mental illness (Fudge et al., 2004). Not all children who have a parent with mental illness will be negatively impacted. However, a number of studies both in Australia and internationally indicate that one to two thirds of these children will experience dysfunction, developmental and educational difficulties or a mental illness (Bee et al., 2013; Reupert & Maybery, 2009). It should be noted that it is not so much the mental illness that causes difficulties (Smith-Osborne et al., 2013b), as the environment in which the illness occurs or the interplay of overlapping conditions such as instability, parent/child attachment, family function/dysfunction or breakdown (Andersson, 2015; Marsanic et al., 2014) as well as other environmental factors often associated with mental illness such as unemployment, housing instability and isolation (Australian Institute of Health and Welfare, 2015).

As well as developing their own mental illness, children may experience other negative outcomes. Coping skills, self-esteem and image, attachment to others and emotional regulation are all affected by the environment within which children develop (Al-Turkait & Ohaeri, 2008; McCormack & Devine, 2016; Oskouie et al., 2011). When reviewing the issues for children associated with parental mental illness, Reupert and Maybery (2007) described a potentially chaotic and threatening home environment, or contrastingly one that is physically safe but where the parent is emotionally absent. Children may find themselves prematurely in a caregiver role for parents or younger siblings, or socially restricted as a result of perceived or actual stigma. For example, Oskouie et al. (2011) presented interview findings wherein children living with a parent with a mental illness reported social isolation, particularly when their parent required hospitalisation. Where these findings relate to children of parents with any mental illness, this thesis is specifically interested in in when that mental illness is PTSD.

1.4. What are the Family Experiences of Military-Related Parental PTSD?

In light of the growing number of military children living with at least one veteran parent with combat-related PTSD, Smith-Osborne et al. (2013b) performed a systematic ‘review of reviews’ investigating the potential neurobiological transmission of trauma from parent to child. The researchers were interested in whether the neurochemical and physical changes in the brain that occur as a result of exposure to traumatic events were passed on genetically from parents to children. The review included ten studies that synthesised over 1000 publications and sampled over 35,000 individuals exposed to trauma, PTSD and healthy controls. The authors noted that at that time (2013) there were no current systematic reviews or meta-analysis of research focused on military children and parental trauma. They concluded that while there were some indications of increased vulnerabilities, the child experience of parental trauma or PTSD was fundamentally different to that of the parent. This is not to imply an intergenerational transference does not exist, but instead that children "feel" and experience PTSD differently to the parent (Smith-Osborne et al., 2013b). Of the studies that included military children, an interplay of genetic-environmental factors attributed to both resilience (in the face of trauma) and vulnerability (potential to develop PTSD or other mental disorders) for these children (Smith-Osborne et al., 2013b) was found. Therefore, the authors suggested that parenting and family stress in the absence of maltreatment, but in the presence of PTSD, may be relevant for future research into the area of secondary trauma (2013b). Therein lies the need for the present project.

Lambert et al. (2014) conducted a meta-analysis on the relationship between parent PTSD symptom severity and child psychological distress. The study further investigated the research based premise that parental PTSD influences child psychological difficulties. While the meta-analysis was not specific to military, war or combat trauma, of the 42 studies included at least half related to PTSD experienced as a consequence war or combat. The researchers were interested in variables such as parent only trauma (for example: combat trauma or interpersonal violence experienced only by the parent) vs parent-child trauma (for example war refugees or natural disasters experienced by both parent and child), type of traumatic event and gender of traumatised parent. The results of this meta-analysis confirmed the relationship between parental PTSD and child distress. The researchers however found no significant difference in child psychological distress when comparing parent only trauma vs parent-child trauma, with the exception of interpersonal trauma experienced by both parent and child. As such, the why and how a causal relationship existed was not fully explored, with Lambert et al. (2014) suggesting further research that includes both parents and other family factors such as ethnicity, child gender and age (2014).

The relationship between parental PTSD and family functioning has also been a focus of previous research, given the impact of parental PTSD identified for children within these families. A study of Croatian in-patient adolescents with fathers diagnosed with war-related PTSD, reported significantly poorer family functioning in the areas of affect, communication and joint problem solving, when compared to matched families where veteran fathers did not have PTSD (Boricevic Marsanic et al., 2014). In another longitudinal quantitative study involving 311 veterans with PTSD, Evans et al. (2009) found a moderate relationship between family dysfunction and outcomes for veterans in treatment for PTSD. Interestingly PTSD symptoms did not predict family functioning (2009). Rather those with higher levels of family functioning were able to maintain this level of functioning over the course of treatment despite significant PTSD symptoms, also showing better veteran response to treatment, defined as a reduction in symptoms over time (Evans et al., 2009). Where dysfunctional family relationships existed, veterans were less able to benefit from treatment. The studies by Evans et al. (2009) and Boricevic Marsanic et al. (2014) were both quantitative studies using various self-report measures to assess family functioning. Where Evans et al. (2009) suggested their measure was brief and did not adequately examine family functioning, Boricevic Marsanic et al. (2014) indicated they only collected data from the adolescents in the family, and recommended that future studies incorporate in-depth explorations of family functioning from multiple family view points. As repeatedly articulated in this thesis, when exploring a family phenomenon, it is important to examine it from different family member viewpoints.

1.5. What is it Like to be a Veteran Parenting with PTSD?

> *We were at a shopping centre, my 5year old daughter [My daughter] and I were sitting in the food court having lunch while my wife ducked into a shop. [My daughter] says with no thought at all: "Daddy that man is looking at me". I immediately feel my heart race, my adrenaline spikes through the roof and I grab my daughter trying to assess the threat. She can't point out the man, and I can't calm down. Everything in my body was shaking; I would not put my daughter down. I just wanted to find the guy and smash him. My wife returned and I had to get out of there. We hadn't done our shopping yet, but I had to get out of there. I knew it was irrational, there was no real threat, but I felt that threat to [My daughter] in my whole body. She couldn't understand why we had to go home so soon.*
>
> (41year old male veteran parent participant)

The above example from one of the participants occurred during casual conversation outside the recorded interviews used in the studies (Included here with permission), and provides a small snapshot into the impact PTSD can have on parenting and participating in routine, daily activities. Perhaps unsurprisingly, PTSD has been found to impact the positive ‘experience’ of parenting (Berz et al., 2008; Khaylis et al., 2011). Hyperarousal symptoms, while often debilitating, are but one of a cluster of PTSD symptoms that impact parenting. Studies from Ruscio et al. (2002), Sherman et al. (2016) and Samper et al. (2004) identified emotional numbing, detachment and avoidance may adversely impact the parent-child relationship and satisfaction with the parenting role. Similarly, in a study of veteran Israeli veteran fathers with PTSD, Cohen et al. (2011) found that these participants reported lower parenting satisfaction, poorer family functioning and higher levels of concern for their children, than non-PTSD veteran fathers. The study also found parental attachment styles of veteran fathers with PTSD (both avoidant and anxious) negatively impacted parental satisfaction. One possible explanation relates to PTSD symptoms of hyperarousal, anxiousness, and avoidance which may impact the veteran parents’ engagement and reduced emotional involvement with their children, thus impacting parental satisfaction and functioning (Cohen et al., 2011).

The previous studies have identified that PTSD has a negative impact on the parenting experience (Berz et al., 2008; Dekel & Monson, 2010; Khaylis et al., 2011). Previous research shows causal associations between parental PTSD symptoms and parent-child relationships (Ruscio et al., 2002; Samper et al., 2004). Likewise, there is a link between veteran trauma and poor parenting satisfaction (Cohen et al., 2011; Sherman et al., 2016). Correlations between PTSD symptoms, parental functioning and parent-child attachment exists (Cohen et al., 2011). What is unclear from the previous literature on parenting with PTSD is how various PTSD symptoms impact the experience of parenting. With most studies referring to parental functioning, satisfaction and attachment in quantifiable terms, I would suggest that there is more to understanding the phenomenon than simply measuring the negative impact of PTSD on these facets of the parenting and family experience. Additionally, previous research has not adequately explored how these veteran parents manage, cope and continue to be part of families, parenting children. A qualitative approach is needed to explore such issues, including any positive outcomes for veteran parents living with PTSD.

1.6. What is it Like to be a Partner and Co-Parent in a Veteran Family?

There has been a growing level of interest in understanding the impact of PTSD upon partners, since early studies such as Maloney (1988) and Carroll et al. (1991). These researchers raised the issue of assessing the family and in particular the partner where a person has PTSD, highlighting the interaction of the family system on the individual and vice versa. Since then, research findings have indicated higher levels of marital aggression, partner fear and mistrust within veteran families with military-related PTSD compared to veteran families without PTSD (Angkaw et al., 2013; Yambo & Johnson, 2014). Similar to families where one parent has a chronic disease, partners of veterans can find themselves in a caregiver role, with associated issues including social isolation, crisis and symptom management and disturbance to the family system (Calhoun et al., 2002; Gursimran et al., 2018). Partners of veterans have also indicated high rates of somatic complaints, increased anxiety, sleep disturbance and mood disorders (Yambo & Johnson, 2014).

One systematic review by Diehle et al. (2017) investigated secondary trauma symptoms in ‘significant others’ of veterans, including parents, partners and children. Of the 48 articles included in the review, more than half focused on partners. The study identified inconsistent findings of PTSD symptoms among veteran's offspring, though a stronger correlation was found among partners than other dependents (Diehle et al., 2017). The authors were cautious to attribute this entirely to veteran PTSD, as many of the studies included in the review did consider independent partner exposure to trauma. That being said, where studies compared symptoms between partners of veterans with and without PTSD, those whose partners had PTSD, reported higher levels of trauma symptoms (Diehle et al., 2017).

Separate to the impact of veteran PTSD upon partner likelihood of PTSD symptoms, it appears that there is a clear relationship between PTSD and partner distress (Renshaw et al., 2011). Similarly, there is an impact on parenting for partners as intimated across partner studies (e.g. Allen et al., 2010; Patel, 2015; Renshaw et al., 2011), though there appears to be relatively little research regarding the impact of PTSD on a partner's experience of parenting alongside a person who has military-related PTSD, outside of caregiver burden. Caregiver burden refers to the objective and subjective burden of caring for a person with a chronic illness (physiological or psychological) (Calhoun et al., 2002).

To date, the lion's share of research regarding partners of veterans with PTSD has utilized quantitative methodologies to measure symptomology, correlations between PTSD and family relationships and caregiver burden. These quantitative studies have significantly improved our understanding of the far reaching effects of veteran PTSD, particularly regarding those factors that can be clearly defined, are measurable and unambiguous (Hammarberg et al., 2016). However, an issue that comes to light across studies on veteran PTSD and the experiences of veterans, partners, families and children has been the difficulty of clearly defining and isolating the variables within the phenomenon. Given human ‘experience’ is fundamentally subjective, it can be ill-suited to being narrowly defined and measured, with interpretations for general application limited to the specific variables being investigated (Gelo et al., 2008). To best explore the human experience, perceptions and meaning-making about a phenomena, a qualitative approach is needed (Kitto et al., 2008). With limited exploration of the parenting, co-parenting roles, challenges and positives experienced by partners of veterans, a qualitative approach is needed, where the narratives of partners is included. Without this, we as researchers are ‘guessing’ about what are important factors for this population (Hammarberg et al., 2016; Patton, 2014).

1.7. What is it Like to be a Child of a Veteran with PTSD?

Since the Vietnam War, there has been increasing interest in understanding the impact of military life (e.g. moving every three years, frequent and extended absences of one or more parent, changing schools and broken friendship groups) on veteran children. Park (2011) reported that these children are at risk for a number of educational and psychosocial challenges, independent of potential parental mental illness. With up to three times the mobility of children from civilian families, secondary school aged children commonly experience disruption to social networks, and need to constantly readjust to new surroundings and school cultures. Parental deployment to a war zone acts as an added stressor for children living within military families (Leiner, 2009). In an early quantitative study in this area, Westerink and Giarratano (1999) found that Australian children of Vietnam veterans with PTSD rated higher levels of family dysfunction, however levels of self-esteem and psychological distress, were comparable to peers living in civilian families. Another quantitative study by Davidson and Mellor (2001) reported similar results, though also recognised complex family dynamics and ineffectual problem-solving abilities in Australian veteran families. Salter (2008) found higher rates of depression, anxiety and anger compared to non-veteran counterparts in their quantitative study of Australian Vietnam veteran children. All three of these earlier studies of Australian children of veterans with PTSD involved young adults with mean ages of 20 – 23 years rather than children or youths. As with other quantitative studies regarding veterans and partners, these studies show children of veterans reported heightened family dysfunction and psychological challenges. Qualitative enquiry regarding the experiences of youth of veteran parents with PTSD is needed to better understand the phenomena of what it is like to grow up in a household, where a parent is living, managing and parenting with PTSD related to their military service.

One such retrospective study by McCormack and Sly (2013) of three sisters aged 28, 34 and 37 years with a Vietnam veteran father, employed a qualitative design to further understand the accounts of these adult children's experiences of growing up with a Vietnam veteran parent. Findings suggested longer-term impacts are not necessarily measurable (limited by pathology), but instead are felt and experienced. They reported both negative and positive experiences, ranging from rejection and imitative behaviour through to personal growth and acceptance. Another similar phenomenological study, McCormack and Devine (2016) report the retrospective experiences of five adult Australian children between the ages of 28 and 38 years. The authors report the interpretations of childhood, where reflective insight helped to make sense of the emotional absence experienced by each adult child (McCormack & Devine, 2016). What is clear from these studies, is that the intergenerational experiences of parental PTSD for children are complex and not yet fully understood.

1.8. Limitations of Research to Date

On beginning this project, there were no known systematic reviews of the qualitative literature on the experiences of veteran families living with PTSD. Two meta-analyses by Lambert et al. (2014) and Smith-Osborne et al. (2013b) provide significant contributions to the literature on the intergenerational transmission of PTSD and the influence of parental PTSD on child psychological distress. The reviews do not focus the experience of PTSD within families, and no qualitative studies were included. A number of narrative reviews have been conducted in this area (Banneyer et al., 2017; Creech & Misca, 2017; Pemberton et al., 2013). Although existing reviews identified the importance of this field of study, particularly around intergenerational impacts, it was difficult to identify the qualitative studies, including those with a mixed method approach within the literature. Additionally, previous reviews often incorporated in studies on partner aggression (Creech & Misca, 2017), the impacts of deployment (Creech et al., 2014; Pemberton et al., 2013), or child pathology (Banneyer et al., 2017), and while all these experiences are important, are not the focus of this thesis.

There appears to be a lack of qualitative studies targeting veteran parents, though there have been some inclusion of qualitative methods within mixed methods studies(e.g. Sherman et al., 2016; Sherman et al., 2015). Similarly, the literature around partners of veterans lacks a focus on the parenting role, and the experience of shared parenting responsibilities with a veteran partner with PTSD.

Another key limitation in much of the research around the child experience is the retrospective nature of the studies, incorporating the reflective views of adult children. This is a limitation because as stated by Oskouie et al. (2011) “understanding children’s perspectives about the effects of their parent’s illness is important, as children’s needs tend to change based on these perspectives” (p34). If clinicians are to appropriately meet the socio-emotional, developmental and educational needs of children growing up in military/veteran families affected thus by PTSD, it is necessary to have a real time understanding of the experiences from their own perspective, alongside those of their parents.

Finally, there appears to be very little research investigating the impact upon the ‘whole’ family, where all stakeholder perspectives are considered, compared and contrasted. This is important, as the needs of one member may not be the same as another’s, and though families can be viewed as a single entity, it is made up of individuals, each of whom have a perspective that is important, when trying to understand the ‘whole’ (Perlesz & Lindsay, 2003).

1.9. Rationale and Research Aims

To date, much of the research related to PTSD, intergenerational transference or impacts upon family has been quantitative by design, and utilised a variety of measures, questionnaires and screening instruments. This approach has yielded strong correlations between PTSD in veterans and increased rates of dysfunction within the family, and identified higher risk among offspring for developing mental illness, compared to other children in the community (See for example, Pemberton et al., 2013). However, these quantitative studies may not fully explore and understand the experience of family life where a parent has military related trauma. There have been very few qualitative studies conducted in the area military-related PTSD and families, with none found to date that examines the holistic experience from the perspectives of children, their parent/caregiver with military related PTSD and the other parent or caregiver.

The aim of this thesis was to deepen an understanding of the phenomenon of veteran families raising children in the context of parental PTSD, and on this basis, develop recommendations for how best to support the whole family. A further aim was to explore the phenomenon through the perspectives of the three family stakeholders: the veteran parent with PTSD; the partner; and the child (or in this case adolescent). Multiple factors impact the healthy development of youths and parents living with PTSD, including interpersonal connections, parental absence/presence, intensity of symptoms in parents and children, and available supports (Banneyer et al., 2017; Collins, 2018; Creech et al., 2016). Thus, rather than choosing one or two potential factors that may or may not be the most significant for this specific community, this thesis explores the topic of living in a veteran family where a parent has PTSD through qualitative enquiry. It is hoped by doing so, those issues, factors and experiences most important to those at the centre of the phenomenon will better inform those in researcher or service provider roles, as to how best to meet the needs of these families.

Chapter 2. The Literature Review: “Military Posttraumatic Stress Disorder: A Qualitative Systematic Review of the Experience of Families, Parents and Children”

One of the difficulties when researching this topic has been finding relevant existing qualitative literature. As described in Chapter 1 at least two meta-analyses existed (Lambert et al., 2014; Smith-Osborne et al., 2013b), though neither included qualitative papers. Similarly, previous narrative reviews (Banneyer et al., 2017; Collins, 2018; Creech & Misca, 2017) focused on predominantly quantitative studies, with selective referencing depending on the specific aim of the review. With poor identification of qualitative studies across search engines and wide ranging keywords and titles used in previous qualitative research, a need was identified to bring together the existing qualitative research regarding the experiences of families living with veteran PTSD. This chapter provides the background literature review of the thesis, presenting the first published paper: “Military posttraumatic stress disorder: A qualitative systematic review of the experience of families, parents and children” (McGaw et al., 2019). This section also outlines the design and methodology for the review, that extends beyond that which was reported in the peer review publication.

2.1. Study Design and Methodology

The study combined two methodologies: firstly, the protocol for systematic reviews as prescribed by the Cochrane Collaboration (Perry & Hammond, 2002) which incorporates the ‘Preferred Reporting Items for Systematic Reviews and Meta-analyses’ (PRISMA) Group’ standard (Moher et al., 2009); and thematic content analysis as described by Braun and Clarke (2006) once relevant studies were identified.

2.2. Protocol for Conducting Systematic Literature Reviews

Developed for supporting best practice within health care through evidence based research, the protocol set out by the Cochrane Collaboration has become known as the 'gold standard' for conducting systematic reviews, due to their rigorous methodological standards (Furunes, 2019). The protocol outlines eight steps for conducting systematic reviews (Perry & Hammond, 2002), and is represented in Table 2.1.

Table 2.1

*Cochrane Collaboration Protocol for Conducting Evidence Based Systematic Reviews**

Steps	Description
1: Background	Provides a rationale for why a review needs to be done. Usually relating to inconclusive literature. Seeks to fill a gap in the existing literature.
2: The Review Question	Systematic reviews explicitly outline a review question, rather than reporting a range of research around a topic. The research questions need to be clear and specific.
3: Search Strategy	The search strategy is developed from the research question and is outlined for each database that is searched, according to the classifications of the particular database. Key elements of the research question are defined prior to searching and reported as part of the methodology.
4: Methods of Study Selection	Identification of potential studies to be included, based on research question. Reasons for exclusion need to be recorded for later reporting. This step is aimed to provide transparency in research methodology.
5: Quality Assessment	Quality for each included study is assessed, based on the type of study design. There are a number of quality assessment measures, and this step should be included in the methodology
6: Data Extraction	Identified outcomes of included studies are extracted, relevant information is recorded, usually in a database.
7: Synthesis	Data is collated and reported, linking back to the research question. Methodology for collation can vary dependant on the type of studies included in the review.
8: Timetable	A timetable/timeline is utilised to guide progress. This may or may not be reported within the review, however will be driven by the volume of available literature.

2.3. Background

An initial literature search indicated a small number of literature reviews (typically narrative in analysis) exploring the experiences of veteran families living with PTSD (Banneyer et al., 2017; Dekel & Monson, 2010; Pemberton et al., 2013). While there were no systematic reviews specific to the topic of parent, child and family experiences of veteran PTSD at the time of conducting this study, there was one systematic review on the impact of military deployment and reintegration on military children (Creech et al., 2014) and a meta-analysis on parental PTSD and child distress (Lambert et al., 2014). However, the former was not specifically focused on PTSD, though parental PTSD it was identified as significantly impacting on children; and the latter focused on quantitative parent-child symptoms, causal relationships and psychopathology. Findings from both reviews indicated a relationship between parental PTSD and child distress, however the nature of the relationship was unclear, and further investigation was warranted where the whole family context is considered. Moreover, included studies across both reviews were predominantly quantitative, with a cause-effect focus related to intergenerational psychopathology.

The narrative literature reviews do extend understanding, however have limitations including potential bias as a result of author determined relevance of the literature included, and relative lack of explicit methodology (Grant & Booth, 2009). For example, the Banneyer et al. (2017) review while detailed, only presented research around PTSD and the effects on children rather than the whole family. Similarly, Dekel and Monson (2010) reviewed the relationship between PTSD and family relations but methodology was not reported making it difficult to determine the completeness of the references utilized. Another review focused more on interventions for children of veterans, not specifically of veterans with PTSD (Pemberton et al., 2013). Since writing and submitting the qualitative systematic review presented in this thesis, there has been another review by Creech and Misca (2017) with a systematic methodology. However, being heavily reliant on quantitative studies (18 of 20 included studies), the review presented a cause-effect argument, rather than a descriptive broadening of the lived experience within these families.

During the initial search of studies related to war trauma, a confounding factor was the clear differences between 'shared trauma' experiences, as in the case of refugees, displaced populations or residents within countries still engaged in war-like activities, and parent-only trauma family experiences (Lambert et al., 2014). Similarly, there were issues around identifying qualitative studies within the databases, and how family was defined within studies. There was a distinct lack of clarity around the term 'family' within military-related PTSD and family studies. At times, it was difficult to determine if the impact on 'family' included children, or whether the term referred to family of origin or family of procreation. The family of procreation refers to families where individuals choose each other with whom to raise their own children, as opposed to families of origin into which a person is born (Gerhardt, 2016). Consequently, it was then hard to establish how family functioning was defined and according to whom. For example, many studies included findings such as "poor family functioning" using self-report measures, or inferred poor functioning from single items within larger scale measures (For e.g. Duranceau et al., 2015; Evans et al., 2009).

Based on the initial literature search, it was determined that a systematic review that focused on qualitative studies where ‘family’ was defined as including children, and where trauma was not shared, would be the best way to fully understand the present state of the research in this area.

2.4. Review questions

Research Question 1: What qualitative research exists to date exploring the experiences of family members living with parental PTSD related to military service?

Research Question 2: What is the experience in families where a parent has PTSD related to military service, from the perspective of parents with the disorder, their partner and children?

2.5. Search Strategy

Six online research databases were searched: Cinahl Plus, Scopus, PsycINFO, Medline, PubMed, and Proquest. These databases were chosen so as to facilitate the most inclusive search. The full list of search terms is provided within the published article. Where possible, searches were limited to ‘English’, ‘peer-reviewed’ and ‘full text’. When these limitations were not available, results were filtered during the screening process. As indicated in the paper, the database results were uploaded to RAYAAN (Ouzzani et al., 2016), a platform specifically designed for collaborative systematic reviews. All database results were title and abstract screened by myself, then Professors Reupert and Maybery screened the first 10% and last 10% of results respectively. Reference lists of resulting articles were also searched, with only one additional study found that met the inclusion criteria for this review.

2.6. Methods of Study Selection

It was decided by the research team that including both quantitative and shared trauma studies would not meet the objectives of the current study, and were therefore excluded. Studies were only included if they reported primary data, from people within a family where at least one person had a military-related PTSD. Parenting or the interaction of PTSD between parent and child (offspring)/family (procreation) needed to be the focus of the study. Studies only reporting a 'measure of family functioning' within a broader research topic were deemed insufficient to be included as 'PTSD and family focus'. Studies needed to include at least some component of qualitative research, explicitly employing either a qualitative or mixed methods design. Where mixed methods were utilised, only the qualitative component of the study was considered for the review. All studies involving child soldiers, children with PTSD, PTSD related to childhood events or non-military trauma were also excluded, as these were outside the scope of the review.

2.7. Quality Assessment

Details of the procedure for quality assessment are outlined in the publication. Using the 'Relevance, Appropriateness, Transparency and Soundness (RATS) qualitative research review guidelines' (Clark, 2003), each included paper was assessed against a 25 question guideline for research quality. Initially completed independently by the first and second author, final quality ratings were discussed by all three authors to consensus. The RATS was chosen because it was specifically designed to be used in peer reviews of qualitative research, and has become a commonly used tool for this purpose in other reviews due to its comprehensiveness (Cambon et al., 2016; Clark, 2003).

2.8. Data Extraction and Synthesis

Once the studies for inclusion in the review were identified, a data extraction table was developed, where themes and relevant information were compiled in a spreadsheet for further analysis. Information included author, country, participant type (e.g., veteran, partner or youth), age of children, era of conflict, methodology, quality rating and key findings.

Data synthesis involved thematic content analysis, applying the six steps outlined by Braun and Clarke (2006). The process for data extraction and analysis is outlined in the publication.

2.9. Timeline

Initial searches began in 2015, with search strategies and protocols determined by March 2016. Database searches were conducted through 2016-2017, with a final search occurring in January 2018. All results were continuously entered in RAAYAN for blind review by all authors, with analysis and write up complete by April 2018. The paper was accepted for publication in May 2019.

2.10. Relevance of the Study

This study was published in “The Journal of Child and Family Studies”. Being the first qualitative systematic review of this topic, it addressed an important gap in the literature, by explicitly exploring the experience of PTSD of veteran families, parents and children within a scientifically rigorous process. By exclusively reviewing qualitative literature, this review brings together lived-experience participant reports with researcher observations and conclusions, identifying themes across studies that previously may not have been recognised due to the silo nature of research into veterans PTSD (Grant & Booth, 2009).

2.11. Citation and Article

McGaw, V. E., Reupert, A. E., & Maybery, D. (2019). Military posttraumatic stress disorder: A qualitative systematic review of the experience of families, parents and children. *Journal of Child and Family Studies, 28*, 2942–2952. doi:10.1007/s10826-019-01469-7

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Chapter 3. Interview Research Design & Methodology

This project included the systematic literature review already introduced, that systematically identified qualitative papers, then analysed them within a qualitative framework. On the basis of the gaps found within the systematic review, three subsequent interview-based studies were then conducted with the three family stakeholders - children, partners and veterans. The next part of the thesis provides a qualitative synthesis across all four studies, presenting the whole family perspective.

3.1. Research Design

The research design conducted across the subsequent three studies in this thesis were qualitative in nature. A phenomenological approach was taken, with the phenomenon in question being the experience of living with PTSD, from different view-points within a family. As such, the interviews were designed to be complementary, utilising similar interview schedules for veteran parents, partners and youth.

3.2. Semi-Structured Interviews

Those working with a qualitative research paradigm may choose to employ a number of different methodologies for data collection, including small or focus group discussions, in-depth or semi-structured interviews, and analysis of written information, visual media or reports on the intended subject. Individual interviews are best suited for understanding experiences from a personal perspective (Hammarberg et al., 2016). Interviews can be structured, semi-structured or unstructured. While structured interviews are commonly used within clinical healthcare settings to determine specific outcomes such as diagnosis (e.g., the Clinician Administered PTSD Schedule; Weathers et al., 2018), a more flexible approach was required for the current research. Semi-structured, individual interviews (schedules in Appendix B) were used to explore the phenomenon of the 'lived' experiences of PTSD within families, by the three stakeholder groups. This approach was chosen both to guide discussion around parenting, PTSD, family and youth experiences, and to reduce researcher bias by allowing exploration of participants' experiences beyond the anchor questions (DeJonckheere & Vaughn, 2019).

3.3. Recruitment

The recruitment procedure was designed for broad dissemination among the veteran community to access the targeted population, while also minimising coercion. The study was promoted to mental health practitioners known to the researcher, and two adult and family mental health services: Toowong Private Hospital and Open Arms (formerly Veterans and Veteran Families Counselling Service). Permission to advertise the study through Open Arms was required, and is provided in Appendix C. Both services cater to a veteran population. Practitioners working in these services were invited to promote the study to suitable clients. Advertising flyers (Appendix D) were also left in waiting rooms. Practitioners were provided with information about the study, along with detailed participant information packs, to give to any families that were likely to be suitable (see Appendix E for practitioner, parent and youth information packs). No practitioner or service was informed of who did, or did not participate in the studies.

The project was also advertised in the public domain through targeted websites including a PTSD forum; a designated website providing all information sheets, consent sheets and researcher contact details; and social media, including a Facebook research page and promotion through LinkedIn. The majority of first contact for the study was made by potentially eligible people registering interest via a short online screening survey that will be discussed in more detail later under 'Materials'. Six participants who made first contact via email were asked to complete the online screening survey. Recruitment was designed to target either veteran parents or partners, however as there were flyers in waiting rooms and online information available, it was also possible for young people to see the advertisements and initiate contact. This did not happen, however, and all first contact occurred through a parent, who then invited other family members to participate (e.g., co-parent or 12+year old child/ren) and/or provided consent for children to be involved.

3.3.1. *Informed Consent*

Prior to screening, all participants were provided with detailed information about the study and provided informed consent. As part of the demographic questionnaire, participants were asked for contact details, consent to contact, and preferred contact method (i.e., telephone or email). Where a participant indicated at least one child between the ages of 12 and 18, they were then invited to introduce the study to their eligible child, and provide parental consent. Youths were also required to provide independent consent on their own behalf. All participants could opt out of the study at any time until approving their interview transcript; they could elect NOT to be contacted; and parents could also elect not to invite their adolescent children or partners to the study. Other than the requirement for a parent to provide consent for youth involvement, no participant was informed by the researcher, of the involvement (or not) of another participant.

3.3.2. *Inclusion Criteria*

Due to ethics approval guidelines, there were some restrictions and contingencies required for participation. Details of the ethical considerations will be addressed in another section. In order to be included in the veteran parent study, participants needed to have exited the Australian Defence Force and no longer be serving, as participation of current-serving personnel would have required both a military sponsor for the research, and ethics approval from an additional committee. There was significant delay in obtaining

Department of Veteran Affairs ethics approval, therefore taking further steps to include current serving participants was not viable for progression of the research project. As such, DVA ethics approval for the research was contingent upon only ex-serving veterans being included. Veteran parents needed to be currently parenting children who were 18 years or younger, and have a formal diagnosis of PTSD related to military service. Formal diagnosis was required by a qualified health professional (e.g., psychiatrist, psychologist or GP), and was determined by way of the participant self-reporting this on the consent and screening survey. Diagnosis was further confirmed as likely through administration of the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) prior to or at the time of the interview. A description of this measure is provided under ‘materials’, and also in Appendix F. Partners included in this study were required to be parenting at least one child 18 years or younger, and whose partner (either current or previous) was a veteran formally diagnosed with PTSD related to military service.

The youth included in this study needed to be between 12 and 18 years of age, with at least one parent who had been diagnosed with military-related PTSD. It was not required that the participating youth also have a participating parent. All those who chose to take part in the study could do so without requiring other family members to participate.

3.3.3. *Exclusion Criteria*

With careful consideration of both the purpose of the project and ethical inclusion of human research participants, a number of exclusion criteria were employed. As previously mentioned, Department of Veteran Affairs Human Research Ethics Committee (DVA HREC) only provided approval for ex-serving veterans to take part, as current-serving members fell outside the human research jurisdiction of the committee. There were seven people excluded from taking part in the research on this basis. Similarly, it was a requirement that all youth involved in the study be at least 12 years of age. Three siblings who would have otherwise been interviewed were excluded, with ages being seven, nine and 10 years. All youth participants also needed to be 18 years or younger; two older siblings were therefore excluded.

People who did not have a formal diagnosis from a treating psychiatrist, psychologist or doctor were excluded to maintain rigour around the description of the phenomenon under study. Only one person was excluded for this reason, as they were only just beginning to explore avenues of intervention through a doctor and had not as yet received a diagnosis. Furthermore, any person (adult or youth) who was seriously unwell or in crisis, for example requiring hospitalisation, was excluded to protect their wellbeing, due to potential risk of distress talking of sensitive subjects and issues around capacity to provide ‘informed’ consent if seriously unwell (as stipulated by the conditions of HREC approval). None who made contact for the study were excluded on this basis.

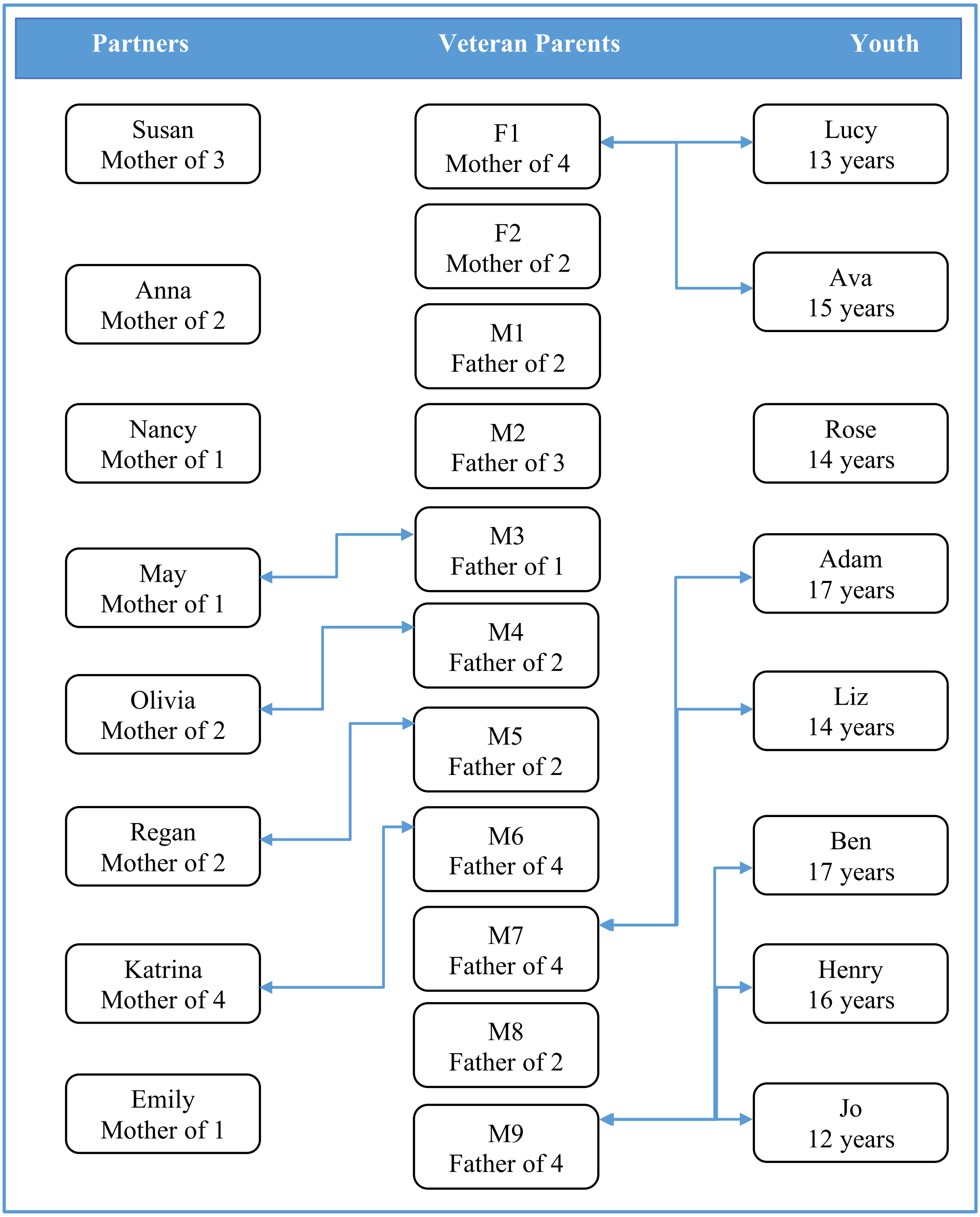
Any person not part of a family unit as described above, or not currently parenting children (e.g., children were now adults or no longer living at home) were not eligible to participate. Two partners were excluded on this basis as their children were in their late-twenties and no longer living at home. Finally, it was necessary for both youth and parent to consent to youth participation. There were four youths whose parents provided consent for participation, however the youth chose not to be involved.

3.4. Participants

The total number of participants in this study was 27, divided across three groups, determined by the role in the family. There were: (i) 11 veteran parents with a diagnosis of military-related PTSD, currently parenting dependent children; (ii) eight partners of veterans with military-related PTSD who were also parenting dependent children; and (iii) eight youth who were the child of a parent with military-related PTSD. Each study presented in Chapters 4, 5 and 6 provide the specific demographics for the participants involved. The family connections between participants is displayed in Figure 3.1, with Tables 3.1 -3.3 providing an overview of demographics, inclusive of information that was not reported in the published studies. It should be noted that not all participants had other members participating in the study. For example, Rose had permission to participate, however her parents declined to be part of the study.

Figure 3.1

Family connections between participants



Note: Not all participants were related to other participants. Arrows denote family connections

Table 3.1

Veteran Participant Demographics

Participant	Gender	Age	Marital/ Family Status	Education	Deployments	Location[1]	Mental Health	No. of Children (ages in years)
Veteran *M1	Male	49	Married	Tertiary	1 – Iraq	WA	**PTSD** Depression Anxiety	2 (18, 19)
Veteran *F1	Female	43	Single	TAFE/ Diploma	1 – Timor	Qld	**PTSD** Depression Anxiety	4 (9, 13, 14, 18)
Veteran *M2	Male	51	Widow	TAFE/ Diploma	1 – Iraq	NSW	**PTSD** Depression	3 (12, 17, 18)
Veteran *M3	Male	31	Married	TAFE/ Diploma	1 Afghanistan	Qld	**PTSD** N/A	1 (1.4)
Veteran *M4	Male	43	Married	TAFE/ Diploma	3 - Timor, Relex, Afghanistan	Vic	**PTSD** Depression	2 (7, 11)
Veteran *M5	Male	42	Married	Completed Grade 12	5 - Timor, Solomon Is, Iraq x 2, Afghanistan	Qld	**PTSD** Depression Anxiety	2 (6, 16)
Veteran *M6	Male	47	Male	Completed Grade 10	4 - Timor x 2, Iraq, Afghanistan	Qld	**PTSD** Depression Anxiety Anger	4 (13, 15, 17, 30)
Veteran *M7	Male	48	Single	Tertiary	1 - Timor	NSW	**PTSD** Anxiety Depression Claustrophobia	4 (14, 15, 17, 20)
Veteran *F2	Female	35	Married	Completed Grade 12	1 - Iraq	Vic	PTSD Depression Anxiety Eating Disorder	2 (4, 6)
Veteran *M8	Male	40	Married	Tertiary	1 Afghanistan	Qld	**PTSD** N/A	2 (1, 3)
Veteran *M9	Male	49	Single	Tertiary	4 – Timor, Afghanistan, Iraq, Indonesia	Vic	**PTSD** N/A	4 (9, 12, 16, 17)

*Pseudonym used in studies

[1] Abbreviations: Qld-Queensland; Vic-Victoria; WA-Western Australia; SA-South Australia; ACT-Australian Capital Territory; NSW- New South Wales.

Table 3.2

Partner Participant Demographics

Participant	Gender	Age	Marital or Family Status	Education	Previous Military Service	Location	Mental Health	No. of Children (ages in years)
Partner F1*Anna	Female	35	Married	TAFE/ Diploma	Yes Nil Dep.	Qld	Depression	2 (3, 6)
Partner F2*May	Female	31	Married	TAFE/ Diploma	N/A	Qld	N/A	1 (1.4)
Partner F3*Regan	Female	38	Married	TAFE/ Diploma	Yes 2 Dep.	Qld	N/A	2 (6, 16)
Partner F4*Nancy	Female	34	Married	Tertiary	Yes Nil Dep.	NSW	Post-natal Depression	1 (3)
Partner F5*Susan	Female	45	Married	Tertiary	N/A	SA	Depression Anxiety	3 (11, 17, 21)
Partner F6*Olivia	Female	43	Married	Tertiary	N/A	Vic	Anxiety	2 (7, 11)
Partner F7*Katrina	Female	48	Married	Completed Grade 10	N/A	Qld	Depression	4 (13, 15, 17, 30)
Partner F8*Emily	Female	27	Married	Tertiary	N/A	Qld	Depression Anxiety	1 (2)

*Pseudonym used in studies

[1] Abbreviations: Qld-Queensland; Vic-Victoria; WA-Western Australia; SA-South Australia; ACT-Australian Capital Territory; NSW- New South Wales.

Table 3.3

Youth Participant Demographics

Participant	Gender	Age	Lives With:	Education	Veteran Parent	Location	Mental Health	Siblings
Youth Y1*Lucy	Female	13	Single Parent	Currently Grade 9	Mother	Qld	Stress	3 siblings
Youth Y2*Ava	Female	15	Single Parent	Currently Grade 10	Mother	Qld	N/A	3 siblings
Youth Y3*Adam	Male	17	Single Parent	Completed Grade 12	Father	NSW	N/A	3 siblings
Youth Y4*Liz	Female	14	Single Parent	Currently Grade 10	Father	NSW	N/A	3 siblings
Youth Y5*Rose	Female	14	Dual Parent	Currently Grade 10	Mother	ACT	Depression Anxiety	1 sibling
Youth Y6*Ben	Male	17	Single Parent	Currently Grade 12	Father	Vic	N/A	3 siblings
Youth Y7*Joe	Male	12	Single Parent	Currently Grade 6	Father	Vic	ADHD	3 siblings
Youth Y8*Henry	Male	16	Single Parent	Currently Grade 11	Father	Vic	Depression	3 siblings

*Pseudonym used in studies

[1] Abbreviations: Qld-Queensland; Vic-Victoria; WA-Western Australia; SA-South Australia; ACT-Australian Capital Territory; NSW- New South Wales.

3.5. Interviews

All participants participated in a one-on-one semi-structured interview exploring their experiences of family life, including but not limited to, information about mental health and family functioning. Separate interview schedules (Appendix B) were used with each participant group. These were developed from the literature and in consideration of the research objectives. Additionally, when developing these schedules, a round table discussion occurred with two other veteran mental health practitioners, discussing both the breadth of the interview schedules, and the order of questions. The order was further refined throughout the interview process, so as to keep the focus on PTSD and family/parental/partner/child, rather than experiences of PTSD and service life. Questions were typically open-ended, with the interviews being semi-structured in nature, so as to allow for further exploration of the participants' experiences beyond the anchor questions. Modification of interview schedules to best fit the participant is standard practice within semi-structured interviews, with the flexibility adding to, rather than taking away from the collection of rich and in-depth data (DeJonckheere & Vaughn, 2019).

Interviews ranged in time, between 30 minutes (youngest participant) and almost two hours (112 minutes) for one of the partner interviews. There were 11 face-to-face interviews across all groups, occurring in public library meeting rooms. Three interviews were conducted via Skype or Facetime, with the remaining 13 interviews occurring via telephone. The interview medium was determined by participant preference and geographical location.

A consideration with this study was the impact that differing methods for conducting the interviews may have had upon comparability across interviews, and capacity to collect 'rich' data via different sources. With growing acceptance of alternative forms of communication, there is also increased use of telephone, video conferencing and other web-based approaches to research, both quantitative and qualitative (Holt, 2010; Janghorban et al., 2014). Providing options regarding method of participation has been shown to have a number of benefits, including greater accessibility for participants, potentially inhibited by geography, time or commitment constraints, or indeed mental health. Holt (2010) also found conducting interviews via non-face to face mediums had advantages in qualitative research involving vulnerable people, as it afforded greater privacy, more control to end the interview if they wanted, and encouraged people to be less inhibited. Because of the often-reclusive nature of veterans and their families, telephone and video interviews provided a valid and comparable medium to be able to reach out to the widest veteran population, uninhibited by distance or capacity to attend in person for any other reason. The interviews were audio-taped and transcribed with permission, then provided back to the participants by email for review. Respondent validation was sought from each person by inviting them to edit their interview material to best reflect their own experiences and delete any identifiable information (Kornbluh, 2015). Of the 27 participants, one youth participant took the opportunity to edit her transcript, predominantly focusing on readability rather than content.

3.6. Materials

3.6.1. *Screening Questionnaire*

The screening tool was presented via Qualtrix (see Appendix G) and used to screen participants based on the inclusion/exclusion criteria. It consisted of basic demographic information (age, gender, education, ethnicity, location) along with questions aligned to the specific inclusion/exclusion criteria for the study. Multiple responses were allowable, however where a person responded in a way so as not to be eligible, the following message was displayed:

Thank you for registering you interest!

One of the conditions for inclusion in the study for ex-serving veterans is a diagnosis of PTSD from a health professional. We are also unable to include any current serving military members. As this is a research project, we are unable to invite you to participate further in the current study.

We do understand however that not all people choose to manage their symptoms with intervention or diagnosis. There may be an opportunity in future studies to explore the experiences of **all** families living with military related PTSD, regardless of formal diagnosis or current military status.

Would you like to be contacted about the results of this study or possible inclusion in future studies?

- ☐ Yes, I would like to be contacted about the results of the current study;
- ☐ Yes, I would like to be contacted about future studies about families living with military-related PTSD;
- ☐ No, I don't wish to be contacted further.

Textbox: Message Displayed to Ineligible Persons

All participants were asked if they experienced any mental health challenges, as well as if they were receiving treatment, in order to ensure they were well enough to participate in the study. Substance abuse and other co-occurring diagnoses were not used as exclusionary criteria, nor was it explored separately in the context of this thesis. Estimates of 86% co-morbidity with other mental health conditions (Walter et al., 2018), suggest the experience of PTSD within families is unlikely to exclude other conditions, therefore the candidate believed that there was no purpose treating co-occurring conditions as separate factors. Rather, participants mental health and existing conditions were accepted as part of their whole experience.

3.6.2. *PTSD Checklist- Version 5 (PCL-5)*

The PTSD Checklist- Version 5 (PCL-5) was used confirm a provisional diagnosis of PTSD and corroborate veteran participant's self-reported diagnosis sourced from a mental health practitioner. The tool was not administered to any other participant groups. This tool is a publicly available, 20-item self-report measure (providing a score of 0-80) that assesses symptoms aligned with the DSM-V criteria for PTSD (Weathers et al., 2013). Although the gold standard for assessment of PTSD is the Clinician Administered PTSD Scale -5th edition (CAPS-5), the PCL-5 is suitable for making a provisional diagnosis, with good reliability and validity (Bovin et al., 2016). Research suggests a cut-off score likely to indicate the experience of PTSD to be approximately 31-33, however as recommended when used to make a provisional diagnosis and minimise false positives, a higher cut-off was used (Bovin et al., 2016). For the purposes of this study with a clinical veteran population, a cut-off of 50 was deemed appropriate (see Appendix F for PCL-5).

3.7. Confidentiality

All participant information and participation in this study has been treated confidentially, from the initial stages when participants registered interest in the study, through to the dissemination of results. Although mental health practitioners supported recruitment, none were informed if or when an individual made contact. Within families, most participants had other family members participating in the study, and therefore knew about their participation. Nevertheless, all interviews were conducted privately and transcripts returned via private email accounts, including youth participants. All youth participants had the permission of a parent (therefore parents had knowledge of their participation), however all confidentiality and privacy protocols for conducting research were maintained. A risk protocol (Appendix H) was developed for the study, outlining what conditions would lead to a necessity to breach confidentiality and what would occur when or if that occurred. There was no requirement to invoke the risk protocol. Audiotapes, screens and transcripts have been stored in line with Monash University regulations, with only the researcher and supervisors having access to the content. All information was de-identified prior to write up of results, with raw transcripts not available in the public domain.

3.8. Ethical Considerations

With any research involving humans, it is necessary to consider possible ethical concerns (Devlin, 2006). This was particularly important in the present project, given the potential vulnerability of the participants (children under 18 years, adults with a mental illness, those exposed to trauma). High ethical standards were important, with approval for the project being granted by DVA HREC and Monash University Human Research Ethics Committee (MUHREC). Ethical approval documentation can be found in Appendix A.

There was some potential for participants to find the process of participation distressing, given the nature of PTSD and potential for discussing upsetting topics and remembering distressing memories in the interview. To mitigate this risk, it should be noted that the interviewer was a mid-career, registered psychologist with 16 years' experience (at the time of the interviews), particularly experienced as a clinician in area of PTSD within military populations. The interviews were all approached with suitable sensitivity and appropriate care, sequencing the questions from routine demographic questions to build rapport, then introducing more sensitive topics once the participant was ready. It should also be noted that it is common within qualitative interviews for participants to experience intense affect when exploring deeply personal experiences. It is the role of the researcher to manage and provide a sense of safety within the interview, strengthen the researcher-participant relationship thereby increasing the richness and depth of the data collected, and enhancing the validation a participant can experience through having an engaged listener(Knox & Burkard, 2009). Across the 27 interviews, only nine participants became emotionally affected during the interviews (seven partners, one veteran and one youth), with time taken to ensure the participant was supported and ready to move on to the next topic. As indicated earlier, a research specific risk protocol was developed and approved by DVA HREC, particularly relevant in interviews where a youth was identified as at risk or experiencing abuse. No youth was identified at risk, and only person (youth participant) required a short break to compose herself, then the interview moved onto the next question at her request. Prior to commencing the interview, all participants were given detailed information about the study, their participation, along with a range of support services, should they find their involvement in the study distressing.

Consideration was given to the potential for coercion to participate, therefore there was no requirement for ‘whole families’ to be involved, so as to dissuade pressure amongst family members to participate. Should a family member be referred to the study – youth included - they were required to provide consent independent of their parents or partner. All participants could discontinue the interview if they wanted and were not obliged to respond to each question. The interview preamble (see interview schedules in Appendix B) was clear about this. Three youth and two veteran parents who had been referred by a participating family member chose not to provide consent or participate. None discontinued participation once they began the interview.

The potential for discomfort or conflict within families through participation was also considered, with the following steps taken to minimise such outcomes: All parents were asked to discuss the study and the subject matter with their children, given that the interviews focused on the youth experience of their parent's mental illness. Each interview was conducted privately, maintaining confidentiality and reducing likelihood that conflicting positions about topics would become a focus of conflict within the family. Similarly, any power differences within families, or inhibition of responses, were minimised through confidential interviews. It was a stipulation of ethics approval that a participant (children in particular) 'could' have someone else present if they so desired. Other than one partner who had her veteran spouse present during the interview, none of the other participants opted to have another person accompanying them through the interviews.

3.9. Data Analysis: Phenomenological Methodology

This study employed two types of qualitative enquiry: thematic analysis (Braun & Clarke, 2006) and Interpretive Phenomenological Analysis (IPA; Smith et al., 2009). The simpler of the two methodologies by Braun and Clarke (2006) systematically describes and synthesizes themes found within the views of each data set as well as the whole. Thematic analysis was initially employed as a foundational methodology at the beginning of the thesis, as the researcher developed familiarity with both qualitative research and the data. IPA also employs a systematic process of data review to develop themes of meaning around experiences, however it does so within a theoretical framework (Smith, 2004), and was applied once there was greater immersion in the overall study.

3.9.1. *Thematic Analysis*

Thematic analysis provides a step-by-step, systematic process for analysing qualitative data, that is not attached to a pre-existing theoretical framework (Braun & Clarke, 2006). Its flexibility comes from the decision-making process across three main analytic paradigms: Essentialist/realist versus contextualist method; inductive versus deductive analytic approach; and semantic versus latent interpretation. As well as having a simply described six step analytic process (detailed description in Chapter 2), research rigour comes from the researcher being both reflexive and explicit in their utilisation of thematic analysis (Braun & Clarke, 2012).

An essentialist (realist) methodological framework is where the intent is to 'describe' reality, whereas a contextualistic methodological framework seeks to 'understand' experiences. Both approaches are frequently used in qualitative research, though not always explicitly stated (Braun & Clarke, 2012). Within this project, thematic analysis was used within the systematic review presented in Chapter 2, as a way of understanding, collating and describing the data collected across the qualitative papers included. Similarly, it was the methodology employed Study 2, presented in Chapter 4. Study 2 predominantly employed a 'realist' methodology, although the subject matter sought to contextualise the specific phenomenology of people's 'experience' of parental military-related PTSD.

The analysis of the data can be inductive or deductive, depending on 'what' guides the production of codes and generation of themes (Guest et al., 2012). Inductive analysis codes the data as it is, without any application of an (apparent) theoretical position. Themes within inductive analysis are heavily reliant upon the actual data such as interview transcripts, and may not reflect the questions driving the researcher's interests (Braun & Clarke, 2006). This approach is often used where little is known about a particular phenomenon. Deductive thematic analysis relies on the research question to guide the coding of data, with information not relevant to the research questions, discarded when generating codes into themes (Braun & Clarke, 2012). The current project incorporated an ‘inductive’ approach to analysis in both the review and Study 2, though it is recognised there was an influence on the themes given the directive nature of the research questions around ‘what research has been conducted and what ARE the experiences of parental PTSD’. Furthermore, in the systematic review, themes reported within each of the identified studies were similarly influenced by researcher questions, methodological approaches and assumptions.

Identification of themes within thematic analysis can be semantic or latent, depending on both the purpose of the research project and depth of interpretation. A semantic approach does not seek to go beyond what is reported in the data, being generally descriptive of patterns (themes) within the data, then interpreted in relation to what implications can be drawn, often in the context of previous research (Burnard et al., 2008). A latent approach goes beyond the written word to understand and conceptualise the data within a theoretical framework to arrive at a deep meaning. This approach is more closely aligned with a contextualistic methodology (Braun & Clarke, 2006). A semantic approach was taken for the systematic review, as the research goal was to review what is known, and identify the limitations within existing qualitative research. Study 2 (the veteran parent study) employed a combination of semantic and latent approaches to theme identification. Though it was important to derive themes directly from the transcripts in a way that was authentic to the participants, deeper meaning was sought through exploring each theme as part of the whole veteran experience.

3.9.2. *Interpretive Phenomenological Analysis (IPA)*

Although IPA has a very similar methodological application to thematic analysis, it is grounded within a theoretical framework, with a set of assumptions, including hermeneutics, phenomenology and idiography (Smith, 2004). Primarily, IPA is interested in exploring the lived experience of people regarding certain phenomena, through reflexive enquiry. The approach acknowledges the researcher role, as an important component of the analytic process (Peat et al., 2019). IPA is particularly interested in the 'individual' experience, being strongly idiographic rather than seeking to generalise about a wider population. Each of these assumptions influences the type of research it is applied to, the way in which the data is interpreted, and how the results are important to the broad research field of psychology (Smith et al., 2009).

3.9.2.1. Hermeneutics. Hermeneutics refers to the interpretive way in which a person makes sense of their own experiences, thus giving it meaning as it applies to that individual. Within IPA, this is an integral philosophical position, derived from earlier works of Schleiermacher, Heidegger and Gadamer (Peat et al., 2019). Understanding is achieved through psychological interpretation by the researcher in regard to the participant, who is also making meaning of their experiences through psychological interpretation. Within IPA, research around human experience becomes part of a 'double hermeneutic' framework, as the researchers' interpretation is also influenced by their own experiences (Smith, 2004)**.**

It was particularly important in phase two of this project (the qualitative interviews) to acknowledge the double hermeneutics involved in the analysis, especially as the candidate had extensive military and veteran family knowledge and experience prior to conducting the research. Concepts, ideas, or even terminology may have been lost on a different researcher, who did not have a shared context within which to place that information. Rather than seek to eliminate potential bias (even if that were possible) the candidate used reflexivity around the interplay between researcher and participant experiences. As a researcher, the candidate engaged in a hermeneutic circle: moving within data sets (making sense of the individual experience) then between data sets (making sense of the individual experience within the larger participant group) then back again to understand broader themes as applied to the individuals. Objectivity was managed through keeping a running journal of both impressions and reactions to the transcripts; then bracketing own experiences and discussion of reflections and theme development with a supervisor; and finally, member checks of transcripts.

3.9.2.2. Phenomenology. Phenomenology is the study of a particular phenomenon with the intent of both description and interpretation, through reflexive inquiry of the *lived* experience (Smith et al., 2009). Incorporating two somewhat contrasting yet complementary approaches, the phenomenological researcher seeks to put aside preconceived ideas (known as bracketing), yet also acknowledge their own role in the interpretation of lived experience (reflexivity), in order to interpret the participant narrative, whilst maintaining an awareness that the phenomena is not shared (Peat et al., 2019).

3.9.2.3. Idiography. IPA is powerfully idiographic, exploring and examining the perspectives of an individual in great depth, before moving on to the next individual. The goal is to arrive at an understanding or sense of completeness in the interpretation, comparing internal themes for similarities for each participant before moving on to explore themes both similar and different between participants (Smith, 2004). Through this in-depth idiographic process, inclusive of the hermeneutic circle, the process of IPA places importance on not only the participant and researchers interpretations of the experiences, but also that the uniqueness of each participant’s experiences (Peat et al., 2019). The idiographic nature of the research is the reason studies employing IPA rarely have more than ten or so participants (Smith et al., 2009).

3.10. Reflexivity and Bracketing

Across all three family studies, a conscious effort was made not to project expected responses upon any participant. Bracketing is the act of putting aside existing theories, frameworks, experiences and knowledge, in order to authentically examine and understand participants' experiences (Smith et al., 2009). For example, from the literature review, one could assume participants might experience violent, chaotic, or unpredictable home environments. However, when interviewing, the assumption of turbulence was sidelined, and instead each person was asked: "when are times more challenging" or "what is an average day like in your house". This allowed room for responses to be something other than 'turbulent', 'violent' or 'unpredictable'. There were times throughout the interviews where clinical judgement was needed to provide a supportive and empathic space, and maintain neutrality within the interview time (Knox & Burkard, 2009). At those times, bracketing my experience as a clinician would have been disingenuous, and potentially damaging to rapport and the expectation of non-judgement regarding participation in research.

The role of reflexivity has been mentioned in different places throughout this thesis, and refers to the practice of awareness of the researcher's role in the interpretation of the data (Alase, 2017). As human beings experiencing the world (for the purposes of research – the data derived from interviews), researchers interpret their experience of the data, through the lens of their own life experiences. Reflexivity involves self-awareness of our subjective 'realities' through varying modes of reflection, and is an integral part of phenomenological research (Alase, 2017) . This thesis begins with a reflexivity or rather, a positioning statement in the Preface, that aimed to provide context regarding the researcher's position, experience and journey of reflection through the research. Similarly, this thesis concludes with the same, with the preface and postface serving to "bracket the researcher's own experiences, reflections, and self-discovery" by providing a space for it, thus allowing the thesis proper to allow space for the research, somewhat independent of the researcher's voice. In addition, every interview transcript was thoughtfully and carefully explored through multiple re-reads, searching line by line for context and meaning. Then in an effort to separate self from participant, representing their unique experiences, yet also reporting the deep awareness gained through my own interpretation, robust discussion of thematic interpretation occurred with supervisors prior to finalising findings.

This chapter has provided a detailed account of the research design and methodology employed primarily within phase two of the research project, involving the one-on-one qualitative interviews. Recruitment and selection were done in a way to reduce coercion, and because of the online nature of screening and flexibility of interview strategy, participants were able to take part regardless of location, lending to most states within Australia having representation. The interviews were semi-structured, and transcripts analysed using both thematic analysis and IPA methodologies. The following three chapters present the interview findings in three distinct studies. Chapters five and six have both been published, with the published versions included herein, and as such formatting, including page numbers differs from the dissertation as a whole. Chapter seven has been submitted for publication, with formatting likely to change in the near future.

Chapter 4. Parenting with Posttraumatic Stress Disorder: A Veteran's Experience

This chapter presents the first of three papers reporting the results from the study. Herein, this paper will be referred to as Study 2. Using semi-structured interviews, veteran parents were encouraged to speak on a wide range of topics, with the interview schedule used as a guide only. The results are reported herein.

4.1. Aims

The aim of this chapter is to report on and discuss the experiences of the veteran parent stakeholder within ex-serving military families, living with PTSD as a result of service.

4.2. Relevance

This study has now been published in "Traumatology", addressing an important gap in the literature, by extending the limited literature reporting on veteran parent experiences. This study begins to paint a framework for the experiences of the veteran family living with PTSD, by providing the veteran parents perspectives.

4.3. Citation and Article

McGaw, V. E., Reupert, A., & Maybery, D. (2018). Parenting with posttraumatic stress disorder: A veteran's perspective. *Traumatology, 24*(4), 255-262. doi:http://dx.doi.org/10.1037/trm00001

Placeholder– Paper 2

McGaw, V. E., Reupert, A. E., & Maybery, D. (2018). Parenting with posttraumatic stress disorder: A veteran’s experience. Traumatology, 24(4), 255–262. https://doi.org/10.1037/trm0000154

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Chapter 5. Partners of Veterans with PTSD: Parenting and Family Experiences

5.1. Background

Having explored the veteran-parents' experiences of parenting and family life, this chapter examines the partners' experiences of veteran families. Issues such as caregiver burden, volatile home environments and a need to protect children were all highlighted by partners in previous research (McGaw et al., 2019). While mindful of these previous experiences, the aim of the current study was to explore the partners' experience beyond assumptions drawn from earlier works, to either support or add new information to what is known of the veteran-partner experience. Through semi-structured interviews, partners of veterans with PTSD discussed a wide range of topics, related to parenting, relationships, family life, challenges and strengths. The interview question schedule was very similar to that used for the veteran parent interviews, although modified to be 'partner centric', and used as a guide only. The results are reported herein.

5.2. Aims

This chapter reports on and discusses the experiences of the veteran partner stakeholder within ex-serving military families, living with PTSD and raising children.

5.3. Relevance

This study has been published in "Families in Society: The Journal of Contemporary Social Services". The paper addresses a lack of literature focusing specifically on the role of the veteran partner as a parent, and accordingly, extends our understanding about these important experiences. This study builds the picture of parents raising children when one of the parents has PTSD, contrasting and complementing the initial veteran study reported in Chapter five. Chapter six provides the partner perspective.

5.4. Citation and Article

McGaw, V. E., Reupert, A. E., & Maybery, D. (2020). Partners of veterans with PTSD: Parenting and family experiences. *Families in Society: The Journal of Contemporary Social Services*. doi:https://doi.org/10.1177/1044389420905753

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Chapter 6. “Don’t Talk about that Stuff”: Experiences of Australian Youth Living with a Veteran Parent with Posttraumatic Stress Disorder

6.1. Background

The veteran parent and veteran partner experiences of parental PTSD were explored in the preceding two chapters; now the third perspective within veteran families living with parental PTSD is presented here, namely that of youth. Previous qualitative research with children of veterans with PTSD has provided mixed outcomes, likely a feature of the various age ranges and foci of studies. The study presented in this chapter employs IPA to develop a deep understanding of the youth perspective. Again, semi-structured interviews guided the conversations, presenting questions similar to those posed to parents, though modified to be youth focused. Youth described a wide range of topics, related to everyday life, parents and family dynamics, school, challenges and strengths. The results are reported herein.

6.2. Aims

This chapter reports on and discusses the experiences of the youths with a parent who is a veteran with PTSD stakeholder within ex-serving military families, living with PTSD and raising children.

6.3. Relevance

This study has been submitted for publication in the journal “Traumatology”, addressing the lack of prospective literature focusing specifically on the youth perspective of veteran parental PTSD, and extending our understanding about these important experiences. This study provides the final piece of the picture of veteran families with children, living with PTSD. It contrasts and complements the veteran study reported in

Chapter Four and the partner study presented in Chapter Five. Chapter Six provides the youth perspective.

6.4. Citation and Manuscript

This manuscript was co-authored with Professor Andrea Reupert, whose contribution equated to 10% of the overall concept, design, development of research materials, analysis and manuscript preparation. The Candidate contributed to 90% of this manuscript, across concept design, development of research materials, participant recruitment, data collection, transcription of interviews, analysis, writing and editing of manuscript, which has now been accepted for publication. The citation for this manuscript is as follows:

McGaw, V. E., & Reupert, A. E. (2022). "Do not talk about that stuff": Experiences of Australian youth living with a veteran parent with PTSD. Traumatology, 28(1), 24–30. https://doi.org/10.1037/trm0000317

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“Do not talk about that stuff”: Experiences of Australian youth living with a veteran parent with PTSD.

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Chapter 7. A Synthesis: The Family Experience Living with Military PTSD

7.1. Introduction

The final stage of this research project is the synthesis and discussion of findings from across all four studies. This chapter first revisits the overarching aim of the research, and the conceptual framework of the thesis introduced in Chapter 3. Then a synthesized approach is taken across all four studies, building on the existing knowledge of the family experience, and presenting new insight about what it is like to live in a family where a parent has PTSD related to military service. This is done through a convergence of the themes presented in Chapters 2, 4, 5 and 6, but will also draw upon additional data within the interview transcripts of all 27 family members, previously unreported due to the size limitations of submitting a report for publication. Both common experiences and those unique to different family members are provided.

7.2. The Objective Revisited

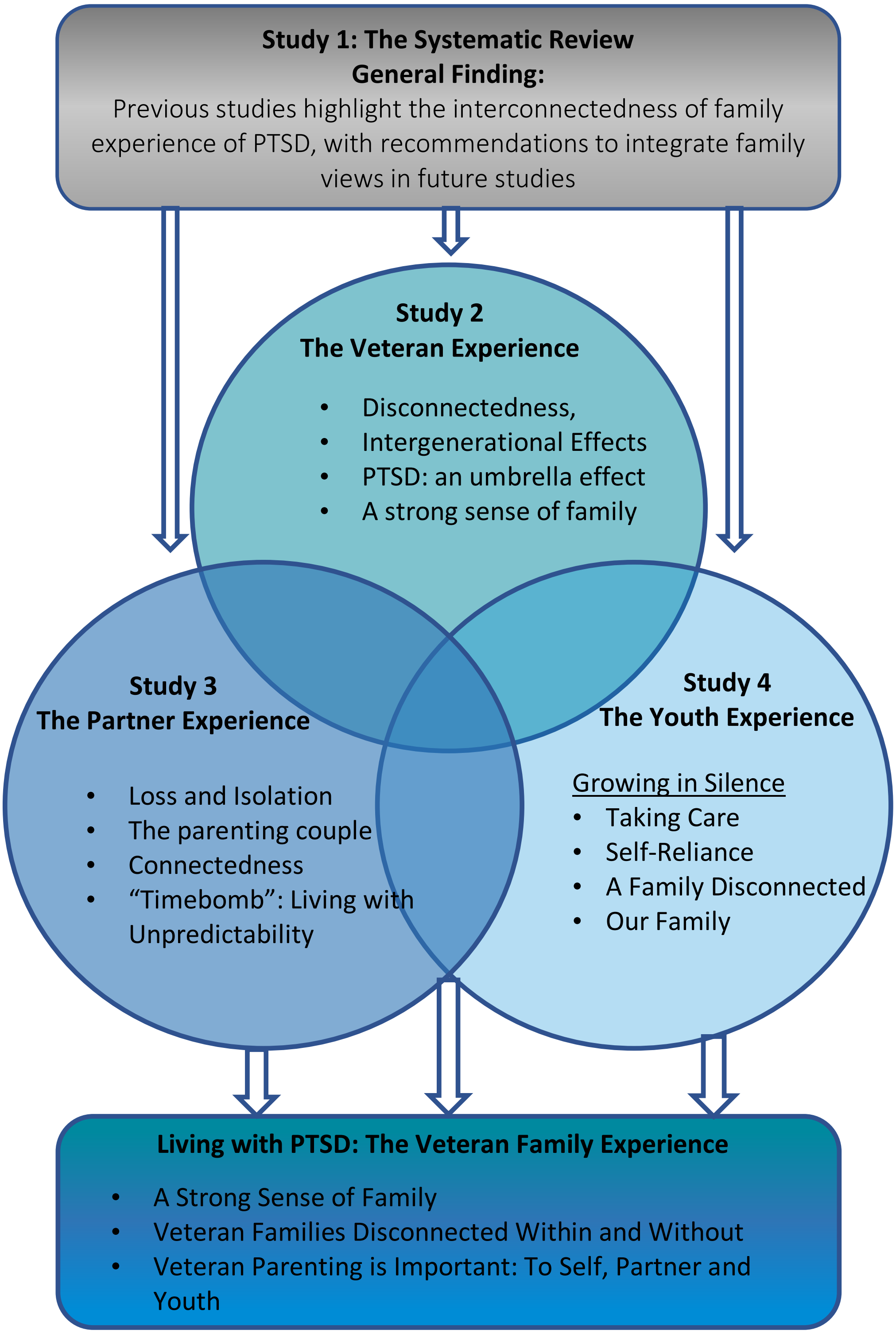
The objective of this thesis was to deepen our understanding of veteran families raising children in the context of parental PTSD, and on this basis, develop recommendations for how best to support the whole family. Because of the difficulty of identifying previous qualitative research, one aim was to provide a systematic review addressing the question: What qualitative research has been done specifically on PTSD in veteran parents, with a focus on parent, children or family; and from the existing research, what is the family experience where a parent has PTSD related to military service? Further, the thesis aimed to explore the phenomenon through the perspectives of the three family stakeholders: the veteran parent with PTSD, the partner, and the child (or in this case youth).

7.3. Methodology for Synthesis

In this chapter, the ‘family’ is the unit of study, using qualitative thematic analysis to revisit each study and re-examine the reported themes alongside the findings of each other study. The methodology was the same as that utilised in the systematic review in Chapter 2, guided by the procedures described by Braun and Clarke (2012). To avoid restating previously described methodology in Chapters 2 and 3, only a brief description of its application to this section is included here. Flexibility was maintained throughout the process by moving through the themes reported in Studies 2, 3 and 4, back to the 27 transcripts, where codes for each study's themes were reviewed alongside the transcripts from all family members. It was not the intention to recode these transcripts, however the process did facilitate some codes and excerpts being redefined in the context of the family. By using a back and forth process through this analysis, new themes were identified both common and unique to the three family member groups (Braun & Clarke, 2012). It should be noted that this synthesis did not independently interview ‘whole’ family units, rather the veteran parent, partner and youth perspectives were represented by the 27 participants across many families. Figure 7.1 shows the conceptual outline of the research project, including the key findings from each of the studies, as well as those identified through the final thematic analysis of all studies and transcripts.

Figure 7.1

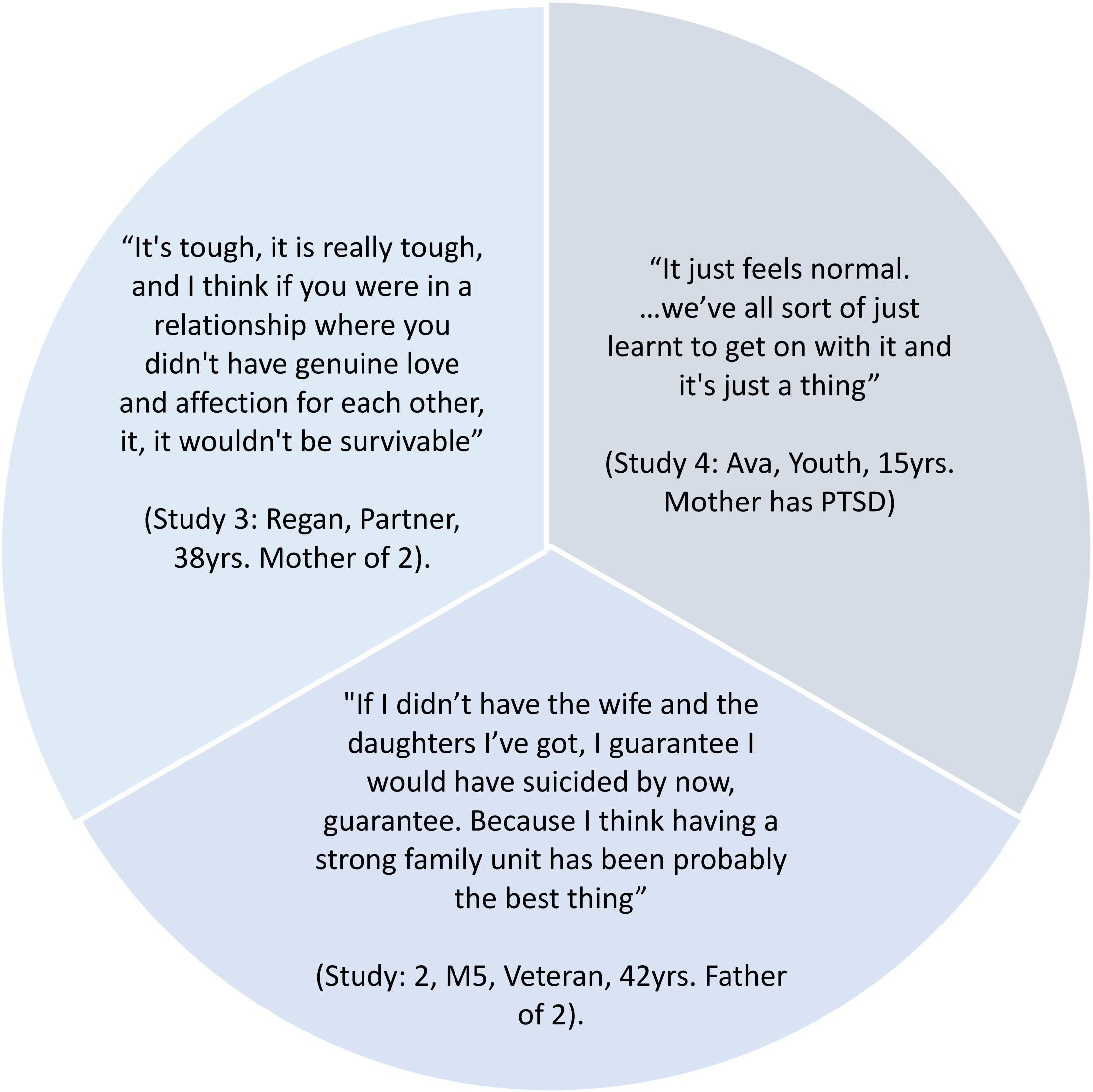
Conceptual framework of the thesis with key findings



7.4. Question: “What is it Like to Live in a Family with PTSD?”: A Comparison of Themes Across Studies

Figure 7.2

Representative quotes from Studies 2, 3 and 4



“It's tough, it is really tough, and I think if you were in a relationship where you didn't have genuine love and affection for each other, it, it wouldn't be survivable”

(Study 3: Regan, Partner, 38yrs. Mother of 2).

“It just feels normal. …we’ve all sort of just learnt to get on with it and it's just a thing”

(Study 4: Ava, Youth, 15yrs. Mother has PTSD)

"If I didn’t have the wife and the daughters I’ve got, I guarantee I would have suicided by now, guarantee. Because I think having a strong family unit has been probably the best thing”

(Study: 2, M5, Veteran, 42yrs. Father of 2).

A fundemental component of this thesis was the question: “what is it like to live in a family with PTSD?”, with representative quotes from the three veteran family studies shown in Figure 7.2 Study 1 reported in Chapter 2 (McGaw et al., 2019) provided the first systematic review of the qualitative research that sought to answer this question regarding veteran families living with PTSD. It showed there have been relatively few qualitative studies and no integration of each family member's perspective within a single study. The review included 11 independent, single-view studies and found themes both common and unique across family members, providing insight into the whole family experience of living with parental PTSD. Five key themes were identified.

The first theme reported in Study 1 is that of the 'absent father/partner'. Veteran parents in Study 2 reported a similar themes around absence in the form of disconnectedness. Partners in Study 3 also reported themes around absence, but also identitied this as loss and isolation. Youth in Study 4, reported themes of absence, reporting a sense of disconnectedness. The review in Study 1 identified a caregiver them, with children and partners experiencing increased burden of care. Similarly in Study 2 veteran parents acknowledged the important role of children and partners, providing support and purpose. Partners in Study 3 directly reported themes of caregiver burden, where the youth in Study 4 spoke of the caregiver role more indirectly, being quite protective of their parents.

The third theme found in the review in Study 1 was that of unpredictable home environments. This was not highlighted in the veteran study (Study2) however was reflected in Studies 3 and 4, with participants across both groups expressing feelings of 'walking on eggshells' or 'taking care'. A strong theme within the review (Study 1) was that of the intergenerational effects of parental PTSD. So too were participants in Study 2 and Study 3 concerns about the impact of PTSD within the family affecting the children. The youth in Study 4 were less concerned about this, though two were experiencing mental health issues at the time of the study, with at least three more previously accessing support for mental health.

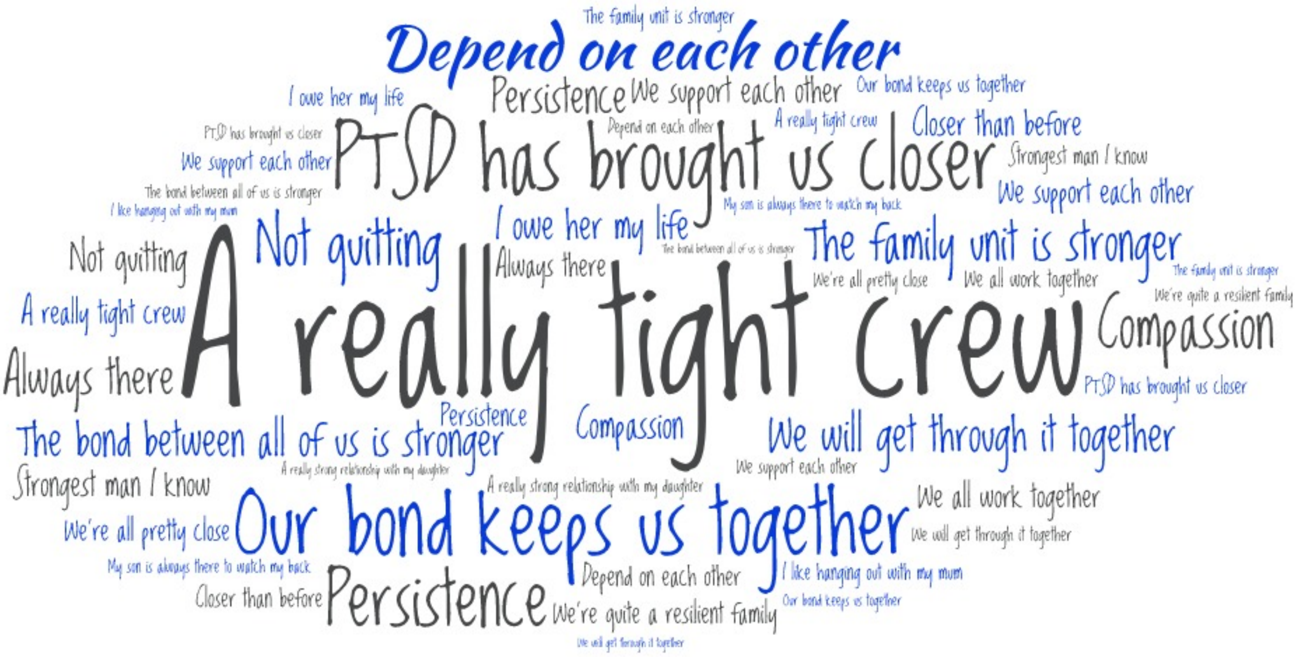
Finally, Study 1 reported a theme around the importance of veteran parents (negative and positive) in the lives of their children, regardless of PTSD. This theme was reflected in the veteran study (Study 2) in a somewhat mirrored context, that being, the importance of family, children and parenting for their own wellbeing. Partners in Study 3 also acknowledged the important role of the veteran parent, alongside the strong commitment and enduring love within their families. The youth in Study 4 downplayed the impact of PTSD, and were fiercely protective of their parent's 'capacity' to parent and the importance of them in their lives.

Each study included in this thesis was reported independently, however they were designed to be four parts of a whole, each providing insight from a different angle about the veteran family living with PTSD. Taken as such, primary and secondary themes from all four studies were reexamined within a qualitative framework, again asking: "what is it like to live in a family where one parent is a veteran with PTSD?". Three global themes across all studies are clear: A strong sense of family; veteran families disconnected within and without; and veteran parenting is important: to self, partner and youth. For each theme, representative quotes from all 27 transcripts were brought together and displayed as a word cloud at the beginning of each theme, demonstrating the interconnectedness of all family member experiences. The word clouds were created by revisiting each transcript, identifying representative quotes, then using an online generator (Word Art, 2020) to create the picture. The most representative quote is the largest shown, with all other quotes being equally representative. It is important to recognise that each person experienced his or her family differently, so while there were global themes, these varied in importance for individual family members. The themes represented by the whole may not be the only themes important to each member within. The first major theme found across the four studies represented in this dissertation, is that relating to a strong sense of family as further elaborated below.

7.5. A Strong Sense of Family

Figure 7.3

Theme: "A strong sense of family". Key quotes from veteran parents, partners and youth.



For those interviewed in this study, all veteran families living with PTSD have a strong sense of family, as demonstrated by the word picture above, created from quotes across all youth, veteran parents and partners. This was a pervasive theme across all interviews, and one that has not been well represented in the literature to date. Most parents (veteran and partner) referred to the immediate 'family unit' as being strong and supportive, though mostly to the exclusion of extended family members. In Study 2 veteran parents described how having a "really tight crew" provided a reason for living, as one stated when referring to his partner: "She saved my life! I owe her my love and loyalty".

They described how all decisions were made “for the good of the team”, rather than any individual, and “we stick together I suppose, we've stuck together through all of this”. Veteran parents also described the bond with his or her children as very much a protective factor or safety net for suicide. “I have a moral obligation to stay on this planet to take care of her” stated one veteran parent. More than one had been interrupted in the act of suicide by their children, and in a couple of instances children were recognised care givers for their veteran parents. The theme of a strong sense of family is one that appears to be new to the literature on veterans living with PTSD. Previous research has hinted at such, with veterans endorsing family centred therapy (Lester et al., 2012; Sherman et al., 2015), the importance of their role as parents (DeVoe et al., 2016; Sherman et al., 2016) and reliance on partners or children for support (DeVoe et al., 2018), as well as a strong desire to protect children from being negatively impacted by their parents’ PTSD (Ross & DeVoe, 2014; Sherman et al., 2015).

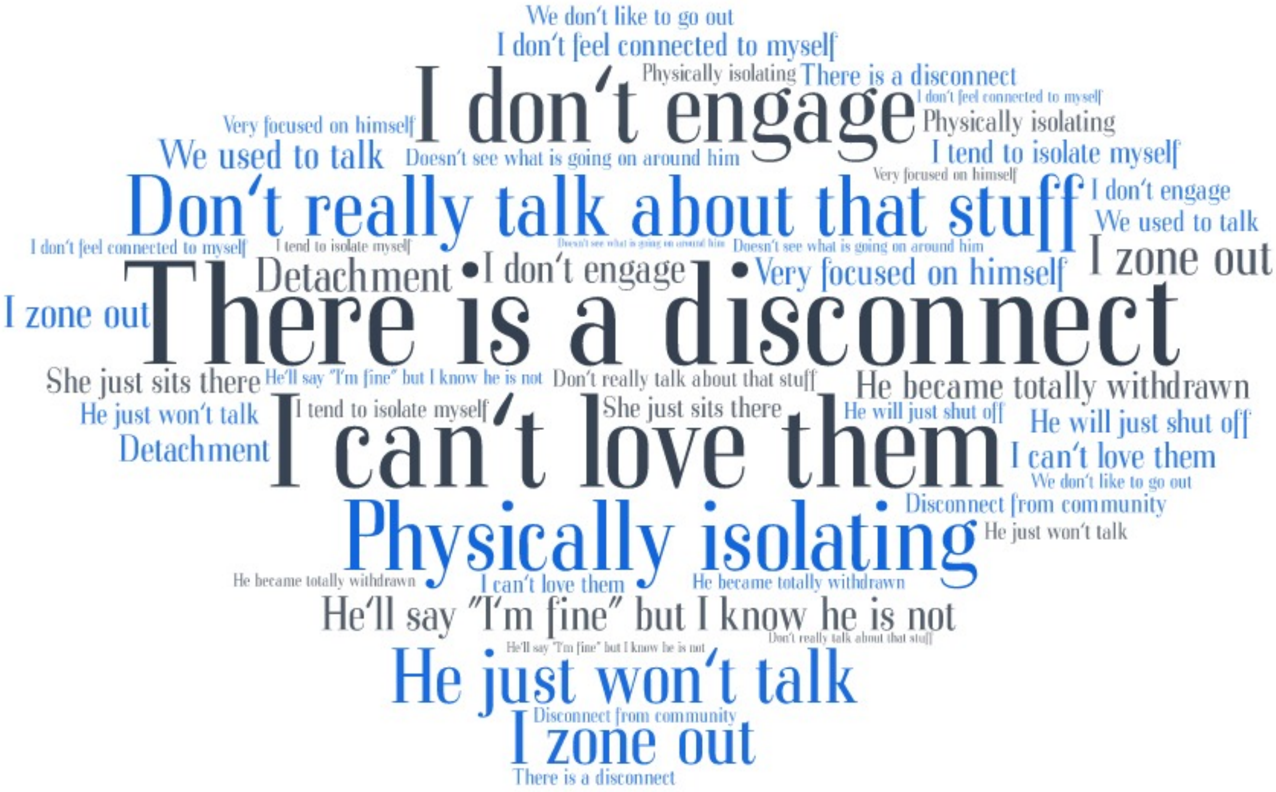
In Study 3, partners described “the bond between all of us is stronger than before”, when describing how PTSD has affected the family. This sentiment was echoed across partner interviews, particularly in the presence of difficult family circumstances. All but two partners described their veteran spouse as supportive partners, their “rock” and “the strongest man I know”. There was an acknowledgement that they “support each other”, equating PTSD to cancer: “you wouldn’t leave your partner because they get cancer, so PTSD is no different”. The strong sense of family as experienced by partners is explicitly stated here, whereas it is less so in previous research, with partners choosing to stay in challenging relationships, often aligning with and protecting children as well as caring for their spouse (Maloney, 1988; Yambo et al., 2016). All partners in Study 3 also described support from their children as a source of strength, as one mother stated: “instead of mother and daughter she’s been like a really good friend for me to lean on and she leans on me a lot too”. Others described children as protective: “my son is always there to watch my back”, and despite at times volatile environments, similar to those expressed in the Yambo et al. (2016) study, the majority of these partners described their veteran partner and children as the most important people in their life, “genuinely enjoy[ing] the company of the three of us”.

Likewise, in Study 4 seven of the eight youths reported their family would “get through it together”, when talking of the challenges of living with a parent who has PTSD. Many reported a close family environment, preferring to stay at home, “hanging out with my mum, I like hanging out with my sisters”. In an early study by R. Rosenheck (1986) one group of adult children described being very close with their veteran father, influencing many of their choices such as type of career, choice of partner and sense of responsibility for their parent. McCormack and Sly (2013) found themes of dysfunctional child-parent attachment, in sometimes negative ways such as alcoholism and choice of drink, identification of feelings as weak, and learned hypervigilance. Where previous studies did not describe a strong sense of family, children of veterans in previous studies were driven to emulate, care for or acknowledge the importance of the veteran parent. In Study 4 some youths also reported negative similarities with their parent (e.g., experiencing a mental illness themselves) however they also described veteran parents as role models, who were able to understand and support them when struggling with their own mental health. “We rely on each other” said one youth, and another stated, “I don’t think I would have felt as comfortable sharing with my mum... if I hadn’t seen her vulnerable side”. Another described the effect of PTSD upon her parent “PTSD, it makes my mother who she is today, I would not change that for anything" because for some of these youth "PTSD brought us closer", creating the strong sense of family.

7.6. Veteran Families Disconnected Within and Without

Figure 7.4

Theme: "Veteran families disconnected within and without". Key *quotes from veteran parents, partners and youth.*



Juxtaposed with the first theme around a strong sense of family, family members simultaneously and somewhat paradoxically described a strong experience of disconnection from other family members, but also from others outside of their families. This theme has been well documented both in previous qualitative and quantitative studies (E.g. Brockman et al., 2016; Creech & Misca, 2017; McCormack & Devine, 2016; Ruscio et al., 2002; Sherman et al., 2016; Snyder et al., 2016). In Study 2 all veteran parents described feeling detached from their families, from their role as a provider or role model, and the community. They spoke of the “disconnect with the community” for not only themselves but also for their children: “Because I isolate, my children become isolated”, one veteran stated. Another stated, “We don’t socialise a lot as a family” and for extended family events, veterans might have to “walk off” or “zone out” or disengage through self-medication. Veterans described the lack of connection within the family unit as well. “There’s disconnect, where I can’t love them”. Similar to veterans in the Sherman et al. (2016) study of veterans’ perceptions of PTSD symptoms on parenting, many of the veterans in Study 2 struggled to show an “adequate amount of love and affection”. One male veteran summed up these sentiments by saying:

> I often have a feeling of like, I just wish I was on my own, I wish I wasn’t affecting these other people. But more selfishly, I just wish they’d leave me the fuck alone, and I just don’t – I don’t want the stress of a child or the stress of having to maintain a relationship with my wife, and it would be so much easier to live in a one-bedroom apartment. (M3, 31yr old father of 1)

In spite of not feeling connected, most veteran parents would go through the motions of saying “Hi/Bye, I love you”, because while they felt “detached”, “I know that I do love them... it’s that my feelings are cut”.

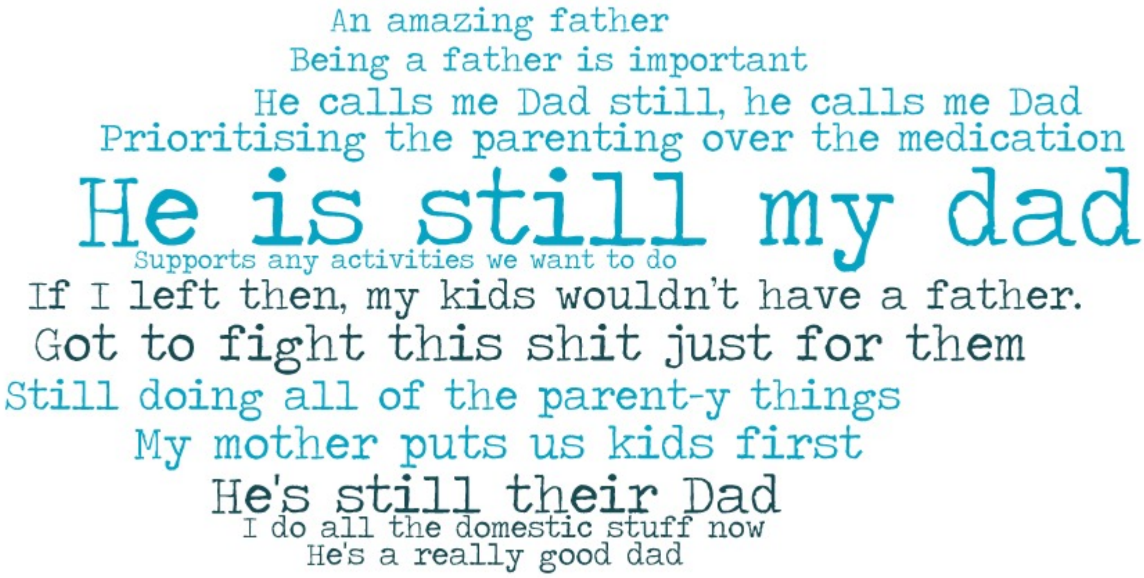
Partners in Study 3 experienced disconnect as one of absence and isolation within their family relationships, which is similar to the few earlier qualitative studies involving partners of veteran with PTSD (Frederikson et al., 1996; Maloney, 1988; Yambo et al., 2016). Partners, both in Study 3 and the study by Yambo et al. (2016) described the loss of the partner and father to the children they had prior to the onset of PTSD: “He is not the same man... he came home another man”. “I would still like to go on dates with him and have fun together... but he is just so dead inside" reported another partner in the present study, when talking about meaningful connections with her husband. Another stated that it "was not unusual to spend an evening without even saying a word". Partners described the disconnection between veteran parent and the children as "initially he was so hands on, he was amazing... now he's withdrawn and cranky". Another described her veteran partner as an "armchair parent", directing the children, whilst being disengaged on a phone, iPad or television, then getting angry if orders are not followed out correctly. Frederikson et al. (1996) also reported the inability to share parenting responsibilities due to the volatility of the veteran parents' responses. Some also described their own need for space, particularly in the face of increased parenting or care giver obligations. "Everyone needs something from you... sometimes you just feel like you want everything to just stop, and you can just have some time on your own". Both veterans and partners described children being disconnected from the family and others also, in particular, one veteran parent indicated "She is going through her own disconnect at the moment", reporting her daughter to be avoiding social invitations or events.

The sense of disconnection reported by youths in Study 4 was different to that of their parents, but still fit within this theme. Youths described their veteran parents isolating or withdrawing from the family, as evidenced by one youth: "he spends a lot of time just watching TV"; and by another who reported: "mum would just sort of have these bad days... and isolate herself in her room or... sit in the car for like hours". Two previous qualitative studies with adult children of veterans also report good days/bad days and disconnected or absent veteran fathers (McCormack & Devine, 2016; McCormack & Sly, 2013). However, these studies with adult offspring are explicit in their recollection of the absence/disconnection theme, whereas the youth in Study 4 report the behavioural evidence of disconnection, such as lack of communication and withdrawal of the veteran parent, without explicitly defining the action as disconnected. Youths also commented on their parents' use of alcohol, particularly when they were not coping. “He was drinking a fair amount, but I didn't think there was anything wrong with it” stated one youth. Though another reported how alcohol had a role in her parent's suicide attempt. The youths in these families reported: “I keep to myself” or “I just go to my room when he's in a mood”, and “I really don't know what he even does, ...it's pretty hard to have an actual conversation with [Dad]”. Another youth reported being closed, private and “definitely less social, I like to keep to myself” since his father had developed PTSD. Two Canadian studies similarly reported youth withdrawing and disconnecting from both family members and friends (Harrison et al., 2014; Kwan-Lafond et al., 2011).

7.7. Veteran Parenting is Important: To Self, Partner and Youth

Figure 7.5

Theme: "Veteran parenting is important: Key quotes from veteran parents, partners and youth.



An amazing father
Being a father is important
He calls me Dad still, he calls me Dad
Prioritising the parenting over the medication
He is still my dad
Supports any activities we want to do
If I left then, my kids wouldn't have a father.
Got to fight this shit just for them
Still doing all of the parent-y things
My mother puts us kids first
He's still their Dad
I do all the domestic stuff now
He's a really good dad

In the families interviewed, PTSD influenced all facets of family life, including that of assuming the parenting role and the experiences of youth being parented by a mother or father with PTSD. However, the significant role of the veteran parent to the family was indisputable in the experiences of those interviewed. Where previous studies investigated the 'impact of PTSD' upon perceptions of parenting (Cohen et al., 2011; Sherman et al., 2016), parent-child communication (Sherman et al., 2015) or family functioning (Kelly et al., 2016), there has been a distinct lack of recognition in the research about of the fundamental importance of parental status to the mental well-being, safety and identity of veterans within this population. The quotes from veteran parents, partners and youth included in the word picture introducing this theme reflect the concept that despite any difficulties or challenges faced by veteran families with PTSD, the parent is “still his, her, their, [or] my Dad/Mum”.

An interesting outcome of this study is the opportunity PTSD afforded veteran parents to become more involved in day-to-day parenting activities. In Study 2, one veteran with 23 years of service stated, “The positive thing out of this whole experience, has been the fact that I get to spend more time with my daughter, and that’s time that I would have never normally had”. These parents previously “left a lot of the parenting stuff up to my wife” or partner, because they were full-time career soldiers engaged in routine activities away from home for weeks or months at a time. Now they were now the stay-at-home dads and mums, “get[ting] lunches done”, and “getting the kids ready for school” then doing school time drop-offs and pick-ups and being present for milestone events. There does not appear to be any other research involving veteran parents with PTSD, where similar outcomes of increased parenting responsibilities has been reported.

Increased involvement did not always mean improved engagement, with some veterans making comparisons between pre-PTSD parenting with older children “previous to this, when you had a child that didn’t want to sleep, you could pace hallways and ...you knew that the next day you’d finally get a couple of hours sleep and it’d all be good”; and post-PTSD relationships with younger children: “now that is very, very hard, and my irritability is easily risen. So, I can go from pretty sort of even sort of mood to very irritable, flash to bang of a very, very short period of time”. Similarly, veteran parents reflected on the changes within their parent-child relationships: “I used to have a really good relationship with my daughter who’s always been a daddy’s girl” stated one. Now many reported a “lot of yelling, telling them to be quiet, or go clean their rooms, or snapping”. Increased volatility is a frequently reported issue among other veteran family studies, with a number of large studies reporting instances of partner aggression, violence and poor family relation quality (Daraganova et al., 2018; LaMotte et al., 2017; LaMotte et al., 2016; Smith-Osborne et al., 2013b). Veteran parents in this study were also aware of the impact of symptoms and medication on their role as a parent. For example, most struggled to be involved in school or sporting events without feeling overwhelmed or medicating. Some veterans spoke of the choice between taking normal medication to reduce and control symptoms, or being alert and providing appropriate supervision or responding to pick up requests from older children. In the Sherman et al. (2016) study, veterans reported similar tensions between the need to be present as a parent versus being reactive and overwhelmed by triggers.

Veteran parents described the important role older children had in providing support to them. For example, one noted the safety contracts with his son around suicide "[He] is my official carer and [we have] formal contracts regarding suicide. ...he was doing it anyway since he was 13 ...he may as well get paid for it and get the title". As with the strong sense of family, parenting became a protective factor for all veterans in this study. Each veteran's connection to their role as a parent drove them to keep living, to: "fight this shit just for them"; because "if I left, my kids wouldn't have a father"; because "I have a family to look after"; and "the children give me something to focus on". An earlier study by Reupert and Maybery (2009) also highlights the importance of parental status for fathers (not veterans) experiencing mental illness, along with the role children play in these father's recovery, coping and support. Interestingly, other than the study by Sherman et al. (2016) and Study 2 in this thesis, there appears to be a lack of research highlighting the support provided by children from the perspective of veteran parents.

In Study 3 there were four main points reported by partners around the important role veteran parents have in the family: first, that they were good parents; second there was an increased engagement between veteran and child; third, children played a role in parental recovery; and last, they highlighted the important role of the veteran parent in the lives of children. Resonating with Maloney (1988) study, for every partner in Study 3, there was a separation of the ‘symptoms’ of PTSD, and their veteran partners personality or capacity as a parent. “He’s a good dad” said one partner, and another stated “He’s not intentionally horrible... it’s not his fault”, and when it was a good day, “He’s a really, really good dad”. Partners also described the increased opportunity for veteran parents to be involved in parenting, due to being unable to work and having PTSD. “We’ve done really well as a parenting couple” stated one partner about her husband’s involvement since discharging from the Australian Defence Force. On good days “He takes over reading the kids stories at night, cooking dinner ... an amazing husband, an amazing father, so, you know, he’ll cook me breakfast and get the kids’ lunches ready etc”. Another partner described the opportunity to have family outings during the week rather than confined to weekends now that their partner was no longer working. As well as increased engagement in family activities or time together, others spoke of the role children had in supporting their veteran parents’ mental state. “She’s been an integral part of his recovery” stated one partner, who equated it to the same way service dogs provide support: “it forces him to be present in the moment and focus his attention on her ...she’s a distraction”. Similarly, another commented how her partner would be incapable of engaging with her as a spouse, but “he’s quite happy to stop and talk and play with her”.

Though there were some benefits, partners also reported the important and sometime negative interaction of veteran parent upon child, and child upon parent. “You never know what is going to trigger them” reported one, and another stated “he simply can’t be with her at times and not have flash backs”. Yet another felt the strain of managing “mood swings from both of them; probably tantrums from both of them – they’re different but they definitely both have them”. Despite these challenges, a common reason partners gave for staying in an environment that was often challenging was that “I love him, because he’s my husband, because he’s [her] dad “. That children needed their fathers (noting all partners in this study were female) was present across all partner interviews. These findings align with previous qualitative studies with partners of veterans that reported the child-father bond with the veteran was important, that the veteran parent was not at fault for their behaviour, as they were injured from war; and finally, that sharing children was a reason for staying in dysregulated relationships (Maloney, 1988; Yambo et al., 2016).

Youths in Study 4 discussed two things: the competency of his or her parents, and their own care giver responsibilities toward their parent. All youth participants were very protective of his or her veteran parent’s capacity parent and, “still doing all of the parent-y things”. “I could never ask for a better mother” or “He is my role model” or “She always makes sure we have food, clothes and somewhere to live” were common statements in the youth interviews. These finding contrast somewhat with studies involving older or adult children of veterans with PTSD, including those by McCormack and Sly (2013), McCormack and Devine (2016) and R. Rosenheck (1986), where veteran parents were described as unavailable and withdrawn from parenting activities. It is likely that within the interviews of Study 4 included in this thesis, youth did not want to undermine their parent, or have the author judge them negatively, as indicated by one youth: “I don’t want [others] to think that my mother can’t care for me. ... people judge me and my family very quickly.” They described their lives as “normal”, that they did not know anything different and that in their view, it was not so hard. These finding support the persevering stigma associated with mental illness within military personnel (DeVoe et al., 2018), and in other families where a parent has a mental illness (Reupert & Maybery, 2015). Stigma was also a theme picked up by Harrison et al., (2014) where youth described the social isolation created by the shame and stigma associated with disclosing their parent's PTSD, and the subsequent desire to preserve the family image.

Youths also described their role within the house, particularly around caring for their parent (medication, reducing potential triggers, assessing suicide risk) or caring for younger siblings. Of the eight youth involved in the study, seven came from single parent families, and all were residing by choice with the veteran parent. When asked about their experience living with a veteran parent, one youth stated "My circumstances are very singular. Nobody else I know has circumstances like this, so in a way it's very special although it's difficult, it is special". Youths saw their parents as important and resilient, and because of that – so too did they see themselves, "I get it from my parents", "I wouldn't change a thing". Likewise, Kwan-Lafond et al. (2011) reported youths describing veteran parents as role models. They also note the caregiver duties these youth assume for their veteran parent and/or younger siblings.

7.8. Unique Experiences of Family Members

Presented so far, are the shared themes within these veteran families that participated in this research. There were also some themes that were unique to each group. Consistent with findings in the Bryant et al. (2019) veteran wellbeing study, where mental illness was perceived as impacting all areas of functioning, veteran parents in Study 2, reported an ever-present nature of their mental illness on every task, in an experience called "the umbrella effect". Secondly, similar to the experiences of guilt and shame by veteran parents in the review by Creech and Misca (2017), veteran parents in Study 2 expressed both shame and guilt, that was not present for partners or youth: “I’ve made her life fucking abhorrent” stated one veteran. Another compared being unable to work with being unemployed, and the stigma associated: “Her dad’s this dude that just sits at home all day doing nothing”. For another it was feeling “completely emasculated, doing lunches and ponytails and looking in the Women’s Weekly for recipes”. A number of veterans also reported feeling guilty that others, particularly their children should be proud of their service, as often those deployments were linked to being involved in incidents that produced shame or horror. “I would rather she grow up and think I was a postman than a soldier” stated one veteran father. In contrast, partners were fiercely proud of their partners, for the battle it took withstand their own experiences: “he is one of the strongest people I know for being through what he’s been through” was a shared sentiment among partners.

Partners in Study 3 while proud, also expressed feeling a sense of loss not found in interviews with other members of the family. “He came home from Afghanistan it just all changed. The whole family just fell apart” stated one partner. Another felt her husband never came back from deployment, “I just want [him] to come back” she stated. For many this meant also feeling like a single parent or becoming more “mother than wife”. The joy experienced in early stages of the relationship were now missing for many of these partners: “He used to dance. He doesn't dance. He used to smile. He never smiles. He used to laugh, never laughs“. While another was able to put it into context that these veterans “come home and their whole belief system is changed”, there was still the loss of the partner, husband and father, who was present, but “he came home another man”. These findings were reported in the previous qualitative partner studies, where a profound sense of loss of a partner was described following trauma and subsequent PTSD (Beks, 2016; Frederikson et al., 1996; Yambo et al., 2016).

Study 4 showed youths, unlike their parents mostly did not express PTSD as being “the elephant in the room just wrecking everything”. One stated “there's definitely hard days and stuff, but it's something you can cope with, it's something that you can live with and move on”. Another reported “I know that I can handle it. I'm not going to boil over with emotion or sadness”, and another admitted “it’s really normal to me. I’ve grown up with my mother like this so would have to say It’s my normal way of life”. Similarly, most felt there was no need to connect with others who had similar experiences, or were seeking intervention, resources or support, a sentiment similar to those expressed by youths in the Harrison et al. (2014) study. An important implication for this theme that was unique to youths is one of providing adequate support and intervention to those families in need. Two of the eight youths had a mental health diagnosis. Another three had received counselling at other times. Finding a way to engage youths that may need support even when they are reluctant is an important issue to address, if service providers are to facilitate positive change for veteran families.

Chapter 8. Strengths, Limitations and Recommendations

8.1. Strengths

The primary strength of this study lies in the triangulation approach undertaken. Triangulation within social research refers to the investigation of a question, event, phenomena or problem through multiple modes, be they multiple investigators, methodologies or data sources (Perlesz & Lindsay, 2003). To the researcher's knowledge, this is the first time such an approach has been taken to investigate the experience of PTSD within veteran families, sourcing experiences from veteran parents, partners and youth. In doing so, this research has been able to report the rich and complex experience of family life in the context of PTSD, including convergent, complimentary and contrasting themes.

Another strength of this study was having existing knowledge of veteran families, gained through my own family background, ex-service military status, and my work as a clinician with military and veteran families. Although this could be regarded as a limitation, fraught with the danger of researcher bias (Ross, 2017), the upfront acknowledgement of my "insider" knowledge in the personal positioning chapter identifies the bias framing of this thesis, and allowed for conscious choices around minimising, reflecting, and supporting how and where this perspective informed the research (Kang, 2020). There were many benefits to researching as an insider, such as access to the population, rapport building and credibility with participants, data collection that was sensitive to the cultural values and norms of those involved, and a richness within the data interpretation because of the existing knowledge (Chavez, 2008).

The interviews that form the data for this research were conducted across a range of platforms, including face to face, telephone and Skype/Video call. There was a definite benefit to conducting interviews via the variety of platforms, as it allowed participation regardless of location or capacity to attend in person. There were initial ethical and research concerns that interviews conducted via telephone or video would not be comparable to face to face interviews, would impede validity or transferability of information gained, or might increase the risk to the participant by virtue of the researcher ‘not’ being in the room to manage distress and risk. However, alternatives to face to face interviewing also allowed participants to ‘choose’ an environment that best suited them. Participants who were geographically remote to the research study were able to participate, as were those unwilling or unable to leave their house. With a growing acceptance of client-led care across medical and mental health practices, there is also a growing acknowledgement of the importance of participant-centred engagement in qualitative research (Delaney, 2018; Heather et al., 2004). Ultimately, providing participants an avenue to choose ‘how’ and ‘where’ they participated in the interviews, was a strength within the research methodology, encouraging engagement of a difficult to reach population and embracing ethical standards around participant-centred research.

8.1.1. Credibility and Trustworthiness

The strength of qualitative research lies in its credibility, trustworthiness and applicability (Hammarberg et al., 2016). Across this thesis there have been numerous researcher actions aimed at fostering data credibility and trustworthiness. From conception, the use of triangulation of data sources was planned, thereby approaching the phenomenon from differing perspectives. Not only did this approach provide rich and complex data, it also increased credibility and trustworthiness of the thesis to authentically represent the phenomenon of veteran families living with PTSD (Perlesz & Lindsay, 2003). Expert consultation was sought through development of the interview schedule, targeting specific areas of interest relevant to the research question and increasing effectiveness of the questions to guide the interviews (DeJonckheere & Vaughn, 2019). Inter-rater reliability testing was employed, particularly in the systematic review, though also in the data analysis stages of the qualitative studies, where codes and themes were reviewed independently. The process of having a third party validate analysis added to the rigour and credibility of the studies contained in this thesis (Burnard et al., 2008). Member checks ensured transcripts and initial researcher impressions were verified and trustworthy representations of participants' views. Reflexivity, bracketing (and when not to bracket), supervision and journal writing were all used to increase the trustworthiness of the study.

8.2. Limitations

There were some limitations to the overall research project, including homogeneity of the participants, small number of female veteran parents and no male partners. Across all the studies conducted, only one person identified as indigenous and another as 'mixed Caucasian/European'. Similarly, a gender bias is acknowledged with veteran parents being predominantly male, and partners being exclusively female. That said, the participants included in this research project have ample experience of 'parenting', 'being parented by', and 'family life' in the presence of a parent with military-related PTSD, and thus might be considered to be 'subject matter experts' regarding the central phenomenon of interest in this research (Creswell, 2005). The gender bias identified within the veteran parent participants (18.2% female veteran parents) is also reflective of similar gender biases currently within the Australian Defence Force, with women representing 17.9% of the permanent workforce (Department of Prime Minister and Cabinet, 2018). This aspect of participant inclusion was coincidental rather than purposeful and in the event this area be further explored, other issues should be considered, particularly different ethnic, cultural and gender groups within veteran, partner and children populations.

Another limitation of this project was the restriction of interviews to ex-serving families. The initial intention was to include both current serving and ex-serving veteran families, so as to reach all families, regardless of capacity (or incapacity) to remain in the Australian Defence Force. To include current-serving military members, a military sponsor for the project would have been needed, along with approval from a third ethics committee. As this project already required two ethics committee approvals (Appendix A), with a third being prohibitive, DVA HREC stipulated the researcher could only recruit from the veteran community. Accordingly, it is difficult to state that the views and themes found in this study of ex-service families, may be illustrative of the experiences and needs of families where the veteran with PTSD is still working as a serving member, managed through the Australian Defence Force. Nonetheless, all parents described their experience while serving, including what would have helped either themselves or their family.

The sample size for each family member group was small, but is appropriate for the qualitative methodologies employed. Nonetheless, caution needs to be employed when considering findings in relation to other military populations, particularly those outside of Australia. The Australian military culture may differ to other countries, health services and veteran engagement may differ significantly, in-service military family culture may be more insulated, or whole family groups may experience systemic war-like turmoil, such as for families in countries in the Middle East.

Finally, consideration needs to be given to whose perspective is being reported and the potential bias of aligning or privileging one view over another. Not only was there a convergence of themes within each study; there was also a divergence of themes and perspectives between the groups. Where parents reported a need for greater resources and support for partners and children, young people emphasised a need for providers and educators to have better awareness of veteran parental PTSD. Where veteran parents and partners described the difficulties of intergenerational effects related to PTSD, young people on the whole did not identify parental PTSD as being overly negative or 'awful'. Nor did young people express a strong desire for particular interventions targeting them. Parents (including both veterans and their partners) discussed themes of isolation and disconnectedness. Youth also reported a silence within their families, however within this, they saw themselves as independent or self-reliant rather than isolated or disconnected from others.

Thus, it needs to be asked, with whom does the truth lie, the veteran, their partner or youth? It is suggested the answer is 'all three', depending on how the information will be used in the future (Maybery et al., 2005). To simply create more resources for youth given the expressed desire by parents, may well miss the mark if those resources do not align with the youth's perspective of their own needs. Similarly, involving a veteran's family in the veteran's mental health management (as desired by partners), without the buy in from the veteran parent, may erode trust between provider and client (Maybery et al., 2005).

8.3. Implications for Training and Resources

All three groups of participants indicated the need for further information or training, predominantly aimed at the service community, rather than towards families. Veteran families identified difficulties related to health professionals, unfamiliar with military and more specifically, veteran culture, military families. Similar difficulties were identified regarding practitioners being inexperienced in treating PTSD. Long known to be crucial to the delivery of appropriate mental healthcare (Bhui et al., 2007), cultural competence is potentially an under-estimated quality among those working with military and veteran families. According to Bhui et al. (2007) cultural competence refers to a practitioner having knowledge of the beliefs, practices and values specific to the cultural background of the client. With a growing acknowledgement of cultural diversity and awareness, so too is it important to understand military and veteran communities as part of a distinct institutional culture (Wilson, 2008). Furthermore, to provide effective, patient-centred care, clinicians who have cultural competence will be better able to develop and sustain rapport and keep people engaged in support (Bhui et al., 2007; Delaney, 2018; Heather et al., 2004).

Outcomes from the studies in this dissertation suggest mental health services external to the Australian Defence Force, engaged by the military to assist their members would benefit from targeted professional development in the area of military culture. Although many health professionals working within these services have long-standing affiliations with the Australian Defence Force, there are also others who are new to working with military populations. Similarly, in Australia, mental health professionals in private practice without previous exposure to veteran clients, may find themselves with a growing client base, with the non-liability mental health care now offered to all ex-service veterans through DVA. Professional development to promote military cultural competence may help address the shortfall identified in this study. There is some movement in this direction, with a number of short webinars discussing a range of veteran and military focused topics, being offered through various channels (e.g., Mental Health Professional Network; Open Arms). There is also at least one adaptation of a known therapy type (Schema Therapy) to suit military and veteran clients (Fry & Redston, 2018). These resources are important for health professionals working with soldiers and veterans, however wider availability and targeted promotion of training around cultural competence is needed, in the context of working not only with veterans but also families and children living with PTSD. The outcomes reported in this research suggest there is an opportunity for further development of such a training package.

Parents and youth also suggested that teachers and schools need more information around managing students who have a parent with military-related PTSD. Within Australia, the impact of military life upon the educational needs of military children has been recognised (Bryant et al., 2019), and hence, a number resources are available for schools and children, such as Defence School Mentors and Education Liaison Officers. These positions are funded by the Department of Defence through the Defence Community Organisation (DCO), working with mobile military families and schools to ensure supportive educational environments are available for military children (Defence Community Organisation, 2020, July 23). These services are predominantly utilised by schools in the vicinity of a Defence establishment, which include high proportions of military children. The same service however, is not available to veteran families, despite being a growing population, with complex needs. Additionally, the findings of the thesis indicate that the support provided to schools and Defence Education Liaison Officers should also be inclusive of issues specific to PTSD within families, including those no longer able to work. This might for example include educating schools that a school aged child may also be a caregiver, or have a volatile home environment. It may incorporate information around how to support a youth or family, where a parent has PTSD. Expanding the current support provided by DCO to support veteran children and schools (regardless of location) is a significant recommendation arising from this thesis for government funding bodies to consider.

Veteran families identified online resources as a readily available source of information, more likely to be accessed than any other medium. As such, all participants, reported children and youth were more likely to access online information, rather than pamphlets, books, or asking parents or educators questions about PTSD or what that might mean for them. While many knew of online resources, they also felt there were either too many, or the websites were too busy with too much information and lacked the specificity around military related PTSD. There is a lack of child friendly online resources, particularly for Australian focused information. Non-Australian online resources designed for youths and family members such as ‘Sesame Street for Military Families’ (Sesame Workshop, 2020) and ‘Military Kids Connect’ (Defense Health Agency, 2020) exist, though the practical helplines or organisation contacts are non-applicable to Australian families. There are relatively fewer resources for ex-serving families and children. The primary support service for Australian veterans and families in Australia (current and ex-serving), Open Arms, does have some downloadable brochures aimed at children, however navigating to this resource according to participants is not user friendly and is designed for practitioners rather than individuals. It is important to note also, that there are relatively fewer e-resources for ex-serving families and children.

Currently, available resources focus on the impact of parental PTSD symptoms on young people (Open Arms brochure), and how young people can ask for or access help. However, outcomes of this research project identified the primary area young people wanted information in was “what is PTSD and how can I help my parent?”, rather than “how do I help myself?”. Previous research has identified the benefits for children to be informed about parental mental illness (Fudge et al., 2004). Given the added avoidance inherent in PTSD and the avoidance of youths in this study to talking about issues, readily available information by way of online resources would provide a critical bridge in the information gap for youth with parents that have a mental illness (Grové & Reupert, 2017; Grove et al., 2016). The international websites catering for military children do provide a useful source of information, some of which embrace child and teen friendly designs. However, it is important to recognise the Australian veteran community and families may be culturally different to other countries. Having resources that use familiar, age-appropriate language, culturally relevant pictures and nationally relevant references for support will help address the shortfall of information for Australian youths living in veteran families, particularly those living with parental PTSD.

One organisation, Children Of Parents with a Mental Illness (COPMI) national initiative, expanded the availability of resources for Australian families living with mental illness, including youth friendly information (Emerging Minds, 2016). Information on a range of mental illnesses such as anxiety, depression and bipolar disorder are all available both in video and text formats, making it accessible for all. Though this is a valuable resource for families and youth, the youth section does not detail information about PTSD, nor is there military or veteran specific information. This could be a valuable resource, if expanded in those areas. For example, following the same format as other videos available, an information package on PTSD might include the following information:

- What is PTSD and what are the general symptom clusters?
- How is PTSD different from anxiety, being scared or fearful?
- PTSD will generally require help from professionals
- How can living with someone with PTSD affect others?
- PTSD is not something that they will catch
- Information about where youths might access more information, or how to access help

8.4. Implications for Practice

There are three direct implications for clinical practice arising from this study: (i) parental status is important when treating veterans with PTSD, (ii) family focused healthcare needs to be prioritised and (iii) supporting youth within veteran families living with PTSD may need to occur through parents.

8.4.1. *Parental Status is Important*

First, clinicians need to recognise that where a veteran with PTSD is part of a family with children, their capacity as a parent will require support as much as their mental illness. As seen in Studies 2, 3 and 4, it is common for the veteran with PTSD in these families to act as the 'primary' caregiver, as they are no longer able to engage in paid employment. As such, parental status needs to be identified for all veterans when accessing treatment for PTSD or other mental illness. Previous studies have shown people with a range of mental illnesses may under-report symptoms or maladaptive behaviours due to the stigma associated with mental illness (from themselves and others), a negative impact to career or losing access to children (DeVoe et al., 2018; Mellotte et al., 2017; Reupert & Maybery, 2009; Van Hooff et al., 2018). The participants in this study supported these findings, suggesting that clinicians need to be cognisant of potential minimisation of symptoms when treating a veteran: "It's natural for us to keep things hidden" stated one youth in Study 4. According to van der Ende et al. (2016) being a parent increases the burdens and responsibilities for a person managing a mental illness. The same was true for the participants in this study, who reported challenges such as balancing medication with their capacity to perform parental duties (for example, driving children to and from events, or supervising children at playgrounds). This has implications for parents with PTSD adhering to treatment, and efficacy of symptom management.

Consistent with van der Ende et al. (2016) findings, the current research found parental status was a protective factor, with parents (veteran and partner) identifying their role as a parent as instrumental in their decision to seek help, and a primary reason to keep living. Clinicians, health providers and services need to change routine practices to incorporate these findings. For example, intake forms could enquire as to ‘parental status’ in addition to ‘marital status’. Initial and ongoing assessments should explore ‘parental and home functioning’ as a critical ‘area of functioning’ as per Criteria G for diagnosis of PTSD in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V; American Psychiatric Association, 2013). Supporting veteran parents with PTSD needs to be an ongoing conversation around how symptomatology is impacting them, their engagement as a parent and their family. By doing this, there is also an opportunity to support youth by way of the parent, which will be discussed further below.

8.4.2. *Moving Towards Family-Focused Practice*

Veteran families involved in this research project are calling for services and mental health practitioners to take a family-focused approach when working with veterans with PTSD. Family focused practice is a term that originated with parents calling for greater involvement in decision making regarding the treatment of their children, and now encompasses the same sentiment regarding families where a member has a mental illness (Foster et al., 2016). In the present research, partners often felt ‘left out’ of the loop when it came to veteran treatment, feeling they had all the responsibility of caring for the family and the veteran, but no information or inclusion in the treatment decisions of the veteran. Similarly, some of the youth were in a position of caregiving to their veteran parent, however other than ‘keeping them from suiciding’ and looking after other family members, those young people in a caregiver role were not overly informed about treatment requirements, risks (for example mixing alcohol with medication) or when to call for help.

Monson et al. (2009) found that when family members are included in a structured way within treatment (i.e., specific family/partner psycho-education sessions), outcomes appear to improve, such as lower levels of mental illness symptoms. Group PTSD programs are now encouraging or including partner information days or sessions to help break down barriers and communication avoidance between veterans and their partners, inherent to the expression of PTSD. This inclusion is likely a response to a number of studies, which call for better family involvement (Batten et al., 2009; Sherman et al., 2012) – recommendations echoed in this dissertation. Based on the growing research around family focused practice, Foster et al. (2016) recommends that all practitioners include strategies of family involvement or at a minimum psycho-education, as family focused practice becomes firmly cemented as ‘best practice’ when servicing families living with parental mental illness (Foster et al., 2016). Families in the current project are also calling for more partner-focused interventions, particularly helping partners connect with others in similar circumstances. Given the isolation expressed by partners and the lack of support to partners indicated by veterans, this is a real opportunity for service providers to address an existing need.

8.4.3. *Supporting Youth Means Supporting Parents.*

A key finding in this research was that youth are reluctant to seek support, and as such, support for these young people may be most effective when generated at the parent level (McGaw & Reupert, 2020). Earlier studies have described long-term adverse impacts among adult children of veterans, not only in terms of how they form relationships, but also across a number of domains (Davidson & Mellor, 2001; McCormack & Devine, 2016; Sherman et al., 2015). Therefore, while the youth in this study did not describe the need for intervention, it may well be appropriate for long term growth. Indeed, the children in this study who were receiving psychological support did so through the veteran parent, who was then described as a role model for how to cope, reducing the self-stigma associated with receiving treatment.

Communication between those youth and parents appeared to positively affect connection; with parent-child communication being an issue for desired support identified by both veterans in the present study (McGaw et al., 2018) and those in earlier ones (For example: Sherman et al., 2015). Furthermore, the present study found veteran parents and partners want support around parenting with PTSD. They want assistance around how to talk with their children about mental illness, which has been a general finding among many other studies around children of parents with a mental illness (Sherman et al., 2015). Health practitioners, clinicians and services might consider how interventions might incorporate parenting, particularly as a means of supporting not only the veteran, but also importantly, the child.

8.5. Future Research

This thesis has provided valuable insight into the experiences of veteran families living with PTSD, from the perspectives of the three main stakeholders, veteran parents, partners and youth. To the best of this author’s knowledge, this is the first time such an approach has been taken, within this specific population, thereby solidly contributing to the academic knowledge base. As with all research, there were some limitations that provide an opportunity to guide future research.

While results of each of the three groups have been published in peer reviewed journals, the final ‘whole’ family perspective was not, with implications around accessibility of findings to the wider public. A meaningful addendum to this thesis would be to present the global family themes discussed in Chapter 7 within a fifth manuscript, including details from Chapter 8 regarding implications, with the intention to publish.

This thesis interviewed family members at one time, effectively a ‘snapshot in time’. As discussed in Chapter 7, it is apparent from previous studies that adult children of veterans with PTSD report different experiences of their childhood to those who are in the midst of ‘living’ it (Harrison et al., 2014; McCormack & Devine, 2016; McCormack & Sly, 2013; Yehuda et al., 1998). Future research might undertake a longitudinal approach, with follow up interviews at differing time points (e.g., one year, two years, five years, ten years). Alternatively, another approach may be to expand the inclusion criteria to ALL family members regardless of age or living circumstances. The views expressed in this project were those of families actively raising children, and youths (adolescents) living with veteran parents. The voice of children under 12 were not included, nor the voice of those over 18 years. Being able to include a wider range of ages is necessary to ascertain how these perceptions and experiences shift over time, along with the influences for that change (negative and positive). Future qualitative studies involving veteran families living with parental PTSD might want to consider how concepts around posttraumatic growth or recovery from trauma are experienced or interpreted by those at the heart of the phenomena. This thesis had not approached the research from any particular theoretical framework, and therefore did not include comment or exploration of these concepts, as they were not represented within the interviews. However, with a growing interest in the research and clinical communities around trauma recovery and growth, these may be important areas where ‘lived experience’ participants can better inform practice.

Future studies involving veteran families living with PTSD might consider service providers as a fourth stakeholder, interviewing clinicians regarding their own experiences working with veterans and their families. This approach was outside the scope of the current project, however such research might consider whether clinicians identify the parental status of the client as part of a needs assessment. Other issues of interest for research with clinicians might investigate clinicians’ emotional experiences when working with veterans in the context of being part of a family, if and how clinicians assess risk to children and families in the context of veteran parent symptoms, and whether such assessment impact decisions for treatment. Given the high rates of PTSD occurring in the presence of other disorders, conceptualising family experiences purely from a perspective of the experience and impacts of parental PTSD alone may not provide a complete picture. Difficulties around co-morbidity both in research and treatment may be an area for future research to consider, particularly when clinicians’ views are incorporated. Researchers might also consider the extent to which clinicians collaborate with veterans and families when considering appropriate treatment models. Similarly, the organisational or procedural barriers experienced by clinicians when treating a veteran who is also a parent and part of a family needs to be considered in future studies.

As mentioned earlier, there are some limitations around demographics and recruitment in this thesis. Further exploration of veteran families living with PTSD should seek to address those limitations, particularly around the demographics of the participants involved. Firstly, it is important to be able to collect information from not only ex-serving veteran families, but also current serving families in which a member has PTSD. Although this may present some difficulties around possible minimisation of symptoms to maintain employment, it would widen the population window for whom these experiences might reflect, and thereby increase our insight about these families. Secondly, more efforts are needed to recruit male partners of veteran with PTSD, along with female veterans. To the author's knowledge there have been no studies that have sought a male partner experience around families living with PTSD. With some evidence to suggest male and female veterans' experience PTSD in the context of parenting differently (Creech et al., 2016; Gold et al., 2007; Kelly et al., 2016), the male partner experience is an obvious omission from existing research. Another recruiting issue mentioned across the bulk of research in this area, is the lack of ethnic and cultural diversity among those that participate. Australia is a multicultural nation, with an indigenous population that has been involved in military service for every war and military engagement within which Australia as a nation has participated. It would behove future researchers to purposefully target the minority populations within the current and former serving Australian Defence Force, thereby bringing a richness not yet seen.

8.6. Policy

This research did not seek to explore existing national nor international policies, procedures or organisational frameworks that impact veteran families living with PTSD. However, it did become clear that there are some barriers faced by families who participated in this thesis, particularly around access to services. Firstly, some services are available for veterans but are not offered to their families. In particular, access to free counselling is available through any provider, for all veterans and ex-serving members through the DVA veteran card. For family members, it is only available through Open Arms counselling service. Open Arms has an extensive network however, where a veteran or family member has had a negative experience through Open Arms, they are unlikely to utilise the service, and so there needs to be an alternative. Both Open Arms and the DVA veteran card scheme are funded by DVA – however there are limitations on services depending on whether you are the veteran or the family member, and acts as a barrier to care, and needs to be considered if we are to reduce this issue.

Another service available for current-serving families, but not accessible to ex-serving families, is that of support within schools. Currently, school and family access to Defence School Mentors and Education Liaison Officers is funded through DCO, an organisation within the Department of Defence and so, it is not available to ex-serving members and their families. Once discharged from the Australian Defence Force, there is no comparable support available to veteran families, who no longer fall under the Department of Defence, rather are administered by Department of Veteran Affairs (DVA). Shifting policy to reflect the continuous connection of families to the military regardless of service status, may help open the way for shared resources and seamless access to support.

Despite there being a wide range of services and support available, eligibility to utilise services is very much tied to employment status, rehabilitation status or veteran status. For example, financial support to families (separate to veteran pension) is conditional on the veteran member having engaged in ‘warlike’ service, which precludes PTSD occurring as a result of humanitarian missions or training accidents. Childcare support is available to support veterans accessing services, however this is limited and again, requires the veteran to be engaged in a rehabilitation program. The key barrier identified in this dissertation is one of funding: who is paying for any given service, who is accessing these services and who is entitled amongst the family to different services. These are issues that are outside the scope of this thesis to explore, but are considerations that need to be addressed at a policy and service level, if we as a nation are going to better meet the needs of our service men, women and children, during and after transitioning out of the Australian Defence Force.

Postface

An Insider's Perspective: Bracketing the Last Word

The purpose of this research was to gain insight, understanding and knowledge about the experiences of veteran and military families living with PTSD, whilst also raising children. The journey has been long, with initial interest born out of concern for my clinical clients, who struggled with a crumbling military career, debilitating PTSD symptoms and responsibilities as a parent. Failure was felt on many fronts, yet as a clinician I only addressed the mental illness in the room. I saw a gap in both research and clinical practice around parenting, family and children, feeling "surely I am missing something as a clinician, how can I better meet the needs of my client?". The only way I could see to do this appropriately was to go to the source and ask them: the veteran parent, the partner and the youth, all living that reality.

Right from the beginning, I wanted the research to authentically reflect the experiences of the people involved in the studies, as free from the influence of existing theories and assumptions as I could manage. My initial and rudimentary researcher experience told me: "research needs to be empirical, have validity and reliability, and qualitative research is so.... unstructured or subjective!". This was the point where I recognised "And so is the human experience". Being new to qualitative research, I followed advice, I discussed my thoughts freely (constantly) with supervisors, colleagues and fellow researchers interested in parental mental illness. I learned about minimising researcher bias, particularly as my intention was not to confirm my own agenda, but to honestly go to the experts and ask, "What is it like living in your shoes, and how if in any way, can your needs be better met?". I attended conferences, immersed myself in the process of developing as a qualitative researcher. I wrote everything down. I recorded supervision sessions, reflected on decisions in diaries, and conducted hundreds (if not thousands) of literature searches. Through this project I FINALLY got my head around IPA, and the reader might see this development, from the earlier veteran and partner studies using a simpler thematic content analysis, to the final youth study, where analysis was reflective of themes 'beyond' the text as I made sense of participants' perspectives. Over the journey of this research, I developed my qualitative research skills, where I now cannot imagine doing research that does not also include qualitative methods.

I can look back now, and the more I became aware of my own lived experience, I realised removing all bias was likely impossible. However, now acknowledging my 'insider' status, there were definite benefits as a researcher. Working as a psychologist in the military, I knew the available resources being accessed by veteran families, allowing me to target this population for the research. When interviewing, my status as 'ex-military' gave me credibility, with some participants telling me that they would not have trusted my motives if I had not been in the military. My background allowed me to understand the context within which PTSD occurred, the military culture within which these families lived, and the nuances of the jargon used within the interviews. Had I been an 'outsider' researcher, it is unlikely I would have had the depth of understanding to authentically present these participants experiences here, along with recommendations to better support their needs.

Reflecting on the rich outcomes of this thesis, it is clear to see the integral role each member plays, supporting the wellbeing of the other members in the family. The difficulties of balancing family needs with individual needs shone through, as did the strong bond experienced within families living with PTSD. For veteran parents, their experience was one of a constant internal conflict between battling symptoms or engagement in treatment and meeting the needs of the family. Interestingly, this juxtaposition has not been well recognised within treatment settings, with a general assumption that treating the symptoms or condition will produce the best outcomes for parenting and the family. The missing part of the treatment was the engagement of families, provision of childcare, inclusion of partners, alternative pathways of providing support for all members and a dual focus on parenting as a primary area of concern in conjunction with PTSD treatment. As such, I have now adjusted my own practices.

Having not worked with the partners of veterans, I now have a much clearer understanding around the burden of care experienced by the women in this study. There was a sense of 'loss of a partner' and isolation from others, as the world shrunk to accommodate their partner's PTSD. Many felt left out of the treatment process, uninformed, and left to cope with treatment/symptom fallout without support. I see now that partners are likely to be strong allies in the provision of mental healthcare, as they are fiercely protective, keen to bridge gaps between veteran and children. These women are strong capable people living with unpredictability and a lack of information. Partners want information, inclusion, supports and acknowledgement. Partners need support prior to their partners leaving the Australian Defence Force and they want better communication with services rather than feeling as though the burden of care was left to them. This perspective has been invaluable to my own practice, as I too felt like I was working without all the information. I now invite veterans to share information with partners, invite them to come along to an information session where appropriate, where support can be provided to the veterans to talk with their spouses.

Talking with the youth in this study provided insight around growing up in a sometimes challenging environment, with (at times) challenging parents. In contrast to the adults in this project, youth did not express the same views. Most felt their parents were supported, competent and capable, even if at times they were unpredictable or needed care. Although they indicated more information might be useful, none were overly invested in acquiring it, nor were they asking for more services. There was a sense of self sufficiency among the youth of this study. Again, like partners, they were very protective of their parents, however, without being cognisant of it, they were also imitating avoidant behaviours, because 'you don't talk about that stuff'. Youth are growing up without language around mental health or accessing services for mental wellbeing. Parents and youth in this study, interpreted the impact of PTSD very differently: for the former, PTSD is significant; for the latter it is "not the elephant in the room just wrecking everything". It was interesting to see how the disconnect experienced as a direct effect of PTSD symptomology, was experienced by each member differently. For youth it was expressed as a reliance on self rather than others, a preference for 'dealing with it' without help. Acknowledging this preference for self-reliance, it becomes even more important to support veteran parents and partners in their parental roles and relationships with their children, particularly around mental health communication and support.

Now at the end of my research, I can observe the changes in my own practice, incorporating what I have learned, as I have made sense of each person's retelling of his and her experiences as part of a family living with PTSD. I ask every client, veteran or otherwise "Who's at home? Do you have children/partner/pets?" I make it routine to explore parent experiences and challenges, regardless of treating condition. I am constantly assessing client needs, partner needs, child needs. I also promote this approach with my colleagues, by providing family focused strategies, resources and professional development within my workplaces. I am also now working with children. My journey of discovery has me taken me from psychologist to researcher, to child/grandchild/great grandchild within a family affected by war trauma and then back to researcher/psychologist. The journey has entailed me recognising my own “insider” status with this phenomenon, that I had not fully appreciated until I began talking with the people in this research and hearing my own family history.

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List of Appendices

Appendix A: Ethics Approval Documents

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Chair of the Monash University Human Research Ethics Committee. The Chair was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: **CF15/3040 - 2015001281**

Project Title: **Military PTSD: A Family Experience**

Chief Investigator: **Assoc Prof Andrea Reupert**

Approved: **From: 17 August 2015** **To: 17 August 2020**

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Nip Thomson
Chair, MUHREC

cc: Mrs Violette McGaw, Prof Darryl Maybery

Australian Government

Department of Veterans' Affairs

Contact: DVA HREC Secretariat
Telephone: (02) 6225 4590
Facsimile: (02) 6289 6227
E-mail: ethics.committee@dva.com.au

Violette McGaw
Consulting Psychologist
Faculty of Education
Monash University
CLAYTON VIC 3168

violette.mcgaw@monash.edu.au

Dear Violette,

Ref: E014/015 – Military PTSD – A Family Experience

Thank you for resubmitting the above proposal for consideration by the Department of Veterans' Affairs Human Research Ethics Committee (DVA HREC).

Your application was approved in-principle by the Committee on 22 May 2015, pending resolution of the following issues:

- Revision of the protocol to include a detailed risk management process in the event that a child becomes distressed;
- Provision of an assurance that the researcher will comply with *National Statement on Ethical Conduct in Human Research (2007)* Chapter 4.2 Children and young people;
- Provision of a copy of the advertisement flyer;
- Evidence of support from the Veterans and Veterans Families Counselling Service (VVCS) National Manager and permission to display the flyer in VVCS offices; and
- Confirmation that the study participants are ex-serving ADF members only and if so, revision of participant information sheet and flyer. Alternatively, if current serving members are to be included, approval from Defence will also be required.

Your resubmission addressing the issues above was received on 12 June 2015. In considering your revised proposal, the Committee noted the detailed risk management protocol and your assurance that the protocol will adhere to the *National Statement on Ethical Conduct in Human Research (2007)* particularly Chapter 4.2 'Children and young people'.

Support with study recruitment from the Veterans and Veterans Families Counselling Service (VVCS) via placement of an advertisement flyer in Brisbane VVCS offices was confirmed with the VVCS National Manager on 16 June 2015.

In your latest correspondence with the Secretariat dated 21 and 31 July 2015, you confirmed that current serving ADF members are not included in the study and the advertisement flyer and participant information sheets have been updated to reflect this.

I am pleased to advise that the Chair agreed your revised proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and gave his full approval.

The Committee has asked that you note that ethical approval does not guarantee access to DVA funding, information or assistance.

The Committee requires six-monthly progress reports from approved projects, until it receives a final report detailing the research outcome(s), or advice that the project has been suspended or abandoned. It is the responsibility of the researcher to ensure that progress reports are submitted in a timely manner. Submission of progress reports can be made by e-mail to ethics.committee@dva.gov.au quoting reference number **E014/015.**

The Committee looks forward to receiving your first progress report by no later than **29 January 2016**. The report should address the questions set out in the Biannual Compliance Report template, available from the DVA HREC website at www.dva.gov.au/ethics.

Failure to comply with the above reporting requirements may result in withdrawal of DVA HREC approval.

Any variation from the agreed protocol or conditions of approval will require the Committee's separate consideration. The Committee should also receive immediate notification of any unexpected adverse event arising from the research and reserves the right at any time to seek further information, noting this may affect the continuation of its approval.

Please feel free to contact the DVA HREC Secretariat to discuss any matters relating to the above study on (02) 6225 4659 or via the Committee's email address ethics.committee@dva.gov.au.

Yours sincerely

Kyleigh Heggie

Kyleigh Heggie
Director
Research Section
Policy Branch
Department of Veterans' Affairs

2 August 2015

Appendix B: Semi-Structured Interview Schedules

Introduction Preamble – Veteran and Partner Interviews

I would like to thank you very much for agreeing to take part in
this interview.

I want to emphasise that all the information that I collect from you will be treated in a confidential manner, so I'll be removing all information that identifies you from the interview notes and you can check that yourself because you'll be receiving a copy of the interview notes before I do any analysis on it. So you can make any changes to it..

A pseudonym, or code name which you may choose, will be used when writing up the results and nothing you say will effect your access to services or entitlements, past, present or future.

Before we begin, I would like to say that what I am most interested in is understanding your experience with what it is like to live in and raise a family now that you or your partner have developed PTSD as a result of military service.

Although I have developed some questions that I feel might be helpful in exploring these issues Its also entirely up to you whether you want to answer all of my questions. So if there's a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question. Please feel free to add any information you see as relevant or suggest other topics around parenting or family issues you feel I might have missed.

The purpose of this interview is to conduct research and your participation in this research is entirely your choice and even though you are participating now you can withdraw from the project at any time without giving a reason.

Even though I understand that you have provided consent to having this interview being taped, I would like to ask you again, whether you are okay with having the interview audio-taped?

I'll start by asking you a few questions about you and your family, how many people and what ages are your children. Then, I will be asking questions related to challenges, strengths, the way you manage conflict and the sharing of tasks, among other things.

Any questions? Ok lets start

(switch on tape recorder)

Semi Structure Interview Schedule for Veteran and Partner Interviews

1. Tell me a little bit about your family structure?
2. Were you with your partner before you/they developed PTSD?
    a. What was life/relationship/family life like then?
    b. What was parenting children like before PTSD?
3. How did you meet what/if any impact did having PTSD have?
4. What/if any- were the challenges/unexpected positives through pregnancy/birth and having a newborn?
5. Describe your parenting style?
6. How (If at all) does your parenting style differ from your partner?
7. How do you negotiate differences with your partner and/or children?
8. What is a normal or typical day like for your family?
9. What impact (if any) do you think you/your partner’s mental health has had upon your partner/you/children?
10. Do you, the children or your partner try to hide how they are feeling because of your/your partner’s PTSD?
11. What is it like to be part of a family living with PTSD?
12. When are times that are more difficult to be part of a family?
13. What/if anything do you/your partner/children do to cope at times that are more difficult?
14. In your role as a mum/dad what are the main challenges you experience?
15. Have there been things you had to stop doing, that you had done before because of PTSD?
16. Have there been things you have had to start doing that you didn’t do before because of PTSD?

17. Who would you regard as providing emotional support when you are sad, frustrated, hurt or angry?
18. How much (if at all) do you share with or rely upon your partner/child?
19. Are you in contact with other ADF serving/ex-serving with shared experiences?
20. If so, how much do you share or rely upon them for support?
21. Do you still identify as being part of the veteran community?
22. What are social occasions like?
23. Since you have developed PTSD, what have you learned about yourself, partner, children, extended family?
24. What are your family's strengths, particularly because you are living with: PTSD/a partner with PTSD?
25. What is your partner's/children/your best quality or strength?
26. What if anything would be important for other people to know about parenting and being part of a family living with PTSD?
    a. Eg. Doctors, teachers, psychologists, counsellors, support organisations, other families, children?
27. My last question is a really open one – which is: Is there anything else you would like me to know about raising a family with military related PTSD?

CONCLUSION

That is all the questions I have for you today. Thank you so much for your time. I appreciate it. I will be sending you a transcript of this interview for you to check and delete any information you think might be potentially identifiable or to add anything you might like to add.

So how have you found talking to me today? Has anything come up that you weren't expecting? Do you have any feedback for me with regards to the questions or any part of todays interview? I need to remind you that if you find this process distressing either now or later there are people to talk to. Just let me know and I can arrange this for you.

Thank you again for your time.

Semi Structured Interview – teens – Preamble and Questions

Preamble

Thank you for agreeing to participate in this interview.

The aim of today is to understand from your point of view what it is like to live in and be part of a family with a parent that has developed military related PTSD.

Did you have a look at the information on the website about the study? I can also send it do you by email if you like.

Now, your participation in this study is entirely your choice and even though both you and your parent have agreed for you to take part now, you can stop at any time without giving a reason.

You can also withdraw from the study any time after, until you approve the interview notes.

It's also up to you whether you want to answer all of my questions. So if there's a question that you'd rather not answer, you can just let me know and we'll move straight on to the next question

Finally, all the information you tell me will be treated in a confidential manner, so I'll be removing anything that identifies you from the interview notes, and you can check that yourself because I will send you a copy before I use it in the study.

You can make any changes you think are necessary

Any questions so far?

I just want to double check that you are okay with having the interview audio-taped?

Continue with:

Semi structured questions

Semi Structured Interview Schedule for Children of parents with military related PTSD

1. When did you find out that your (mum/dad) had something called posttraumatic stress disorder or PTSD?

2. Do you think you would like to know more about it?

3. What is it like for your (mum/dad)?

4. What is it like to live in a family where your parent has PTSD?

5. If you remember -what it was like before your (mum/dad) developed PTSD?

6. What is a normal or typical day like for you?

7. Are there some times that are more difficult than others?

8. What do you/yourparents do to get by at those times?

9. How does your family or how do you manage conflicts or fights?

10. What is the best thing about living in your family?

11. What is your mum's/dad's/brother/sister's/ your best quality?

12. Since your (mum/dad) had come home from deployment and developed PTSD, what have you learned about yourself/Mum/Dad/Family:

13. What (if anything) have you have had to stop doing, that you had done before PTSD?

14. What (If anything) have you have had to start doing that you didn't do before PTSD?

15. When you are feeling sad, hurt or angry who would you talk to about it?
    a. When things at home are hard, who (if anyone) would you talk to about it?

16. Are there other people you know have similar families to you?

17. What are social occasions like? Eg. Birthdays, Friends over, Christmas

18. If you were asked to tell other people what it is like to have a mum or dad with PTSD, what would you like them to know?
    a. Eg. Doctors, school, counsellors, families, parents, kids?

19. Those were my last questions, Is there anything else you would like me to know?

CONCLUSION

That is all the questions I have for you today. Are there any other comments, issues or concerns you would like to make about this?

I will be sending you a transcript of this interview for you to check and delete any information you think might be potentially identifiable or to add anything you might like to add.

Thank you so much for your time. We appreciate it. I need to remind you that if you find this process distressing either now or later there are people to talk to. Just let me know and I can arrange this for you.

Appendix C: VVCS Letter of Approval for Recruitment

PDF to follow

Violette McGaw C/o Associate Professor Andrea Reupert,
Faculty of Education, Clayton Campus
Monash University,
Victoria

TO WHOM IT MAY CONCERN

Re: Project : Military PTSD : a family experience
Student Researcher: Violette McGaw

I acknowledge your request to recruit participants from the Veterans and Veteran Families Counselling Service for the above named research.

I have a good understanding of the research project "Military PTSD: A Family Experience" including our organisation's role in recruiting participants and hereby give permission for this research to be conducted.

Yours faithfully

Lyn Needham
Deputy Director

28 July 2014

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15 Astor Terrace
SPRING HILL QLD 4000

PO Box 166
SPRING HILL QLD 4004

TELEPHONE (07) 3037 2100
24 HOURS 1800 011 046
FAX (07) 3831 4340
INTERNET www.dva.gov.au/vvcs
EMAIL vvcs.qld@dva.gov.au

A service founded by Vietnam veterans

Appendix D: Research Flyer

To Register Interest:

www.militaryptsdfamilystudy.com

> *"It is hoped this study will better educate care providers and services about a condition that is often treated in isolation, yet affects and is experienced by the whole family"*
>
> *- Violette McGaw*

This study is being conducted through Monash University, in partial fulfillment of Violette McGaw's combined MPsych/PhD of Psychology (Educational & Developmental). Associate Professor Andrea Reupert (Monash University, Faculty of Education) is the primary supervisor and chief investigator. Department of Veteran Affairs and Monash University Ethics committees have granted approval for this study (E014/015 & CF15/3040-2015001281)

MILITARY PTSD:

A Family Experience

A Monash University qualitative research study exploring the lives of Australian ex-Service families raising children where one parent has military-related PTSD

MONASH
University

VOLUNTEERS NEEDED FOR RESEARCH STUDY

What is it about?

We are looking to interview volunteers about their experiences of living in and raising a family, where one of the parents has military related PTSD.

Topics will include:

- Parenting Practices
- Daily routines
- Adjustments after PTSD
- Family strengths
- Services used or services needed

Why do this study?

The aim of this study is to put together:

- The views and experiences of veteran parents with PTSD,
- The views of partners raising families with veterans with PTSD, and
- The view of the children living and growing in these families.

We hope to explore the 'whole family' experience, giving families living with PTSD a voice

What is involved?

- You will fill in a short online questionnaire.
- If you are who we are looking to interview, you will be contacted and an interview will be arranged.
- The interview will be either: face-to-face, via phone, or Skype depending on your location and preference.

How long will it take?

The online questionnaire takes approximately 5 minutes to complete,

The interview will take approximately 30-60 minutes, either face-to-face, over the phone, or via Skype, depending on your location and preference.

Families living with military-related PTSD

We are looking to interview

- Ex-Serving Australian Defence Force (ADF) personnel who experience PTSD as a result of deployment, and who are currently parenting children between 0-18years old.
- Partners of ex-Serving Australian Defence Force personnel who experience PTSD as a result of deployment, who are currently parenting children between 0-18years old.
- Adolescents between the ages of 12-18years old who have a parent that is an ex-Serving ADF personnel with PTSD as a result of deployment.

To Register Interest go to:

www.militaryptsdfamilystudy.com

Contact Us

Violette McGaw
Primary Researcher

0439443480
violette.mcgaw@monash.edu

Assoc Prof Andrea Reupert
Chief Investigator
Andrea.reupert@monash.edu

www.militaryptsdfamilystudy.com

Appendix E: Explanatory Statements

Information sheet for adolescents 12+ years

"Military PTSD: A Family Experience"

Hi

This sheet is for you to keep.

My name is Violette McGaw and I am a PHD student at Monash University, working with Dr. Reupert. I am doing a research project to find what it is like to live in a family where one parent has military-related posttraumatic stress disorder (PTSD). I am asking you and your parent if it is okay for you to take part in this research.

We are trying to explore the 'whole' family experience of PTSD, including how things might be different, good, bad, more challenging or unexpected benefits. We want to find out how your family relates to one another. Your experiences and views will help us understand what it is like for the children in these types of families, so that other children and families can be better helped.

Your parent has already provided permission for you to be involved in this study, but it is up to you whether you are involved or not. You do not have to be a part of this research, it's up to you.

What will I have to do if I take part?

1. If you agree to take part, we will organise a time to meet or talk with you either in a public place like a library, by Skype or phone – whichever you prefer.
2. You will be interviewed, which will take between 30 and 60 minutes. Questions will cover topics mentioned above, along with "how much do you know about PTSD" and "what, if anything would you like to learn about it?".

You may withdraw from participating in the project at various times. In the interviews you might not like the questions – again, we can stop the interview. When the interview is finished we will send you the interview notes – you can change any of this, if you think it is wrong or someone might be able to tell that it is you. After you approve these notes, you will not be able to withdraw from the project (there will be a cut-off date for this to occur).

No one will know what information you give us in the interview. No one will be able to tell that the information comes from you. Your name will not be written in any report.

The information you give us will only be used by the researchers. No one else is allowed to use this information. The information you provide us will help give a clear understanding of families like yours, so that more can be done to lessen the impact war experiences have upon society. All research related information will be in kept on a password protected computer and kept for five years. Only researchers will be able to have access to it.

It might be upsetting for you to talk about family issues. We don't think there is much chance of that but if you do feel upset first we would encourage you to talk to your parents or if you have a counsellor you see, you should talk to him or her. There are also other places you can turn to such as:

Kids helpline	1800551800 or http://www.kidshelp.com.au/
Lifeline	13 11 14
Beyond Blue Info line	1300 22 4636

What do I need to do?

If you are interested in being involved, let your Mum or Dad know, sign the consent form and ask your parent return in the included envelope – or via:

Mail:
Principle Researcher:
Violette McGaw
C/- Dr Reupert
Faculty of Education
Clayton Campus
Monash University, Vic, 3800

Email:

Violette.mcgaw@monash.edu

You can also register your interest, find the explanatory statements and consent forms online at:

www.militaryptsdfamilystudy.com

If you have any questions, you can ring or email either of the researchers listed below.

Thank you.

Violette McGaw
Masters/PHD Psychology (educational & developmental) candidate
Faculty of Education
Monash University
Telephone: 0439 442480
violette.mcgaw@monash.edu

Andrea Reupert
Associate Professor and psychologist
Krongold Centre
Faculty of Education
Clayton Campus
Monash University, Vic 3800
Telephone: 03 9902 4587
Fax: 03 9905 5127
andrea.reupert@monash.edu

If you have a complaint concerning the manner in which this research is being conducted, please contact:

Executive Officer, Human Research Ethics
Standing Committee on Ethics in Research Involving Humans (SCERH)
Building 3e Room 111
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052 Fax: +61 3 9905 1420 Email: scerh@adm.monash.edu.au

MONASH University

Explanatory Statement for parents

“Military PTSD: A Family Experience”

This information sheet is for you to keep.

My name is Violette McGaw and I am conducting a research project with Dr Andrea Reupert (Associate Professor in the Faculty of Education) towards a combined Masters of Psychology (Educational and Developmental)/Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a short book.

You are invited to take part in this study. Please read this Explanatory Statement in full before making a decision.

This research seeks to inform Educational and Developmental psychologists, along with clinicians in the greater field of psychology, about the ‘whole’ experience of families living with military-related posttraumatic stress disorder (PTSD). Areas to be explored include, but are not limited to: parenting, challenges, changes, strengths, conflicts and resolution skills.

The primary research question is: “What is it like to live in a family where one parent has military-related PTSD?” Secondary level research questions are:
“What is it like to be a parent with military-related PTSD?”
“What is it like to be a co-parent where your partner has military-related PTSD?”
“What is it like to be growing up with a parent who has military-related PTSD?”

The aim of this study is to put together all three perspectives in the one project, to investigate the experience holistically and give “families” a voice. It is hoped this will better educate care providers about a condition that is often treated in isolation, yet affects the entire family.

To be involved in this study you must:

- Be either a mother or a father currently parenting children between 0-18yrs;
- Be an ex-serving Australian Defence Force (ADF) person and have been diagnosed with PTSD related to military service

OR

- Your partner is an ex-serving Australian Defence Force (ADF) person who has been diagnosed with PTSD related to military service

We are also seeking consent for your child/ren to be involved in the project if they are 12 years or older. As the parent it is up to you whether you involve your children or not. You might want to participate in the project first before making a decision, and we would also encourage you to discuss the opportunity with him or her as well before providing consent.

Being in this project involves the following steps:

- First you will need to read, fill in and return the included consent form either by email, mail or in person, at the beginning of the scheduled interview;
- A time to meet will be organised;
- At the time of the interview you will be asked to complete a short mental health screen, likely to be familiar to the ex-serving ADF parent, for the purposes of screening for wellness to participate, and clarification of PTSD symptoms present (central to the theme of the project). The screen will take approximately 5 minutes at the start of the interview, and is descriptive, not diagnostic. Responses will be briefly explored at the start of the interview, with two possible outcomes:

- Where responses are significantly elevated, indicating current level of distress, options for engaging in support will be explored rather than continuation with the interview.
    - Where responses are indicating low to significant elevations but the person is not in a current state of distress, the interview will commence.
- Thirdly, an interview will be conducted that will take approximately 60 minutes, although sometimes may take a little longer.

You can also register your interest, find the explanatory statements and consent forms online at:

www.militaryptsdfamilystudy.com

The interviews will be focusing on your experiences of family life in the presence of PTSD and with your permission will be audiotaped. These interviews will take approximately one hour and will be conducted either face-to-face in a public place such as a local library conference room, or over the phone or Skype- whichever you prefer. Once the interview has been completed you will be provided with a copy of the interview and given the opportunity to add, delete and/or change any information you believe is potentially identifiable or incorrect. There will be a cut-off date for this to occur (three weeks after the transcript has been sent to you).

We are also asking for participation from your children, if they are 12 years of age. If you provide consent, we would then talk to your child about the study and invite him or her to participate. They would then be invited to participate in a similar interview likely to be 30 – 60 minutes in length, either face to face in a public setting, via phone or Skype.

Your involvement, and the involvement of your children, in this study is voluntary and you are under no obligation to participate. Your involvement or non-involvement will not impact on any clinical services you receive, and is confidential. If you no longer wish to participate, you (or your child) can withdraw at any time up till you approve of your interview transcript.

If you or child is seriously ill, suicidal and/or hospitalised you, he or she are not eligible for participation.

All information reported will be de-identified and at no times will names or identifying information will be reported. Storage of the data collected will adhere to university regulations (password protected computer) and be kept for five years. Only the researchers will have access to the data.

We believe you the experience of participating in the project is likely to be an empowering one, providing a voice for your story. However, some people may find doing the mental health screen and/or the interviews distressing. If you do find being involved in the project distressing, the organisations listed here might help you. We would also encourage you to talk to your usual health care provider. However, we believe that there is low risk in being involved in this study. Exploration of the trauma, exposure to events places or people likely to cause physiological responses will not form part of the interview.

Organisations that might support you if you do experience distress are:

VVCS	1800 011 046
Relationships Australia	1300 364 277 http://www.relationships.org.au/
Lifeline	13 11 14

Your participation in this project will help give a clearer understanding of these families' experiences, so that more can be done to potentially lessen the long reaching impact war trauma has upon our society. If you would like to be informed of the results of the study, please contact Violette McGaw by sending an email to violette.mcgaw@monash.edu or by phone, on 0439442480.

If you have any questions, you can ring or email either of the researchers listed below.

Thank you

Violette McGaw Masters/PHD Psychology (educational & developmental) candidate Faculty of Education Monash University Telephone: 0439 442480 violette.mcgaw@monash.edu	Andrea Reupert Associate Professor and psychologist Krongold Centre Faculty of Education Clayton Campus Monash University, Vic 3800 Telephone: 03 9902 4587 Fax: 03 9905 5127 andrea.reupert@monash.edu

If you have a complaint concerning the manner in which this research is being conducted, please contact:
Executive Officer, Human Research Ethics Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052   Fax: +61 3 9905 1420 Email: scerh@adm.monash.edu.au

MONASH University

Letter of invitation

“Military PTSD: A Family Experience”

Dear (.....Practitioner Name/Organisation.....),

This is a letter inviting you to assist in a study currently being conducted at Monash University regarding families where a parent has combat related posttraumatic stress disorder (PTSD).

Parental mental illness can impact on family dynamics, parenting and children in many ways, with a number of studies indicating trans-generational consequences for children of veterans. At present, there is a scarcity of research that includes a holistic collection of information from all three components of these families: the veteran parent with PTSD, his/her partner and co-parent, and thirdly, their children. Additionally, studies to date that DO include veteran-child provided information, tend to be retrospective in nature, and collected from adult children of veterans or trauma survivors.

This project invites ex-serving Australian Defence Force (ADF) parents and their partners to participate in a one-hour individual interview to explore family life since either they or their partner developed PTSD as a result of military service. Topics will include but are not limited to the challenges and changes since return home, strengths, weaknesses, negotiating conflict, and other aspects of family dynamics.

We are also asking participants for permission to contact and include the alternate parent (this may be the non-PTSD co-parent or ex-serving veteran parent), as well as permission for their children aged 12+ to be involved. Individuals may be involved in the study regardless of his or her family’s participation. Once the parent provides consent for their child to be involved, we would then describe the project further to the child and invite him or her to participate in the study. Each interview will take approximately 60-90 minutes per person, which will be audiotaped and the transcript provided for him/her to make changes or approve.

As a mental health care professional with clients in our target population, we would appreciate your assistance in helping us recruit participants for our study, purely by informing appropriate clients that you believe may like to participate - that the study exists. Eligible families or individuals are:

1. Ex-serving Australian Defence Force (ADF) personnel who experience PTSD as a result of military service, and who are currently parenting children between 0-18yrs old.
2. Partners of ex-serving Australian Defence Force (ADF) personnel who have experience PTSD as a result of military service, who are currently parenting children between 0-18yrs old.
3. Adolescents between the ages of 12 – 18yrs old, who have a parent who is an ex-serving Australian Defence Force (ADF) personnel and experienced PTSD as a result of their military service.

If a parent or child is seriously ill, suicidal and/or hospitalised they are not eligible for participation.

We have obtained ethical approval from DVA *(E014/015)* and Monash University (CF15/3040-2015001281). However we also appreciate that your own organisation might have its own ethical procedures for involving clients in research. You will need to ensure that your involvement in recruiting families in this project is consistent with the protocols of your own organisation.

➡

If you are interested in helping us with recruitment, please distribute the information packs I can provide you that include explanatory letters and consent forms; or I can provide you flyers as attached for your waiting rooms.

People can also register their interest, find the explanatory statements and consent forms online at:

www.militaryptsdfamilystudy.com

Your participation will help develop a clearer understanding of these families' experiences, so that more can be done to potentially lessen the long reaching impact war trauma has upon our society.

Please ensure that your client understands that his or her involvement/non involvement will not impact on the services you provide, nor will you be informed whether or not contact was made with the researchers.

If a parent and/or children feels distressed as a result participating in the interview, the researcher will halt the interview, debrief the participant and direct the participant to either his or her mental health practitioner, and/or to one of the organisations, namely the Veterans and Veteran families Counselling Service listed within the explanatory letters.

It is felt that the while there is some potential for participants to experience distress as a function of discussing family life, exploration of trauma will not form part of the interview. Additionally it is also likely the experience of participating in this project will be an empowering one, providing families living with PTSD a voice.

If you have any queries, please contact the chief investigator of this project on andrea.reupert@monash.edu or primary researcher Violette McGaw on violette.mcgaw@monash.edu or by phone 0439442480.

Thanking you in anticipation

Violette McGaw
Masters/PHD Psychology (educational & developmental) candidate
Faculty of Education
Monash University
Telephone: 0439 442480
violette.mcgaw@monash.edu

Andrea Reupert
Associate Professor and psychologist
Krongold Centre
Faculty of Education
Clayton Campus
Monash University, Vic 3800
Telephone: 03 9902 4587
Fax: 03 9905 5127
andrea.reupert@monash.edu

Appendix F: PTSD Checklist Version 5 (PCL-5)

PCL-5

<u>Instructions</u>: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.

In the past month, how much were you bothered by:	***Not at all***	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being “superalert” or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Appendix G: Qualtrix Demographics, Consent and Screening Survey

Military PTSD: A Family Experience

Demographics and Criterion Questionnaire – Via Qualtrix

Start of Block: Block 1

Q1

Welcome to the Military PTSD: A Family Experience
Registration of Interest
Thank you for showing interest in our research into Australian families living with military related PTSD and filling in this short form.

Today we will be asking basic information about you, your family and your mental health to find suitable individuals and families who would be willing to participate further in the study.

Your answers and personal information are confidential, will not be shared with third parties, and only sought for the purposes of the study. The survey is approximately 20 questions long and should take no longer than 4-5 minutes to complete.
If you haven't already, please read more about the study by clicking on these downloadable information sheets: Information for adolescents Information for parents

Please press "Next" when you are ready to begin.

End of Block: Block 1

Start of Block: Default Question Block

Q2 **Please select one (or more) of the following statements that applies to you:**

☐ I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs. (1)

☐ I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs (2)

☐ I am a child of an Australian veteran parent with PTSD, between 12 and 18yrs old. (3)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

✱

Q3
Parent Consent Form
NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory statement for parents and/or Explanatory statement for adolescents which I can keep for my own records.

I agree to be interviewed by the researcher
I agree to allow the interview to be audio-taped

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that any information I provide is confidential , and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that data from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

☐ I have read the explanatory statement and the consent form (1)

☐ I agree to be interviewed by the researcher (2)

☐ I agree to allow the interview to be audio-taped (3)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q4
Adolescent Consent Form
NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project shown above. I have had the project explained to me.

I agree to be interviewed by the researcher
I agree to allow the interview to be audio-taped

I understand that it is up to me to be involved in this project; no one is making me do this.

I understand I can stop at any point during the interview if I feel upset. The interview will stop and the information we have collected will be deleted at this point.

After the interview, I know that the researcher will send me notes about my interview. I understand that I can only withdraw the information I give to the researcher before I send back the notes from the interview (or after a certain date).

I know my name will not be reported.

I know that the information the researchers get from me will be kept in a safe place. No one but the researchers will be able to get it. I know that all the information the researchers have on me will be destroyed after five years.

☐ I have had project explained to me and I have read the consent form above (please download here for your records Information for adolescents and Adolescent consent form) (1)

☐ I agree to be interviewed by the researcher (2)

☐ I agree to allow the interview to be audio-taped (3)

☐ I have my parent's permission to participate *(If you are under 18 please provide mum or dad's best contact (email or phone) to verify permission)* (4) ____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q5 Personal Details - Remember **THIS IS CONFIDENTIAL AND WILL NOT BE SHARED** with any 3rd party.

○ Name (1) ____

○ Address (2) ____

○ City (3) ____

○ State (4) ____

○ Postal Code (5) ____

○ Country (6) ____

○ Phone Number (7) ____

○ Email (8) ____

○ What is your preferred contact (phone or email) (10)
____

○ Are you a current serving military member? (9)
____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q27 Personal Details - Remember this is confidential and will not be shared with any 3rd party.

○ Name (1) ________________________________

○ Address (2) ________________________________

○ City (3) ________________________________

○ State (4) ________________________________

○ Postal Code (5) ________________________________

○ Phone Number (7) ________________________________

○ Email (8) ________________________________

○ How would you like to be contacted? (10)

____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Q6 **Please fill in the following information:**

○ Length of military service (1)

____

○ Number of deployments (2)

____

○ Places of deployment (3) ________________________________

○ Time since discharge from the ADF (4)

____

Q7 **Gender**

▼ Male (1) ... Female (2)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q8 How old are you?

▼ 12 (1) ... Over 18 (8)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q9 **How old are you?**

▼ 18 (1) ... 100 or over (83)

Q10 **Ethnic Background**

☐ Caucasian/White Australian (1)

☐ Aboriginal/Torres Strait Islander (2)

☐ European (3) ____

☐ Middle Eastern (4)

☐ Asian (5)

☐ Indian (6)

☐ Pacific Islander/Maori (7)

☐ Other (please specify) (8)

____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q11 **Highest level of education that you have completed**

○ Year 6 - Primary School (1)

○ Year 12 - Secondary School (Or if incomplete, what was the last full Grade completed) (2) ____

○ TAFE/Diploma (3)

○ Undergraduate tertiary (4)

○ Postgraduate tertiary (5)

○ Other (please specify) (6) ____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q28 **Education: Are you in....**

○ Year 6 - Primary School (1)

○ Secondary/High School (what year level?) (2)
____

○ TAFE/Trade school (3)

○ Undergraduate University (4)

○ Other (please specify) (6) ____

Page Break

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q12 **Please provide some information about your children**

○ How many do you have including your own and your partners? (1) ____

○ What ages are they? (2) ____

○ How much of the time do the children live in your home? (3) ____

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Q13 Do you have a diagnosis of PTSD?

○ Yes (1)

○ No (2)

Skip To: Q24 If Do you have a diagnosis of PTSD? = No

Display This Question:

If Do you have a diagnosis of PTSD? = Yes

Q14 From whom did you receive this diagnosis?

○ Psychiatrist (1)

○ Psychologist (2)

○ Doctor (3)

○ Worked it out myself (4)

○ Other (Please specify) (5) ____

Skip To: Q24 If From whom did you receive this diagnosis? = Worked it out myself

Display This Question:

If Do you have a diagnosis of PTSD? = Yes

Q15 Do you experience any other mental health problems?

○ Yes (please specify) (1) ____

○ No (2)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q16 Do you experience any mental health problems? For example anxiety/worry, low mood or learning difficulties?

○ Yes (If so, please specify) (1)
____

○ No (2)

Skip To: Q19 If Do you experience any mental health problems? For example anxiety/worry, low mood or learning dif... = No

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q29 Do you experience any mental health problems?
For example anxiety, worry or low mood?

○ Yes (Please provide more information) (1) ____

○ No (2)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q17 Are you currently receiving treatment for PTSD or any other mental health problem?

○ Yes   *(Please specify who is your current health care provider for example " Dr Know, psychologist" or "VVCS")* (1) ____

○ No   *(When did you last see your health care provider?)* (2) ____

Display This Question:

If Do you experience any mental health problems? For example anxiety, worry or low mood? = Yes (Please provide more information)

Q30 Do you speak with a counsellor, psychologist or doctor about your issues?

○ Yes (Please provide details of who you see, for example "Julie a counsellor" or "VVCS" or "Dr Know" (1) ____

○ No (Have you ever talked with someone? And how long ago? (2) ____

Q18 How long have you received services from a health care provider for PTSD or any other mental health issue?

○ I haven't (1)

○ Less than one year (2)

○ 1 -2 years (3)

○ 3-4 years (4)

○ 5-6 years (5)

○ 7-8 years (6)

○ 9-10 years (7)

○ 10+ years (8)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Q19 Have you talked to your children about PTSD?

○ Yes (1)

○ No (2)

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q20 Have your parents talked to you about PTSD?

○ Yes (1)

○ No (2)

Q21 Have you previously received any support specifically designed for parents, families or children who are experiencing PTSD or any other mental health problem?

○ Yes (Please describe) (1) ____

○ No (2)

Display This Question:

If Do you have a diagnosis of PTSD? = Yes

Or Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Or Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

Q22 Thank you for answering these questions. Your family experiences are exactly what we are aiming to explore and we would like to invite you to participate further by way of an interview (face to face or via phone/Skype).

The Information for parents and Information for adolescents has all the details regarding involvement.

If you would also like to download the consent forms for your information, or also provide consent for your adolescent child to participate you can do so by clicking these links:

Parent consent form
Parental consent for child
Adolescent consent form

If you are under 18 or you would like to provide consent for your child (12yrs+) please indicate in the box below.

○ Provide consent for child involvement (1)

Display This Question:

If From whom did you receive this diagnosis? = Worked it out myself

Or Do you have a diagnosis of PTSD? = No

Or If

If Personal Details - Remember this is confidential and will not be shared with any 3rd party. Are you a current serving military member? Is Contains yes

Q24 Thank you for registering you interest!

One of the conditions for inclusion in the study for ex-serving veterans is a diagnosis of PTSD from a health professional. We are also unable to include any <u>current serving</u> military members. As this is a research project we are unable to invite you to participate further in the current study.

We do understand however that not all people choose to manage their symptoms with intervention or diagnosis. There may be an opportunity in future studies to explore the experiences of **all** families living with military related PTSD, regardless of formal diagnosis or current military status.

Would you like to be contacted about the results of this study or possible inclusion in future studies?

☐ Yes I would like to be contacted about the results of the current study (4)

☐ Yes I would like to be contacted about future studies about families living with military-related PTSD (5)

☐ No I don't wish to be contacted further. (6)

Display This Question:

If Thank you for registering you interest!   One of the conditions for inclusion in the study for e... = No I don't wish to be contacted further.

Q25

End of Questionnaire

Thank you for your time!

Display This Question:

If Please select one (or more) of the following statements that applies to you: = I am the partner of an Australian veteran with PTSD related to military service, raising children who are under 18yrs

Or Please select one (or more) of the following statements that applies to you: = I am a child of an Australian veteran parent with PTSD, between 12 and 20yrs old.

And Thank you for registering you interest!   One of the conditions for inclusion in the study for e... != No I don't wish to be contacted further.

Or If

Please select one (or more) of the following statements that applies to you: = I am an Australian veteran parent and have been diagnosed with PTSD related to military service, raising children who are under 18yrs.

And Do you have a diagnosis of PTSD? = Yes

And From whom did you receive this diagnosis? != Worked it out myself

Q26

End of Questionnaire

Thank you for your time and we will be in touch shortly!

End of Block: Default Question Block

Appendix H: Distress Protocol

Protocol for management of risk in the event that a young person (12yrs-18yrs) or adult becomes distressed as a result of participation in the study

It is possible that due to the nature of PTSD, there may be some risk for participants to experience discomfort or or distress when discussing current symptoms or circumstances. However as the Principle Researcher is experienced in discussions of this nature, with this population, we feel confident that the subject can be navigated with sensitivity and awareness regarding the participant's current level of discomfort. In the event that distress should occur, the following actions will guide the management of risk.

1. The interviewer will check with the participant that he/she is still willing and consents to continue with the interview;
2. Where the participant indicates they would like to continue, and is not so distressed as to compromise capacity to consent, compassionate support will be offered, and the interview will continue.
3. The participant will be asked to identify an appropriate support person (who may or may not be contacted depending on the circumstances) or alternatively be encouraged to access support through his/her counsellor, VVCS or other resources as provided on the participant information sheet.
4. Where a participant indicates that they do not wish to continue OR exhibits distress at a level that compromises capacity to consent, the interview will be stopped. The participant will be asked to identify an appropriate support person (who may or may not be contacted depending on the circumstances) AND be encouraged to access support through his/her counsellor, VVCS or other resources as provided on the participant information sheet.
5. In the event a young person becomes so distressed as outlined above in Action 4, his/her consenting parent/guardian will also be contacted and informed, encouraging both the young person and his/her parent to access the existing support services, VVCS or other services outlined in the information sheet. It should be noted that where appropriate the contents of the interview responses of the young person will remain confidential and not disclosed to the parent, nor will the information be included in the study data.

6. In the event an individual indicates significant threat of harm to self or others, reports the abuse of a child currently under the age of 18 years, or where a child indicates being at significant risk of harm/abuse, appropriate action will be taken to ensure safety of the individual and/or child. Actions may include (but are not limited to) notifying a parent; accessing emergency services or government child safety agencies; or facilitating contact with the individual's current mental health practitioner. This information is clearly stated on the explanatory statements and any action will be first discussed with the participant (where appropriate). In all circumstances, participation in the research will discontinue.

It is believed that risk of significant distress to young people or his/her parents through participation in this study is low, and also mitigated by the experience of the interviewer with regards to the content, and by the intent of the interviews; which is to explore family life in the presence of PTSD. While young persons involved in the study may not be directly receiving counselling or treatment, his/her parents will have been in treatment for PTSD, familiar with accessing supportive services, with young persons eligible to access a range of services in the face of distress. Finally, it is expected that families who choose to participate in the project may find it a positive experience, providing the opportunity to talk about a subject often kept silent.