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PSYCHOLOGICAL SUPPORT FOR EX-MILITARY FAMILIES

SECTION A: What is the impact on families of veterans with mental health difficulties?

What psychological support is currently offered to families of veterans with mental health difficulties?

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SECTION B: Ex-military Families' Experience of Family Therapy: A Narrative Approach

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### Summary

Part A provides a systematic review of the literature and research pertinent to veterans' mental health, the impact on their family, and psychological interventions currently used with veterans and their families. Veterans' mental health and organizational context including Government reports are discussed prior to the research from the literature search. Papers are discussed and critiqued whilst clinical implications and future research opportunities are proposed. The review found that veteran's voices about their experience of mental health difficulties and receiving mental health services are largely missing from the UK literature, along with the voices of their families. It also highlighted a complex interaction between the wellbeing of the veteran and wider ability of the family to function.

Part B aimed to explore ex-military families' experiences of family therapy using a narrative approach. Narrative interviews were conducted with four veterans and five spouses and analysed using a narrative analysis. Results from the meta-narrative suggested family therapy was experienced as helpful with an improvement in familial relationships, improvement in communication and gaining an alternative perspective for both the veteran and spouse. Results are discussed in relation to the research questions and relevant theory whilst limitations are also addressed.

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SECTION A:

What is the impact on families of military veterans with mental health difficulties? What psychological support is currently offered to families of military veterans with mental health difficulties?

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Eleanor R. Constant



### Abstract

The structure of the Armed Forces is changing. As personnel are withdrawn from current deployments and redundancies are made due to the economic downturn it is likely that the number of veterans in the UK will increase in the coming years. The majority of veterans will successfully transition, however for some, the transition may involve difficulties including psychological distress, which can often impact on their familial relationships and may require family members involvement in their care. A systematic literature search of ASSIA, EBSCOhost, Psych Info, Ovid Medline and King's Centre for Military Health Research (KCMHR) was conducted using the following search terms [veterans OR ex-service personnel OR ex-military] *and* [mental health OR mental ill health OR psychological distress OR mental disorders] *and* [family OR spouse OR couple]. Eighteen empirical studies and twelve theoretical papers were included. International papers and those looking at currently serving personnel were included, while papers focusing on traumatic brain injury, violence, suicide and substance misuse were excluded. Results suggested psychological difficulties experienced by veterans are similar in type and prevalence to those of the general population however stigma experienced by veterans around mental health can prevent them accessing services. Systemic considerations suggested families may experience difficulties with reintegration of the veteran and an association between relational problems and Post Traumatic Stress Disorder (PTSD). Interventions for veterans and their families were reviewed highlighting a complex interaction between the mental health of veterans and family functioning, which could benefit from a systemic approach, as an individual approach with the veteran may not give optimal outcomes. The review highlighted a lack of family interventions within the UK for veterans, which would be an important area to explore.

Keywords: Veterans, Family, Mental Health, Interventions

## **Introduction**

As the Armed Forces are progressively withdrawing service personnel from deployment, and with an increase in redundancies within the forces due to the economic downturn, it is likely that the number of veterans from recent service will increase in the UK. Although the number of veterans from the National Service era is expected to halve over the next two decades (Woodhead et al., 2009), the recent unexpected peak in combat veterans of recent times due to redundancies suggests the number of military veterans will nevertheless continue to rise. In the past two years, approximately 30,000 service personnel have been made redundant (Lord Ashcroft, 2014) with the current number of veterans in the UK standing at 4.8 million (NHS England, 2014). Coupled with the recent changes proposed to the structure of the Armed Forces, such as recruiting more Army reservists and reducing the number of full time Army personnel, it is predicted that the need for psychological interventions for common mental health difficulties for military veterans will increase (Fossey, 2012).

## **Definitions**

A veteran in the UK, as defined by the Ministry Of Defence (MOD) in 2001, is any person who has served for one day or more in any of the three British Armed Forces, along with their dependents (Rice, 2009). Given that this definition is so broad, ex-service personnel themselves do not always agree upon it. Burdett et al. (2012) found only 52% of ex-service personnel agree that they would call themselves a veteran. The term 'military veteran' is used in all governmental documentation to describe ex-armed forces personnel, therefore this phrase will be used throughout this review.

Dandeker, Wessely, Iversen and Ross (2006) discussed a range of definitions considered by the UK government prior to the adoption of this definition. These included "All personnel who have completed basic training", "All personnel who have completed one

term of engagement” and “All personnel who have served in an active deployment”. These definitions each have their advantages and disadvantages, however, it was decided that it became hard to then define ‘active deployment’ or ‘term of engagement’ and excluded a large number of personnel.

The majority of research cited in this introduction consists of UK literature, however occasionally international literature will be drawn upon when this is limited. This will be reported as it occurs.

### **Veterans in the United Kingdom**

It is widely acknowledged that the MOD definition is a broad and highly inclusive one, which it is thought, in 2009, could include approximately 5.5 million ex-service personnel and about 7.5 million dependents. This totals 13 million people, which is approximately one fifth of the UK population (Rice, 2009).

It is documented that 20,000 service personnel leave the Armed Forces every year (Defence Analytical Services and Advice, 2011), which is set to increase in coming years due to the previously mentioned economic downturn and changes to structure.

It is recognised that the majority of those who leave the Armed Forces have a positive and successful transition from military to civilian life; Thomas, Hynes, Mottershead and Brettle (2013) found that 86% of military veterans transition with no major difficulties. However, some service-leavers find this transition extremely challenging for a variety of reasons, such as finding employment, housing, becoming socially excluded or imprisonment, which can contribute to mental health difficulties (Iversen & Greenberg, 2009).

### **Veterans and Mental Health**

The prevalence of mental health difficulties in the veteran population is thought to be similar to that of the general population, although prevalence rates vary depending on the

cohort being studied (Samele, 2013). This is contrary to public belief and media portrayal suggesting post-traumatic stress disorder (PTSD) is the most prevalent. Sundin, Fear, Iversen, Rona and Wessely (2010) found the prevalence of PTSD in UK military personnel who had returned from Iraq was between 4% and 6%, while in the US this raised to between 8% and 15%. Service in the Armed Forces is not associated with an increase in psychiatric disorders (Forbes, Fear, Iversen & Dandeker, 2011) however for those who do experience mental health difficulties when leaving the Armed Forces, barriers sometimes prevent them from accessing mental health services. Although this is not a unique problem for the veteran population, some aspects of the military culture may contribute to some of the barriers (Hines et al., 2014).

Outcomes for those veterans who do experience mental health difficulties, and access mental health services in the UK are not as good as those who are seen in theatre during deployment. This is particularly evident for those who have been in the Services for a short time (Kings Centre for Military Health Research, [KCMHR] 2010), referred to as 'early service leavers'.

## **Organisational Context**

### **How veterans are currently cared for.**

When service personnel are in the forces their medical care, including mental health, is provided by the MOD through the Armed Forces (Macmanus & Wessely, 2013). When they leave the forces this care is transferred to the National Health Service (NHS) (Macmanus & Wessely, 2013). This process can be challenging for veterans who have frequently reported that their history is not understood and their needs are not met which acts as a barrier to them accessing care within the NHS (Dandeker, Wessely, Iversen, & Ross, 2003).

It is suggested that the historic use of mainstream NHS services has generally been inadequate in identifying and responding to the specific needs of veterans (Macmanus &

Wessely, 2013). This is, in part, due to the fact that many veterans present as ‘too complex’ to be seen by mainstream primary care services, yet do not meet the threshold of complexity to be seen in community mental health services, or secondary care. These veterans have therefore frequently fallen between the nets of services, with only a few of them being ‘caught’ by third sector services (Macmanus & Wessely, 2013). Services such as Combat Stress actively recruit veterans into their services in order that veterans do not slip through the net.

The multiple third sector charities play a large role in filling these gaps by providing care for veterans. However each charity has a different approach to the service they offer, which can make it difficult to identify the boundaries of offering support or offering treatment. This has often led to veterans becoming confused as to the care they receive and what they believe may be beneficial (Macmanus & Wessely, 2013).

Literature from the US suggests that family members of veterans frequently play a large role in caring for veterans suffering with mental health difficulties (American Psychological Association [APA], 2011). The spouses and families of veterans are often expected to fill the gap for the services, however this caring role can have an impact on the marital relationship and put strain on the family (Makin-Byrd, Gifford, McCutcheon & Glynn, 2011; APA, 2011)

### **UK Government policies.**

Historically, veterans have been entitled to care through the NHS with policy stating that veterans should be entitled to priority access to any care as long as it is related to their service (Powell, 2011). The recent Armed Forces Covenant (MOD, 2011), states that military veterans should not be disadvantaged as a result of their military service, including their health care. This, however was not made legislation and is therefore seen as a ‘code of practice’ attempting to ensure veterans receive the care they are entitled to and are

compensated for the sacrifices made during their service (Forster, 2012). Walters (2012) documented that care had been taken with the wording of the covenant to ensure those who perceived the terms not to have been met could not take legal action. Walters (2012) stated that the covenant remains 'deliberately ambiguous' which has led to criticisms such as not having enough deliverable outputs.

Recently, the government have invested in, and made recommendations for, the development and provision of regional, veteran-specific, mental health services partly as a result of the 'Fighting Fit' paper (Murrison, 2010). This paper states that extra support will be provided for veterans' mental health needs in the hope of rebuilding the Military Covenant (Murrison, 2010). These services collaborate with Combat Stress to provide the specific care that veterans need in a variety of ways including signposting from a 'veteran champion' and providing veteran specific IAPT (Improving Access to Psychological Therapy) services. Greenberg et al. (2003) suggested it is unlikely, as with many other populations, that a 'one size fits all' approach to veteran mental health would be successful. The recent government developments may help tackle some of the barriers veterans have experienced around accessing mental health care, for example, preferring to see a clinician with an understanding of the military culture (Ben-Zeev, Corrigan, Britt, & Langford, 2012).

The government has acknowledged the impact on the families of veterans with mental health difficulties and have recently pledged to invest over £3.8 million to support veterans and their families (MOD, 2013). With this recent development aiming to support families, it would seem appropriate to consider what the impact is on families of military veterans with mental health difficulties? And what psychological support is currently offered to families of military veterans with mental health difficulties? The term 'family' may incorporate co-habiting partners, children, parents, same-sex couples and reconstituted families.

### Literature Search

A systematic electronic search of ASSIA, EBSCOhost, Psych Info, Ovid Medline and King's Centre for Military Health Research (KCMHR) was carried out followed by a hand search of local resources. The combined search terms used included [veterans OR ex-service personnel OR ex-military] *and* [mental health OR mental ill health OR psychological distress OR mental disorders] *and* [family OR spouse OR couple]. This search was used for key terms, titles and abstracts. This search was not limited within date parameters, however only papers published in English were reviewed (Appendix 1).

All titles and abstracts of the retrieved searches were read and the references and bibliographies of those papers were also searched by hand. Due to the paucity of research in this area, international papers were also considered. Papers were excluded if the primary focus of the research included substance misuse, violence, traumatic brain injury and suicide. These are areas thought to warrant individual focus of research and review. The Critical Appraisal Skills Programme (CASP, 2011) and '*How to Read a Paper*' (Greenhalgh, 2010) were used as a basis for critique (see Appendix 2 for summary of empirical papers). Using this critique highlighted studies that may have been below the intended quality threshold. However, having a high threshold for good quality research meant fewer papers could be included and less overall coverage of important issues could be discussed. Therefore, the threshold was lowered slightly to include more papers with less transparent or robust methodologies, allowing a larger overview of research in this area to be discussed. The critiques of these papers are discussed in depth to ensure the quality is transparent to the reader.

Eighteen empirical studies (seven UK based, eleven international) and twelve theoretical papers were consolidated to form a meta-synthesis and used to evidence veterans' access and barriers to mental health services; veteran mental health and systemic

considerations and adaptations; reintegrating veterans and systemic readjustment, how systemic functioning impacts on veterans mental health and finally interventions for veterans and families.

The majority of research has focused on serving personnel with relatively little conducted with veterans. Although serving personnel have not yet had to manage their transition to civilian life and the challenges this may present, much can be learnt from the issues that may be present for this population around their attitudes towards mental health. The fact that 'today's serviceman is tomorrow's veteran' (MOD, 2006, p.8) means that a great deal can be learnt from themes emerging from literature on serving personnel's attitudes and beliefs about mental health as they may relate to those views held by veterans which may impact the care they, and their families receive. Therefore studies referring to currently serving personnel will also be discussed.

### **Literature Search Findings**

Veterans' accessing mental health services.

The most common mental health difficulties experienced by veterans mirrors that of the general UK population (Jenkins et al. 1997). These include depression, anxiety disorders and alcohol misuse (Ikin et al, 2004; Toomey et al. 2007) which were highlighted in a study of UK military veterans (Iversen et al., 2005b). Iversen et al. (2005b) carried out a quantitative study using telephone interviews to administer questionnaires to 315 military veterans. They found that only 58% of British Veterans who reported experiencing mental health problems sought professional help, and only 28% from a third sector organisation. Only 28% of those seeking help were seen in secondary care services while a large number were cared for by primary care. It should be noted that although this study included participants from all strands of the military forces, the sample was taken from a previous cohort study which had a poor response rate from young single males, who currently make up



a large percentage of military veterans. When these mental health problems are not treated, suicide can result, especially for the younger veterans.

Sautter et al., (2006) highlighted in their telephone survey of 83 Vietnam military veterans and their cohabiting female partners, that the amount of involvement the partners had in their care was positively and significantly associated with the likelihood of the veteran engaging with services. Likewise, Meis, Barry, Kehle, Erbes, and Polusny (2010) in their study on National Guard soldiers found that access to services and care was facilitated by a supportive romantic relationship. These studies suggest that spouses may play an integral role in helping veterans access services.

This literature suggests that the prevalence and type of mental health difficulties experienced by veterans mirrors that of the general UK population, however 42% of veterans experiencing such difficulties do not seek help. It is likely that having supportive relationships may encourage veterans to engage with services, however many veterans may not have such supportive networks available to them. It should be noted that these findings may be difficult to generalise given the limited samples used which included either female spouses only, or White males from one unit of the military in the Midwest. Some of these studies used self-report tools which may limit the research as it does not take into account the reports and perspectives of intimate partners who may have valuable and alternative information about levels of distress, relationship adjustment and treatment utilisation. Therefore the suggestions made by the literature should be interpreted cautiously. This literature may be used to highlight that family members are impacted by veterans' mental health difficulty as they may be expected to support the veteran through these difficulties and encourage them to access support. It is possible this could in turn impact their relationship and family functioning. This will be discussed throughout the review.

**Barriers to veterans' accessing mental health services.**

As with the general population, military and ex-military personnel experience stigma attached to mental health difficulties, which contributes to the barriers in accessing care. Forbes et al. (2013) compared attitudes about mental illness of 821 UK military personnel with 1729 members of the general population in England. Although this study used different methods of data collection for the two samples (telephone interviews for military personnel and face-to-face interviews for general population) making results hard to compare, it is difficult to ascertain if this impacted the results. The authors acknowledge that attitude statements included in the study were limited in variety with just five attitude statement items being included. Results suggest that attitudes about mental health in the military is comparable to the views held by the general population, however military personnel have more negative views about the job prospects and rights of people with mental health difficulties and more positive attitudes about the causes of those difficulties. It is possible that this positive attitude about the causes of mental health difficulties may help the veteran to understand their difficulty; however it is likely that some veterans may be reluctant to seek help for their mental health difficulty for a fear of it impacting on their new career.

Although attitudes may be similar to those found in the general population, the stigma experienced is still a concern (Browne et al., 2007). Gabriel and Neal (2002) estimated that approximately 50% of military personnel who develop a mental health difficulty as a result of traumatic events do not seek help.

Military beliefs and culture may also play a part in preventing the veterans accessing care, for example the belief that they should be able to manage alone and the historic belief that they should not talk about their difficulties (KCMHR, 2010). It is also the case that veterans have reported that NHS staff do not understand their military background, along with the culture and beliefs they have and therefore cannot always meet their needs

(Dandeker, Wessely, Iversen, & Ross, 2003). This can also prevent veterans from accessing the mental health services they may need.

The research highlights some barriers faced by veterans when it comes to accessing mental health care including the beliefs and attitudes held about having a mental health difficulty and stigma surrounding veterans accessing care. It appears that veterans hold similar attitudes about mental health to those of the general population and, if anything, have more positive views about the causes of such difficulties. The main difference in barriers in accessing care between veterans and the general population seems to be the impact of the military culture and strongly held beliefs resulting from their time in the forces about accessing help.

These barriers are important to consider given the research suggesting that family members and supportive relationships may encourage veterans to engage with services. It is possible that beliefs and attitudes held strongly by the veteran may make this encouragement from family more difficult, potentially resulting in disagreements and tensions between the veteran and family members. This may further impact the family as they may be required to offer support which is not being gained from professional services while the veteran is not seeking help.

### **Veteran mental health and systemic considerations.**

#### **UK systemic research.**

A minority of families will be negatively impacted by military service or mental health difficulties of the veterans. However, for those who are affected, the impact on their lives and family functioning can be devastating. Spouses of military and ex-military personnel have been described as ‘overlooked casualties of war’ (Royal Naval and Royal Marines Children’s Fund [RNRMCF], 2009), which highlights the potential impact on family members. There is currently a paucity of research on the families of veterans in the UK, with

much of the focus of recent times being around the impact of deployment of serving personnel on families along with the impact of PTSD on families. This research illustrates attitudes towards mental health in the military, which may continue to be held through transitioning and potentially impact veterans' experience of mental health difficulties, their experience of care and the impact this may have on their family. Therefore some of this literature will be addressed holding in mind the potential connections with veterans.

De Burgh, White, Fear and Iversen (2011) conducted a systematic review of literature to explore the impact of deployment on the partners of military personnel. The authors acknowledge the limitation of the difficulty in trying to compare research with different methodologies directly, however conclusions were suggested. The review highlighted that a number of factors impacted on the psychological wellbeing of the spouse, including longer deployments or extensions, and if military personnel suffer from PTSD. They highlighted a lack of studies that had been conducted in the UK, and found the majority of studies were undertaken in the US.

Greenberg et al. (2003), in a study of UK peacekeepers, found that approximately two thirds of those who had returned from deployment spoke about their experiences, while 95% of those peacekeepers who wanted to talk about their experiences spoke to their spouse or partner. Although this is helpful for the peacekeepers and is associated with less psychological distress, the family members are not trained professionals and therefore also have to manage difficult emotional stories while offering support to their partners which can impact on their own mental health. The study employed a quantitative questionnaire sent to 1202 peacekeepers on return from deployment. The study was carried out in 2001, which is a whole decade after the peacekeeping operations in 1991. It is therefore important to consider the possibility of recall bias in this study. It was also not possible for the authors to

determine causality in relation to talking about their experiences and decreased psychological distress although an association was found.

This literature highlights the paucity of research in the UK. Given the methodological differences in the studies, the potential recall bias, and difficulty in determining causality, it is important to interpret any results and conclusions cautiously. It is likely that veterans, who may have similar experiences to serving personnel that could impact on their current mental health, may also talk to their spouse about these experiences, rather than accessing professional support. This is likely to impact families of these veterans who may have to manage difficult and emotional stories without support for themselves. It is also likely that the psychological well-being of spouses of veterans experiencing PTSD may be affected in a similar way to the spouses of currently serving personnel.

#### **International systemic research.**

Families are impacted throughout the deployment cycle of the military personnel. Newby et al. (2005) completed a quantitative survey with 951 US Army soldiers and also asked them to write positive and negative comments about their experiences. The study highlighted that 15% of married service members reported that deployment has meant missing important family events and 11% reported worsened marital relationships. This strain on military families continues when the military personnel return, however may be experienced slightly differently as they adapt to living together again. Although this study has a good sample size, all participants were from the US Army, making it difficult to generalise to other military personnel. The study also relied on self-reports rather than including any family members perspectives. This study was limited as there was no follow-up to determine the long-term impact on the family functioning. Leaving the Armed Forces can be considered part of the deployment cycle and therefore this study might have

implications for veterans who are reintegrating into their family home. It is possible, as with the above study, that some of these marital relationships will be experienced as 'different' or potentially 'worsened'. This is also demonstrated with literature in the following section.

**PTSD, veterans and systemic considerations.**

Sherman, Zanotti, and Jones (2005) highlight the adverse effects of mental health, including PTSD, on intimate relationships as they suggest a new framework for conceptualising couples therapy for military veterans with PTSD. Kessler (2000) conducted a literature review of the prevalence of PTSD and the societal cost, reviewing papers between 1995 and 1999 and found that combat veterans experience a high rate of marital instability. It is acknowledged that this review is dated, however no follow up reviews have since been conducted.

Riggs, Byrne, Weathers and Litz (1998) conducted a quantitative study with 50 American veterans serving in Vietnam to determine relationship satisfaction in couples with PTSD. 26 veteran couples with PTSD were compared with 24 veteran couples without PTSD using a variety of standardised self-report questionnaires. They found over 70% of veterans with PTSD and their spouses reported clinical levels of distress in their relationships compared with just 30% of those without PTSD. They also found that couples with a veteran who experienced PTSD used more severe terms to describe their marital difficulties and had taken more steps towards a divorce than those without PTSD. This was a thorough quantitative study of male American veterans and their spouses. As all participants were volunteers, it is possible that there is an over-representation of help-seeking couples which may contribute to the results. It is noted that the sole use of self-report tools may be problematic and it is unknown how generalisable findings may be to other cohorts of veterans and female veterans. Although these findings are still cited today, it should be acknowledged

that this research was conducted over 15 years ago. No follow up study has since been conducted to provide more up to date findings, making it difficult to draw conclusions.

Monson, Taft and Fredman (2009) conducted a review of research which highlighted that when compared with partners of veterans without PTSD, those of veterans experiencing PTSD experience less satisfaction generally (Jordan et al., 1992). They also documented the rise in caregiver burden, and decrease in their ability to adjust psychologically (Calhoun, Beckham & Bosworth, 2002). This review also highlighted the relationship between PTSD and problems within intimate relationships of veterans and their spouses. They noted that for those who experienced PTSD there was an increase in relationship distress, and physical aggression while there was a decrease in emotional and physical closeness. It should be noted that the authors of this review do not state how the review was conducted and although this appeared to include a large range of studies, little was discussed about how the original studies were conducted and their limitations.

Dekel and Monson (2010) discuss constructs and models that help to explain the association between family relational problems and PTSD. They present research that supports these constructs however do not provide a methodological search structure for the research and therefore it is not possible to know if this was systematic, although they do state that all studies were empirical research. This paper notes that evidence suggests PTSD symptoms are associated with poorer significant other and family functioning. It is suggested that this is the case for veterans serving in various wars from various countries and is not specific to one cohort of veterans.

Renshaw, Blais and Caska (2011) proposed a model of partner distress related to their understanding of PTSD symptoms and behaviour. They suggest that if a spouse has an understanding of PTSD and interprets the veterans' behaviour and symptoms as a part of the PTSD rather than, for example, the veteran's change in feelings towards them, then partners

are likely to experience less psychological and marital distress.

Similarly, Renshaw and Caska (2012) completed a study exploring relationship distress in spouses of veterans with PTSD from two combat cohorts. The first involved 258 couples from the recent Iraq and Afghanistan era, while the second involved 465 spouses from the Vietnam era. The study explored spouses' perceptions of PTSD symptoms using self-report measures. The two cohorts used in this study came from two individual studies, therefore different measures were used in each of the studies. Although different measures were used, each study had a measure of PTSD, psychological distress and relationship distress. They found that if partners perceived there to be increased levels of any type of symptom, such as withdrawal and numbing, they were more likely to report greater personal psychological distress and increased marital distress. This finding was applicable to both cohorts, and as these cohorts are widely different in terms of their experiences, it is suggested these results may be more generalisable to other cohorts of veterans. It should be noted that the cross-sectional data was collected and therefore no conclusions of causality could be made.

The literature discussed has shown common results that marital and familial relationships can be negatively affected if the veteran experiences PTSD. Although there are limitations discussed for each study that should be taken into account, this suggests similar results are found from a variety of studies from different authors with different samples and locations. These results would be important to consider when thinking about the impact on families of veterans experiencing mental health difficulties, and what services might be suitable to meet these needs.

Systemic adaptations and mental health.



Pincus, House, Christenson and Adler (2001) compiled a narrative article which suggested that spouses of service personnel have to adapt throughout the deployment lifecycle, having to become autonomous and independent whilst the service member is away and then losing this autonomy and having to readjust when the service personnel returns home (Drummet, Coleman and Cable, 2003). They suggest there are five stages of deployment ('pre-deployment, deployment, sustainment, re-deployment and post deployment') which service members and families might need support through. The authors of the article are all military psychiatrists who have put their professional and personal experiences together to form the article. Although they draw on some relevant literature, it should be noted that this narrative is mainly based on the integration of professional experiences.

This literature can be considered useful for thinking about the impact the returning veteran (post-deployment stage) might have within the family home and how this could potentially impact relationships. This may be particularly important if the veteran is experiencing mental health difficulties when reintegrating as the literature reviewed thus far has suggested the negative impact this could potentially have on marital and familial relationships. It is possible these relationships may be further negatively impacted as not only does the spouse have to support the veteran through their mental health difficulties, they may have to juggle this with their changing roles within the family, which may be a challenging time.

### **Reintegrating veterans and systemic readjustment.**

One difficulty family members, particularly spouses, face when the service member returns, is the adjustment to the attitudes and behaviours of the service personnel or veteran. Sayers (2011) considers the integration of different treatments that could be used with couples. This paper highlighted that service personnel may find it difficult to alter their

attitudes and behaviour, which may have been appropriate and even helpful whilst on duty, but is unsuitable in a family environment. This often results in a controlling and very aggressive relationship, or a less communicative relationship.

Sayers (2011) provides useful examples of this when describing a case study of a veteran who frequently uses vulgarities and tries to 'command' his wife and family. Another example offered by Sayers (2011) was of a veteran who did not want to talk about his experience of deployment with his family, including his spouse. When his partner asked him about it he would close down and was very reluctant to talk about it. This was viewed as secretive by his family and withholding from his non-military spouse. These examples highlight that the veteran may have to adapt his or her attitudes and behaviours whilst deployed to fit in with the military culture and in order to do their job. This however does not fit in with their families' expectations of them, or memories of who they were before deployment. This causes problems when the veteran finds it difficult to alter these attitudes and behaviours whilst living in the family home (Sayers, 2011).

When veterans are unable to change their behaviours and attitudes, it may result in the spouse and family having to adapt to accommodate these behaviours, which may cause relationship difficulties. This builds on literature previously presented and suggests that family members may be expected to not only support the veteran through their mental health difficulty, potentially adjust to new roles within the family to allow the veteran to take up his role, but may also be expected to accommodate unhelpful or difficult attitudes and behaviours of the veteran. It is possible that if veterans and family members experience these difficulties with reintegration, their relationships may be negatively impacted upon.

Fredman, Monson and Adair (2011) review knowledge on the association between PTSD and relationship problems, and explain how Cognitive Behavioural Conjoint Therapy might be beneficial. They support Sayers' (2011) idea with their argument that returning

service personnel or veterans find it challenging to make a number of practical and emotional adjustments and sacrifices, which is often exacerbated by their mental health difficulties.

This was illustrated by a case study, which although may have been in depth and useful in building this knowledge, would benefit from further research.

The difficulties highlighted by Sayers (2011), Pincus, House, Christenson and Adler (2001) and Drummet, Coleman and Cable (2003) are common experiences of those families who do find it difficult reintegrating the veteran, yet as Sayers (2011) argues, existing intervention and treatment recommendations are not adequate at addressing the complexities experienced by the families.

Sayers (2011) also draws on earlier work from Sayers, Farrow, Ross and Oslin (as cited in Sayers, 2011) which suggested the difficulties that families experienced when reintegrating the veteran was related to an increase in symptoms of psychological distress. In their study of veterans from Afghanistan and Iraq, Sayers, Farrow, Ross and Oslin (as cited in Sayers, 2011) found that those who experienced depression, PTSD or other common mental health difficulties, had an increased risk of simultaneously experiencing at least one family readjustment difficulty. They also reported a positive association between severity of symptoms of psychiatric disorders and family integration problems for those veterans referred for an evaluation of their behavioural health. Although no conclusions can be drawn from this one study, it could be suggested that a 'vicious cycle' can occur whereby mental health difficulties impact on family life while a difficult family dynamic also has a negative impact on mental health (Sayers, Farrow, Ross and Oslin, 2009 as cited in Sayers, 2011).

The adaptations families, service members and veterans make during the deployment cycle can result in prolonged difficulties during reintegration to the family home. Sayers, Farrow, Ross and Oslin (as cited in Sayers, 2011) also found that those veterans who had a diagnosis of depression were more likely to be uncertain about what their responsibility

within the home was. They reported that those veterans with a diagnosis of depression or PTSD were three times more likely to express feeling like a guest in their own home (Sayers, Farrow, Ross and Oslin, 2009 as cited in Sayers, 2011). It is possible that this could have negative impacts on their familial relationships as the veteran and family attempt to readjust their roles to accommodate the veteran's return, whilst supporting the veteran through the mental health difficulty. This finding ties in with previously mentioned literature that families may have to adapt their roles within the family which may impact their relationships.

### **Systemic functioning impact on veteran mental health.**

The finding that family life can also impact on the mental health of the veteran is corroborated by a study by Browne et al. (2007) who conducted a large scale quantitative study with UK personnel who were deployed to Iraq in 2003. This was one of the largest studies to be conducted in the UK with health questionnaires sent to over 16,000 personnel with an overall response rate of 61%. One of the findings highlighted that PTSD symptoms of currently serving reserve and regular Armed Forces personnel were affected by problems at home. This suggests that problems in the family home, and potentially within familial relationships may have a negative impact on the mental health of serving personnel, particularly symptoms of PTSD. It is possible that this could have implications for veterans who may experience PTSD as they may also be subject to problems in the family home on a daily basis which may impact their mental health.

Evans, Cowlshaw, Forbes, Parslow and Lewis (2010) also support this theory and found that higher family distress resulted in greater PTSD symptoms. This Australian study involved 1822 veterans with PTSD and 702 partners. Veterans were asked to complete a PTSD checklist and, along with their partners, asked to complete the McMaster Family Assessment Device (FAD-12). They found that poorer family functioning could predict increased hyperarousal, intrusions and avoidance. Taking the perspective of both the veteran

and their spouse was a strength of this study. Similarly, Figley (1986) support this theory as they found veterans PTSD symptoms were significantly decreased with an increase in support from their wives. These studies collectively highlight the important roles family members, particularly spouses, can play in reducing mental health symptoms of veterans.

Although family members can have a positive impact on the mental health of the veteran, this is only the case if they are not experiencing difficulty in their own mental health. Verdeli et al. (2011) completed a review of literature and discuss their findings that service members mental health is negatively affected if their partner is experiencing depression themselves. The research discussed thus far highlights a complex relationship between family functioning and mental health of both the veteran and the family, as well as the important role family can play in reducing veteran's mental health difficulties. It also highlights how family members' mental health difficulties may impact on the mental health of the service personnel and veterans.

#### **Family perception of veterans' mental health.**

Another important factor to think about when considering the impact of mental health difficulties on families of veterans, is the family members' perceptions of the level of difficulties they believe the veteran is experiencing. Family functioning can be disrupted when there is an incongruity between the families' perceptions of what the veteran or service personnel have experienced and the level of mental health difficulty the service personnel are experiencing. For example, Renshaw, Rodrigues, and Jones (2008) carried out a study involving 49 National Guard soldiers from Utah and their wives. Wives and soldiers completed questionnaires three months after the soldier returned from deployment to Iraq. The questionnaires included a PTSD checklist, Center for Epidemiologic Studies—Depression Scale, Relationship Assessment Scale, Combat Exposure Scale and the Spouse Perception Questionnaire. They found that wives' marital satisfaction was negatively

associated with the severity of their husbands Post Traumatic Stress symptoms when they perceived they had experienced low levels of combat exposure. This relationship was not noted when the wives perceived they had experienced greater levels of exposure to combat during deployment. This study used a variety of standardised measures with a robust statistical analysis undertaken, however only a limited sample was available. This suggests there was a low power to detect interactions and large bands of error, which makes the strength of results and conclusions limited, although the results do support the importance of interactions in the area. It is clear that no conclusions can be drawn from this study, however this literature may support the notion that family functioning may be impacted upon by the veterans' mental health difficulty. This is in line with literature discussed throughout the review.

### **Summary of Systemic Considerations – What is the impact on families of veterans with mental health difficulties?**

The research discussed highlights that there is limited UK literature around veterans' experiences of mental health and the impact on families; however some important factors can be identified from the existing literature. It is clear that a minority of families will be negatively impacted by a veteran's time in the military, the transition period and mental health difficulties, as prevalence rates and types of mental health difficulties mirror that of the general UK population. Of interest is the role family members may play in supporting and encouraging veterans to seek help and engage with services. The literature suggested that service personnel, and therefore potentially veterans, may hold strong beliefs about having to manage any difficulties alone and may only want to speak with close family members about their difficulties rather than professionals. This may impact the families as they may be required to offer emotional and practical support at these times, particularly if barriers exist which are difficult to overcome when encouraging the veteran to seek help from services.

The literature also highlighted the complexities involved in family functioning when a veteran is experiencing mental health difficulties. For example, family functioning is both affected by and affects treatment outcomes for mental health, particularly PTSD (Fischer Sherman, Han & Owen, 2013). The reviewed literature acknowledged the impact on families when a veteran is reintegrated into the family home, such as potentially having to change roles within the family and become less independent, possibly having to accommodate unhelpful attitudes and behaviours from veterans that they previously would not have done, whilst trying to support the veteran through their mental health difficulty. Little from this literature has been suggested about the services that might be required by these families and what psychological interventions are currently offered. A review of interventions follows along with discussion about their effectiveness to deal with these complexities.

### **Psychological Interventions for Veterans and their Family**

Family involvement in mental health care of the general population has shown to lead to an increase in treatment participation, greater satisfaction with care and improved hope, knowledge, and empowerment (Murray-Swank et al., 2007). As previously mentioned, there is little research conducted in the UK about interventions specifically for veterans and their families therefore international studies will also be considered.

Riggs (2000) and Galovski and Lyons (2004) carried out literature searches on systemic interventions for PTSD. Both of these reviews, along with this current literature search highlighted a lack of empirical studies focusing on the treatment of children of parents with PTSD or parent-child interventions. There has been slightly more focus on studies of therapy involving spouses of veterans, however most of these interventions involve psychoeducational programs to run alongside individual treatment for a veteran with PTSD, rather than family therapy interventions. With this in mind, studies that included family involvement will be considered, some of which may be older research, however this still

offers important considerations to discuss.

### **Behavioural Family Therapy**

Glynn et al. (1999) completed a rigorous randomised control study, which involved 42 veterans from Vietnam being randomly assigned to either a waiting list, 18 sessions of twice-weekly exposure therapy sessions or 18 sessions of twice-weekly exposure therapy sessions followed by 16 sessions of Behavioural Family Therapy (BFT). The BFT was broken down into three sessions of orientation and psychoeducation about PTSD, followed by the remaining sessions focusing on communication and problem solving. A total of 11 veterans were in the group taking part in both family therapy and exposure therapy. These veterans were found to show a greater reduction of PTSD symptoms than those who only received exposure therapy. Although these results were not statistically significant, it was argued that these veterans experienced double the reduction in PTSD symptoms than did the exposure therapy only veterans. Participants who completed BFT and exposure therapy as opposed to exposure therapy alone did show more improvements in interpersonal problem-solving which was statistically significant. It should be noted that the sample population was limited and comparison of treatments is a difficult task meaning results should be interpreted with caution. It is acknowledged that this study was conducted over a decade ago, however it is still used to highlight the effectiveness of the intervention today, particularly in the US when accumulating the guidelines for the Veteran Affairs department for clinical practice (Monson, Macdonald, Brown-Bowers, 2012). BFT is still frequently used within the US, however no recent studies were available.

### **Reaching out to Educate and Assist Caring, Healthy Families (REACH)**

REACH is a psychoeducation programme, which was adapted from previous evidence-based practice for schizophrenia and other common mental health difficulties in the



US. The program was altered and tailored for use with veterans experiencing PTSD and their families (Fischer, Sherman, Han & Owen, 2013). One hundred veterans and 96 family members took part in a longitudinal evaluation of the programme. They received the intervention between 2006 and 2010, which involved three phases over a nine-month period. The evaluation showed significant improvements for both veterans and family members over time. Veterans experienced increased communication and family problem-solving skills, increased relationship satisfaction and quality of life as well as an increased ability to manage their PTSD symptoms. Family members also improved in areas such as relationship satisfaction, social support and quality of life. Both veterans and family members highlighted an improvement in family functioning. This suggests family involvement in the care of veterans is important to reduce family distress. It should be noted that no comparison group was available, so although it is possible that improvements were attributable to the programme, it is also possible that improvements were due to other external factors. A second limitation of the study was the measures used did not have a specific PTSD scale. Although this was a limitation, PTSD information was available elsewhere to ensure a diagnosis and changes could be noted. This programme is frequently used in the US, however no such intervention currently exists in the UK.

### **Cognitive-Behavioural Couple Therapy (CBCT)**

In the US, Cognitive-Behavioural Couple Therapy (CBCT) for PTSD is a relatively recent development as an intervention for veterans and their spouse. CBCT is designed to concurrently decrease symptoms of PTSD including avoidance, emotional numbing and anxiety whilst improving intimate relationship functioning. Early evaluations of this therapy suggest it is a promising therapy for couples, which has so far been successful (Fredman, Monson, & Adair, 2011). Monson, Schnurr, Stevens and Guthrie (2004) conducted a pilot study with seven couples where the male veteran had a diagnosis of PTSD. They found that

CBCT for PTSD resulted in a significant decrease in symptoms as rated by both the partner and clinician, while there was also an increase in partner satisfaction levels. Although this study had a small sample size, the pilot study offered new knowledge to the research base. No research from the UK was available on this type of therapy and it is not widely recognised as a treatment option for veterans in this country where NICE guidelines are typically followed.

### **Structured Approach Therapy (SAT)**

Structured Approach Therapy (SAT), is another recently developed manualised intervention for veterans experiencing PTSD and their partners which uses empathic communication training and stress reduction strategies to help couples improve their ability to cope with anxiety related to trauma with a focus on reducing emotional numbing (Sautter, Armelie, Glynn & Wielt, 2011). When SAT was initially developed, a pilot study involving six Vietnam veterans showed a significant reduction in PTSD symptoms as rated by clinicians and partners of veterans (Sautter Glynn, Thompson & Franklin, 2009), with a particular reduction in symptoms of emotional numbing and avoidance. This study used a variety of ratings from various sources making the results more robust than a simple self-report tool. More recent evaluations of SAT have shown a positive experience of the treatment by veterans with a low dropout rate (Sautter, Armelie, Glynn & Wielt, 2011). This is another intervention that is not routinely used in the UK, yet preliminary studies highlight the positive impact this could have on families.

### **Desire for Family involvement in Veterans' Care**

The interventions discussed above have highlighted that family involvement in veterans' care can be effective in reducing family distress, increasing family functioning and decreasing mental health difficulties experienced by veterans. Not only can family

involvement be helpful but research suggests it is also desired by veterans and their family. This involvement can span from moderate levels of family participation such as psychoeducation through to intensive involvement such as Conjoint Behavioural Cognitive Therapy. Family involvement is strongly recommended in care of veterans in the US (Lehman et al., 2004), however, no such guidelines specific to veterans are evident in the UK.

Murray-Swank et al. (2007) conducted a quantitative study with 69 veterans from an American Veterans Affairs Centre and found that 67% of veterans expressed a desire for family participation in their psychiatric treatment and there was a positive association between the frequency of contact with family and the veterans' desire to have them involved in their care. Veterans also rated the importance of family counselling as "moderate". Over half of those wanting to involve family thought developing their communication skills and having family counselling with one clinician would be helpful while approximately 50% of them believed their families would find a family support group helpful. They also noted that the 45% of veterans that had contact with their family less than once a week also wanted their family to be involved in their care. This study highlights the desire of veterans to have their family members involved in their care which, in the UK, is not currently routinely offered. Although this study appeared to be thorough, using a range of outcome measures and questions, it should be noted that the sample was limited. The majority of participants were male and represented the local African-American population which may make generalisability more difficult as family relationships and views about family involvement may not be shared by the wider veteran population.

### **Critique of the Research**

The majority of research in this area comes from the US, which, although useful as a starting point for development in the UK, should be interpreted cautiously due to the differences in the military structure, service requirement and veteran care services. Some of

this research is now dated however more recent studies have not been conducted. Although this is a limitation of the research, much of this is still useful and referred to in this area today.

A renowned and reputable team of researchers working at King's College London Military Health have undertaken the majority of research completed in the UK. Though this research is scientifically rigorous, it should be noted that it is frequently completed by the same authors using the same sample of veterans, from a medical classification perspective, limiting the literature in this review in some respects. There is a paucity of research undertaken into the family experience of veterans' mental health difficulties in the UK. Given the number of veterans living in the UK and the potential number of family members affected by these difficulties it would be an important area to explore further.

The literature reviewed was mostly of a quantitative nature, which although helpful in identifying areas for further research, lacks an insight into the experience of receiving these interventions. Although this research may highlight whether or not interventions are helpful for recipients, it does not highlight how this is helpful or the areas that might be less helpful which would be important to understand when developing services.

The research samples used in the studies were largely of those suffering with PTSD rather than any other psychological difficulties such as depression and anxiety despite these conditions being more prevalent in the veteran population. This may reflect the recent public interest in the area and the need to be seen to be helping those that do suffer from PTSD. It is therefore important to consider how other psychological difficulties may impact and be experienced differently within families and how family interventions may be experienced within this population of military veterans.

It should also be noted that there are some difficulties in diagnosing PTSD, therefore the samples used in the studies throughout this review may have differing routes to diagnosis.

For example, some services such as Combat Stress get paid for treating PTSD which may have implications for diagnosis. Veterans prefer to be diagnosed with PTSD as they find it to be a more socially acceptable label rather than anger and behavioural issues, or personality disorder. A secondary gain for veterans may be that of compensation. Some GPs may be inclined to diagnose PTSD when they realise that somebody is ex-forces. It may be worthwhile keeping this in mind when reviewing studies where the sample has a diagnosis of PTSD as it is not usually documented how such a diagnosis was made.

It is also important to consider that samples used in the research discussed were willing participants who volunteered to take part. It is likely that this population of veterans may be qualitatively different to those who may not have wanted to participate or those who could not be reached.

### **Gaps in the Research**

As discussed previously, there has been little research focusing on the impact on children-parent relationships within an ex-military family or the children's experience of family interventions.

There has also been a lack of research exploring the majority of veterans and families who do not go on to develop mental health difficulties and live functional lives. It would be interesting to explore this population to see what can be learnt about their successful transition and wellbeing as opposed to solely looking at those who do have difficulties.

There has been no research to date that explores veterans and spouses experience of family therapy, either individually or together. It is therefore not possible to ascertain how, if at all, family therapy might be beneficial for the military veteran population and their family, even though there is a desire for it to be offered as an intervention.

## **Summary and Conclusions**

### **The Future for Veterans and Family Mental Health**

The research included in this review highlights some of the difficulties veterans and families face with regards to mental health and the possible psychological interventions used internationally to offer support for some of these difficulties. It was clear that there was limited research in this area, but of particular note was that qualitative research documenting the direct voices of veterans, and their families, about their experience of receiving mental health services appeared to be missing from the UK literature. These voices are important as they provide a basis for further expanding existing services whilst creating new specific services focusing on the needs and experiences of those who would use them. This is important given the government plans to continue to provide good care for the veteran population.

Given the limited research and critique of the quality of literature, it is difficult to make clear conclusions. However, some important considerations from this literature are noteworthy. There appears to be a complex interaction between the wellbeing of the veteran and wider ability of the family to function, with both the mental health impacting on family functioning, and at times, family functioning negatively impacting symptoms of mental health difficulties. The research discussed also highlighted some of the difficulties experienced by families of veterans with mental health difficulties, such as offering support, having to adapt to accommodate changes in veterans' behaviours and attitudes, and changing family roles to accommodate the veterans' return to the family home. Some research has also highlighted that family members want to be involved in the veterans' care, while veterans have also expressed this wish. It might therefore be important to consider including family involvement in the care of veterans. This could potentially help address some negative impacts on the families discussed within the review, while potentially encouraging families to

review their expectations of the veteran, improve the way in which the veteran and family interact whilst improving the veterans' individual mental health difficulties. Addressing the individual mental health needs of the veteran without systemic considerations is likely to result in a continued pattern of dysfunction within the family (Sherman, Zanotti & Jones, 2005).

Although family therapy is recommended in the US, it is not clearly recommended specifically for veterans in the UK. There has been a recent development of ten veteran specific services ranging from signposting, to assessing with recommendations, to full clinical service including couple and family therapy. Although some of these services may provide family therapy locally, this is not routinely offered, and where it is, participants have not been asked about their experience of this process. This would be an important area to explore further to ensure the services that veterans and families need are being offered and ascertain how they are experienced.

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SECTION B:

Ex-military Families' Experience of Family Therapy: A Narrative Approach

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### **Abstract**

There is a complex interaction between familial functioning and veteran mental health, with familial relationships often being affected. Family therapy is not routinely recommended or offered for veterans in the UK. This study used a narrative approach to explore the experiences of veterans and spouses having received family therapy. Specifically, this study aimed to explore what stories individuals in an ex-military family would tell of their experience of family therapy, what meta-narrative occurs and what the perceived impact on familial relationships was following family therapy. Individual narrative interviews were conducted with four veterans and five spouses. Individual interviews were followed by joint couple interviews with two couples. Individual narrative summaries are presented followed by a meta-narrative based on common threads throughout the individual narratives. Main findings included the shared narrative suggesting family therapy was experienced as helpful with an improvement in familial relationships, improvement in communication and gaining an alternative perspective for both the veteran and spouse. Limitations, clinical implications and future directions are discussed.

**Keywords:** Veteran, Family Therapy, Narrative Analysis

## **Veteran Mental Health Difficulties**

There is a constant cycle of personnel through the military system, which will continue with the ending of current conflicts, as new conflicts begin (Morgan, 2006). Approximately 20,000 service personnel leave the Armed Forces annually (Defence Analytical Services and Advice, 2011) which is likely to increase given the economic pressures and changes to the structure of the Armed Forces. Everson and Figley (2011) documented that the military is likely to be downsized over the next decade resulting in many service members returning to their families and civilian life. Iversen and Greenberg (2009) recognise that for some service personnel, the transition from being military personnel to military veterans<sup>1</sup>, may be challenging, impacting on their mental health due to difficulty finding employment, housing, becoming socially excluded or imprisonment.

The prevalence (Samele, 2013) and type (Jenkins et al. 1997) of mental health difficulties experienced by military veterans mirrors that of the general population including depression, anxiety disorders and alcohol misuse (Ikin et al., 2004; Toomey et al. 2007). For those experiencing mental health difficulties there are often barriers preventing them accessing services, some of which may be contributed to by the military culture (Hines et al., 2014).

## **Psychological Therapies for Veterans**

In the UK, military veterans with mental health difficulties are treated as the general population, with reference to the National Institute for Health and Care Excellence (NICE) guidelines, which recommends Cognitive Behavioural Therapy (CBT) for a range of mental health problems including depression, anxiety and Post Traumatic Stress Disorder (PTSD).

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<sup>1</sup> A veteran in the UK, as defined by the Ministry Of Defence (MOD) in 2001, is any person who has served for one day or more in any of the three British Armed Forces, along with their dependents (Rice, 2009).

Although empirical evidence highlights the effectiveness of CBT it does not take into account some of the specific needs and difficulties that may be experienced by veterans. For example, veterans may have difficulty reintegrating to the family home, impacting on their familial relationships. This may not be due to 'dysfunctional' thinking as CBT would aim to challenge, but may be as a result of military experience and culture, spending long periods of time away from home and challenges with transitioning (Everson & Figley, 2011).

### **Systemic Implications of Mental Health Difficulties**

Veterans experiencing mental health difficulties frequently rely on their spouse or family members for support, which can impact on their mental health and the familial relationships. For example, Riggs, Byrne, Weathers and Litz (1998) found over 70% of veterans with PTSD and their spouses reported clinical levels of distress in their relationships. Service members with PTSD and other mental health difficulties put strain on families, which can contribute to and predict family breakdown (Dekel, Goldblatt, Keider, Solomon & Polliack, 2005).

### **Family Therapy for Ex-military families**

Everson and Figley (2011) suggest there is an acute need for family therapy services for veterans due to a number of converging factors including an increase of combat deployment, return to the family home, difficulties associated with reintegration and increased use of health care by families.

Hogencamp and Figley (1983) pose that family systems theory and practice is crucial to understanding the functioning of military families while Everson and Camp (2011) postulate that systems theory is applicable for military and ex-military families as the family system and military system become intertwined, influencing each other across contexts. These systems come together with others to form a larger system (Everson & Camp, 2011).

Triangulation can be a common tension within these families, causing anxiety and relationship difficulties (Everson & Camp, 2011); for example triangulation within an ex-military family of the veteran with the military, his spouse and his children. These are some difficulties that could be explored within family therapy.

Rothery and Enns (2001) suggest the use of a systemic approach with military veterans as families coexist and interact with different systems. Family systems can both be impacted by, and impact on, this variety of systems positively and negatively (Berg-Cross, 2000). The military is one system that a veteran and their family might have an affiliation to. The military has its own social network, unique culture (Regar, Etherage, Roger & Gahm, 2008), and norms and values to be adhered to. This interaction, and perceived loss of system, may play an integral part in the mental health of the veteran and their family, which would not be addressed within a traditional CBT approach.

In response to needs identified by veterans and their families, some specific efforts are being made to provide family interventions tailored to veterans within the context of a pilot Military Veteran IAPT service.

### **Summary**

Veterans experience similar mental health difficulties to the general population, which frequently impact on their familial relationships. Ex-military families are thought to have unique and specific needs given their experience of the military culture, values and beliefs and their transition to civilian life. National Institute for Health and Care Excellence (NICE) guidelines typically recommend CBT for common mental health problems experienced by veterans, however a systemic approach warrants consideration.

There is a lack of qualitative research into ex-military families' experience of family therapy, which is not routinely offered within services. Exploration of this approach is important in further developing specific services for this population.

### **Present Study Research Questions**

This study aimed to explore ex-military families' experience of family therapy through the following research questions.

1. What stories do individuals tell about being an ex-military family and their experience of family therapy?
2. What meta-narrative occurs from ex-military families' experience of family therapy?
3. What is the perceived impact of the experience of family therapy on familial relationship functioning, as perceived by those in receipt of it?



## **Method**

### **Qualitative Design**

In order to explore important factors involved in the experience, and to build knowledge in the area for future research, a qualitative design was employed. Previous research into family therapy also successfully used a qualitative approach (Larner, 2004).

A narrative methodology was used for data collection and analysis allowing participants to share their individual experience whilst exploring the cultural context of being an ex-military family. It is proposed that a narrative approach provides an opportunity for individuals to share, and make sense of their experiences through articulating their unfolding story (McAdams, 1993). Bruner (1990) suggests a narrative approach can help individuals make sense of their experiences through internalising their narratives and Adler and McAdams (2007) suggest participants can find it therapeutic to share their narratives about their experience of therapy which may be considered an ethical strength. Plummer (1995) stated a narrative approach is useful when exploring the interaction between the individual, cultural and societal stories. The narrative approach recognises the importance and significance of the personal story to each individual while highlighting the importance of cultural and societal narratives in shaping individual stories. This approach provides an opportunity to take full narratives and incorporate them in to the wider context.

### **Epistemological and Author's Position**

The narrative approach is part of the social constructionist position (Lyons & Coyle, 2007), which argues that language is used to make sense of ourselves, our experiences and other people. As the narrative approach suggests that stories are co-constructed and individual identity can influence how stories are told and understood, it is important to understand the authors' position in relation to the topic area and what influences may be apparent. The researcher has a history of interest in the military and has spent much of her

time throughout adolescence and adulthood as a volunteer in a military cadet organisation for young people. This may have given the researcher an experience and understanding of some aspects of the military culture through visits to military bases, working with military personnel and having personal friends joining and leaving the military. It was thought this may give the researcher an advantage in understanding some of the military language used during interviews allowing the participants to continue to tell their story uninterrupted without worrying they may have to stop to explain 'military jargon'. The author has experienced, first hand, how some families may be affected by having a 'loved one' in the Armed Forces as well as the impact of their return. The author is aware that these experiences are individual and vary significantly, however remained curious as to how families may be impacted by these circumstances when their family member returns and experiences mental health difficulties. In order to remain reflexive and ensure previous experience and assumptions did not influence the results of this paper, a bracketing interview (Appendix 9) and reflective journal (Appendix 10) were kept in order to capture some of these issues, as well as frequent discussions during supervision.

### **Ethical Considerations**

Approval was gained from the NHS research ethics committee and the local Research and Development committee (Appendix 3). The British Psychological Society 'Code of Ethics and Conduct' (BPS, 2009) was followed. Written consent was gained from all participants, interviews were audio recorded, transcribed verbatim and made anonymous.

Children were invited to participate; therefore a separate information sheet for young people was devised. The consent form required parents to sign to allow the young person to participate. Careful consideration was given to the inclusion of children in this study, particularly when bringing the family together for a joint interview. This was discussed in

depth with the NHS ethics panel and it was decided that the researcher would remain mindful should any concerns arise.

## **Participants**

Participants were recruited using purposive sampling from a pilot Military Veterans IAPT (MVIAPT) NHS service, offering psychological therapies for military veterans and their families. Veterans who had completed family therapy were sent an invitation to participate and information pack (Appendix 4) in the post followed by a telephone call from the service. Family members were recruited through the veterans unless the spouse had been seen in their own right. Exclusion criteria included excessive substance use and those who were non-English speaking.

The narrative literature suggested sample sizes vary with no minimal sample size required (Squire 2008). Previous narrative studies were reviewed to inform the number of participants. A total of nine participants (aged between 36 and 55 years old) took part in the study, five veterans and four spouses (from six couples) (Table 1).

All veterans were male, the majority served in the British Army (this typifies the profile of military veterans in the North West). The years served by veterans ranged between four and 22 years, while the time passed since leaving the Armed Forces ranged from five to 32 years. Four couples met whilst the veteran was in the Armed Forces, and two met since leaving. All families had dependent children however none participated. All veterans were operationally deployed. The most common diagnosis was mixed anxiety and depression, with three veterans having this diagnosis. Other diagnoses included depressive episodes and panic disorder. Outcome measures (GAD-7, PHQ-9) were routinely collected by the service (Appendix 6).

Table 1

Participant Demographics.

<b>Participant</b>	<b>Pseudonym<sup>2</sup></b>	<b>Gender</b>	<b>Age</b>	<b>Forces</b>	<b>Rank</b>	<b>Years served</b>	<b>Years out</b>	<b>Operationally Deployed</b>	<b>Primary Referred Problem</b>
Couple 1	Tim	Male	41	RAF	Junior Non Commissioned Officer (NCO)	15	9	Yes	Mixed anxiety and depressive disorder
	Julie	Female	41	Partner RAF	Partner Junior NCO	15	9	Partner Deployed	Depressive episode
Couple 2	Jack	Male	49	British Army	Private or equivalent	17	13	Yes	Mixed anxiety and depressive disorder
	Sharon	Female	D/K	Partner British Army	Partner Private or equivalent	17	13	Partner Deployed	Undiagnosed
Couple 3	Martin	Male	55	British Army	Senior NCO	22	11	Yes	Depressive episode
Couple 4	Tommy	Male	47	British Army	Private or equivalent	7	32	Yes	Panic disorder [episodic paroxysmal anxiety]
Couple 5	David	Male	37	British Army	Junior NCO	8	5	Yes	Mixed anxiety and depressive disorder
	Lorna	Female	39	Partner British Army	Partner Junior NCO	8	5	Partner OP Deployed	Undiagnosed
Couple 6	Sophie	Female	36	Partner British Army	Partner Private or equivalent	4	29	Partner OP Deployed	Undiagnosed

## **Procedure**

An information pack was given to clinicians working in the service following individual briefings. Potential participants were identified (this included all veterans who had completed family therapy), asked if they would be interested in participating, offered a conversation with the primary researcher and booked for an interview at venues local to them. Participants were provided with the research contact details if they had any queries.

Prior to commencing interviews participants read the information sheet, were given the opportunity to ask questions and signed the consent form. The majority of interviews lasted between 28 and 140 minutes (median 44 minutes). One couple interview was terminated after five minutes because the couple felt they had nothing to add from individual interviews.

## **Narrative Interview Guide**

A narrative interview guide (Appendix 5) was prepared with a Clinical Psychologist and piloted with an ex-military member of staff working in MVIAPT. The pilot interview allowed for discussion about the appropriateness of the questions and the guide was edited to reflect the discussion. Changes to the interview guide included allowing the participant to tell the interviewer about their experience of family therapy freely, as it was important to them, without being interrupted, prior to any further follow-up questions being asked. Participants were asked to “Please tell me about your experience of being an ex-military family and your experience of family therapy. That is all those events that are important to you up to now. You can start wherever you want and take as long as you want” (Wells, 2011). Participants were told they would not be interrupted. The narrative guide was only referred to when participants had told

their story fully, to further explore general topic areas that the participant may have only briefly touched on during their interview.

### **Data Analysis**

Given the numerous approaches and flexibility in conducting narrative analysis, a variety of aspects from various methods were combined for this piece of research (Labov, 1972; Murray, 2003; Riessman, 1993). There are no specific guidelines as to how to complete a narrative analysis, which allowed the researcher to take a flexible approach, paying attention to both the narrative form and content of each participant's story. Transcriptions were read several times whilst audio recordings listened to, enabling the researcher to immerse themselves into the data and gain a holistic view of each narrative. Labov's (1972) linguistic framework was implemented to highlight the structure of the narrative allowing the core narrative to be determined whilst highlighting elements the participant wanted to emphasise or leave out (Appendix 7). The second stage of analysis involved a literary narrative analysis (Murray, 2003) allowing common threads to emerge (Appendix 8) whilst the genre, narrative tone, characters and positioning were recorded. This allowed analysis of the types of stories individuals told about their experience of family therapy. Using the information gathered from the first two stages of data analysis, a narrative summary for each participant was composed highlighting the core narrative, tone, genres and positioning which enabled the researcher to get a sense of the story as a whole. These summaries allowed the researcher to explore what stories individuals in an ex-military family tell about their experience of family therapy. Each narrative and summary were then used to compile a shared story or meta-narrative about the experience of family therapy.

## Results

### **What stories do individuals tell about being an ex-military family and their experience of family therapy?**

#### **Tim's Story**

Tim is a 41-year-old veteran who served for fifteen years in the Royal Air Force (RAF). Tim's story started with the date he left the RAF, explaining that two months later he met his current wife, Julie, and had two children. Tim's tone was at times regretful, for example he often wished he had not left the RAF, as he believed this is when his difficulties started. Tim often played with the idea of re-joining but always decided not to because of the impact of frequent deployments on his wife and children. Tim's story had darkness to it at times when he described feeling suicidal and the difficulties he has experienced. Tim usually brought each element of his story back to his family and the impact it might have on them. Tim's experience of family therapy was positive, with an important element being the 'non-judgemental' environment, the increase in 'confidence and understanding of our problems' and the therapists understanding of the military culture and standards that Tim had. Tim acknowledged that communication at home was more difficult but that family therapy had helped the communication process. Tim's story had a romantic element to it when describing his relationship to the military and the way he views his progress within family therapy. There was also an element of vulnerability in Tim's narrative when he described his fears of being seen as 'weak, foolish, silly, and a bit soft' by having therapy.

**Julie's Story**

Julie, Tim's wife, told a tragic story of disappointment and hopelessness with regards to the difficulties the family had experienced. Her tone was deflated when describing how Tim's military background had impacted negatively on the family leading them to access family therapy. Accessing family therapy appeared to be a turning point in Julie's story as a more positive tone was utilised as she described Tim realising how the family were affected and gaining more realistic expectations of the family.

**Jack's Story**

Jack is a 49-year-old Army veteran who served for 17 years. Jack's story was of a tragic nature as he described becoming violent towards his partner Sharon and noticed himself becoming a 'changed man'. Jack told his story passionately as the turning point of accessing family therapy became clear. Jack decided to access family therapy with Sharon as their relationship was becoming volatile. Jack had been encouraged by the improvements he had noticed in his relationship so far and acknowledged this was a work in progress.

**Sharon's Story**

Sharon's story was of a similar tragic nature to Jack's, however Sharon conveyed more anger, disappointment and dismay at their situation as it had been developing. Sharon's narrative was of the forgotten family who were turned away by several services before finding the veterans' service and accessing family therapy. The turning point in Sharon's narrative appeared to be accessing services. Sharon had a positive view of family therapy despite her fears of 'confiding in a stranger'. Sharon also found it helpful to be able to talk about her feelings and 'offload'.



### **Martin's Story**

Martin is a 55-year-old Army veteran who had served for 22 years. Martin's story started with the breakdown of his marriage shortly after leaving the Army and the chaotic family life that ensued. Martin was reflective and controlled as he told his story, which was positive in nature with an element of romance entwined within it when he described his relationship with the Army. Martin's narrative was based on his difficult relationship with one of his teenage daughters and how family therapy had resulted in noticeable positive changes for their family. Martin spoke of how his military background impacted his current relationships yet seemed to have a romantic view of his time in the military. Martin's tone and nuances of his narrative suggested he wanted to try and change the public stereotype of ex-military personnel by telling his story whilst addressing some of the stigma attached to veterans seeking help with the use of his positive experience.

### **David's Story**

David is a 37-year-old Army veteran whose narrative tone was sad, deflated and in some respects reflected a sense of shame. David's narrative was somewhat tragic and sorrowful as he spoke about his relationship with his partner Lorna and his two children, and how these relationships had been negatively impacted by his mental health as a consequence of his time in the Army and the transitioning period. David's narrative had various dark moments as he spoke about suicide attempts and serious episodes of self-harm which had impacted his relationship. David had a positive experience of family therapy as it increased communication within his relationship with Lorna.

### **Lorna's Story**

Lorna, David's partner, told an epic and adventurous story covering a range of topics that felt important to her. Lorna's tone was one of determination, resilience and independence. Lorna utilised her own personal experiences of loss to understand David's experiences and tried to help him. Lorna's narrative appeared to be about supporting David and the difficulties in doing so, with a clear message that Lorna would not give up on him. Lorna's narrative highlighted a positive experience of family therapy, which appeared to facilitate communication and help David to open up, which in turn was helpful for Lorna to gain an understanding of his difficulties.

### **Tommy's Story**

Tommy, a 47-year-old Army veteran, told an extremely positive story with elements of romance and adventure. Tommy's tone was excited and in some respects quite insistent, as if he was really trying to persuade the audience of the 'truth' behind his story. Tommy's story at times had a sense of being unbelievable in a positive way. Tommy's overarching narrative was of being a 'changed man' since experiencing family therapy, which helped him learn how to manage his anger within his relationships and accept a more positive way of relating to people. Tommy's story highlighted a change from a suicidal, angry and unhappy man to a positive, happy and friendly man who enjoys life to the full.

### **Sophie's Story**

Sophie is a 36-year-old spouse of a veteran in the British Army who told a story of sadness, anger and being let down. Many aspects of her story resembled a sorrowful-tragedy, which started with her long military family background. Sophie described her husband buying

himself out of the Army as the war in Belfast became ‘the last straw’ and he ‘didn’t come back the same man’. Sophie had a strong feeling of being ‘kicked to the curb’ by the Army and support services. This appeared to be a story of a victim who had been forgotten about by the ‘military family’ and wider society, who was not provided with the knowledge of how to help herself or her family. A turning point in Sophie’s story was the realisation that there were services who could help and that family therapy was available to her. Sophie’s sadness was somewhat alleviated when she was able to ‘off-load’ in family therapy when she was unable to communicate with her spouse about her emotions. Although Sophie found this helpful, her husband found it hard to ‘open up’ making it difficult for the therapy to continue. Sophie described how the ‘communication barriers’ came up when she tried to talk to her husband about his time in the military or how they might be feeling emotionally. This seemed to lead her to a position of acceptance that ‘if they’re going to talk about it they’re going to talk about it, if they’re not, they’re not, but the more you push, the more a barrier comes up.’ Sophie’s tone was of anger towards the Army, as though she blamed the Army for the difficulties the family were now experiencing. Sophie described ‘giving up’ with family therapy as it was a difficult process for her husband.

### **Summary of Individual Stories**

Interestingly, given the space to ‘start’ wherever the participants’ wanted, it became clear that although talking about family therapy would inevitably happen, it was likely to be mixed in with other aspects of their narrative that they thought were important and wanted to share. For example, how the lack of support offered during their transition period contributed to their relationship difficulties. This highlighted that the stories individuals told when asked about their

experience of being an ex-military family experiencing family therapy were varied with many contributing factors. One example of such individuality was the type of relationship that was being impacted upon. These difficult relationships were not only between the veteran and spouse, but also between father and daughter (Martin). Alongside the variety and individual nuances of the narratives, there were also some commonalities within the narratives. Although these common themes existed they were presented and used differently within each narrative, however a shared narrative was clear.

### **What meta-narrative occurs about ex-military families' experience of family therapy?**

#### **A shared narrative**

#### **Chapter 1 – 'The main dramas' start – The role of transitioning and lack of support.**

At the beginning of their narratives, all participants felt it was important to contextualise their experience of family therapy with how and when their difficulties started. For most veterans, the time of leaving the Armed Forces and reintegrating to the wider society and their families saw the beginning of their difficulties:

'I think the main dramas that have happened for us, probably a year or two after I got out, probably lie about that, probably happened straight away' (David).

The stories all included a perceived lack of support from the military during this phase and from services within society. This was told with a sense of rejection, disappointment and surprise from most participants, particularly from spouses who also utilised a tone of anger:

'Because once you come outside of the Army, they don't want to know, you're kicked to the curb' (Sophie).

Veterans' stories describe this lack of support from the military as understandable, and defend the military in some respects although a sense of rejection was also communicated: 'Obviously, you need, you get rid of that feeling of being by yourself. (...) As I say the Army has got its own problems to deal with. They have got to look after the lads that are in it at the end of the day, that's the main thing. (...) So the general rule of thumb is, you're out, by yourself' (David).

This defense of the Armed Forces may represent the veterans' relationship to, and 'romantic' view of, their 'military family', while the tone of rejection suggests the pain in feeling 'let down' by this 'family'.

Although transitioning and lack of support may not be a direct experience of family therapy, it seemed important to all participants that the audience had an understanding of the struggle they experienced prior to accessing family therapy. There was a sense that if this support had been offered at the early stage of transitioning from the military, they may not have faced the difficulties they encountered. This context also seemed important for the audience to understand the process of the decision-making behind accessing family therapy, which it could be suggested, is a significant experience leading to and influencing their narrative of family therapy.

## **Chapter 2 – 'I want to be back to my old self'**

This chapter represents an important factor in the participants' decision to access family therapy and is told with a sad and negative tone by all participants. All individuals had noticed a change in the veteran, such as the way he behaved or how he related to others. Veterans could notice this

within themselves and there was a sense that this realisation of change was a turning point in their story: ‘I want to be back to my old self, I don’t like, when I look in the mirror I don’t like what I see. I would like to be my old self’ (Jack). This realisation appeared to form part of the tragic aspect of some of the stories (Jack, David, Martin and Sharon):

‘You come out of the Army, you have got a family and you’re not the same person you were when you went in to the Army as you came out. Because you are a different person. You’re a completely different person. You’re the shadow of the person you were’ (Sophie).

The imagery involved in describing a ‘shadow of the person you were’ was a powerful way of getting the sadness and sense of tragedy across to the audience. This appeared to be important to Sophie who was communicating a sense of injustice and a profound sadness that she attached to this change.

The changes noticed in the veteran appeared to impact the spouses’ sense of self as described by Sharon and Jack:

‘Sharon: I just, I’m looking forward to some day having the old Jack back and in return, giving the old Sharon back, because I’m not the same person.

Jack: Hmmmm...no you’re not...but that is down to me though, not down to you.

Sharon: No that’s down to circumstances

Jack: And the circumstances are me’.

Interestingly, this change in the spouse was not told with so much sadness or blame, but with a sense of hope. Sharon recognised the changes in herself as a result of their current circumstances, which had previously been communicated through sadness, but in this example, a sense of hope appeared to be more important to Sharon.

Not only were these changes noticed in the veteran, and sometimes within the spouse, but the negative impact this had on their relationship was a large part of many of these narratives, including how volatile their spousal relationship had become, the negative impact this had on their children, reduced communication and in some cases, relationship breakdown. Martin describes the breakdown of his marriage and the impact on the rest of his family.

‘Then my marriage split up, my wife went back to live in Northern Ireland and I was, I was, I had the five children, you know they’re my children, I looked after them, I was still working full time, erm, there were a few issues and arguments and one of my older daughters, she went to live with her mother and then some of the younger children went to their mother, some came back, it was backwards and forwards, it was just chaotic to be honest with you, it was awful’ (Martin).

This part of the narrative also highlights a change in the communication style of the veterans, which impacted on the relationship between the couples. Spouse narratives emphasized this particularly, however some veterans were able to notice this in themselves too which helped encourage them to seek help. Communication ‘barriers’ were frequently referred to within the spouse narratives (Sophie, Sharon, Lorna and Julie), which included both ‘bottling things up’ and avoidance. The stories included attempts by the spouse to encourage the veteran to talk about his experience or emotions but this would usually result in the veteran ‘shutting down’:

‘If they’re going to talk about it they’re going to talk about it, if they’re not, they’re not, but the more you push, the more a barrier comes up’ (Sophie);

‘There is a part of David that I, I think I have resigned myself to the fact that I won’t know about. Because the more I probe, the more he shuts down, puts the barriers up anyway. But even if I leave him to talk about it when he wants, he won’t’ (Lorna).

These changes seemed to fuel the families’ decision to access family therapy and remained a constant reminder throughout therapy of what they were hoping to achieve; a positive change in their relationships with the hope that this would include changes in the veteran and the spouse.

### **Chapter 3 – ‘Family Therapy Helpful’**

This part of the story reveals a turning point in many of the stories, offering hope and an opportunity to work towards changing some of the difficulties in the familial relationships.

Although this chapter is part of the shared story, there are qualitative differences between how veterans and spouses experience family therapy as helpful. Generally, veterans seemed to find family therapy helpful because it provided a safe environment to talk and gain an understanding of their difficulties, while the family therapist was non-judgmental which encouraged them to talk about things they might usually find difficult: ‘It has given us a lot of confidence and a lot of understanding of our problems and it has allowed us a safe environment to talk about our problems’ (Tim). Veterans tended to speak positively about this experience with a sense of romance and adventure.

Spouse narratives also found family therapy helpful as it allowed them a space to ‘off-load’ and ‘vent’ their feelings like a ‘release valve’ (Sophie). There were also some qualitative commonalities within this chapter of helpfulness between veterans and spouses.



All stories indicated that family therapy had been helpful in encouraging communication between the couples, which was stated as helpful from both sides:

‘He can’t talk, (...) he can’t verbalise what he wants to say...he can’t...without somebody occasionally asking, questioning...it can’t be me because I’m the...can be the big bad...because I’m asking him stuff or...erm...but with the counselor there...because they were a third person if you like, they’re not involved with the situation, he was actually able to then actually start bringing things out and actually seeing where his experiences were actually causing him problems now’ (Julie).

The narratives also included a sense of how family therapy appeared to allow a shared understanding of the difficulties, as seen from each other’s perspectives which had been difficult prior to family therapy: ‘where the family counselling really came in, it kind of got him to sit back and actually realise how it was affecting us and how his expectations were unrealistic for our children and for me’ (Julie);

‘It would give her an understanding of what I have been through in my life and what have you. And you know I suppose without that, we wouldn’t be in the position that we are in now’ (Tommy).

This improvement in communication and increase in understanding of others’ perspectives was communicated as a fundamental aspect of how family therapy had been experienced as helpful and important for encouraging changes in their relationships.

#### **Chapter 4 – Resolution or a ‘work in progress’?**

As the narratives start to draw to a close, there appeared to be two types of endings, with another qualitative difference between veteran’s stories and those of their spouses. Veterans’ seemed to come to a resolution of their difficulties, and although acknowledging their situation was not perfect, emphasised the improvements that had been made throughout therapy: ‘Since then [family therapy] things have been fantastic you know (...) I have completely, completely changed my outlook on life and other people’ (Tommy). Many of the veterans described such improvements, which would fit with the typical ending of a ‘romance’ where a positive resolution is reached.

This contrasts with the ending of the spouse stories that were typically more reserved about the improvements that had been made and, although acknowledging these improvements, their emphasis was that it was still a ‘work in progress’: ‘It really will help families (...).you know it was one of the one things that we were sort of working towards to try and help keep our family together (...) trying to work towards being a nice family unit again rather than him being on the outside’ (Julie).

These two different endings may not be surprising given that veterans and spouses are likely to enter family therapy with varying hopes, expectations and personal values and experiences. They are likely to experience family therapy with these past experiences in mind and therefore their narratives are likely to incorporate these experiences.

### **Exceptions to the shared narrative**

As would be expected with nine personal stories, and was highlighted in the individual story summaries, there are some aspects of participants' stories which were not common to the shared narrative although were common to one group of participants. This was particularly evident for spouse narratives, which highlighted their experience of an 'emotional rollercoaster' throughout their story. This thread ran throughout the stories of spouses, often starting while the veteran was still in service, continuing throughout his transition, the start of their difficulties and the process of seeking help and experiencing family therapy. This imagery of a rollercoaster was a powerful way to describe the endless emotions, positive and negative, felt by the spouses. It appeared that one of the most difficult aspects of the rollercoaster was the unpredictability of it. At times the spouse felt very resilient and able to support their partner through anything, while at others they felt close to 'breaking point' as Sophie describes: 'My heart has come to breaking point, and it is a case of, you stand back and, I think well...if I give up on this person, what is going to happen to them'.

### **What is the perceived impact of the experience of family therapy on familial relationship functioning?**

The impact on familial relationships was described positively by participants and suggested that family therapy had been helpful in bringing about changes within the family. This was a significant part of the shared narrative as discussed in Chapter 3 above. Individual stories, and shared narratives highlighted several areas within their familial relationship which participants felt had been impacted by family therapy. Interestingly, there were some aspects of

the story that were more pertinent to veterans than spouses, and vice versa. For example, veterans described noting an improvement in their communication skills and improvements in their understanding of the importance of communication for their relationships.

But I think after the sessions themselves we were fine, as the sessions were going on, even when we had the gaps in between sessions we were fine. I think we were talking a bit, trying a bit harder. (David)

While narratives of spouses offered an alternative perspective as to what they felt the impact of family therapy had been. Spouses suggested that family therapy had helped the veteran to gain a more realistic expectation of the family. Spouses described that this was a positive impact on the family relationships, particularly within the veteran-child dyad.

He sees the children, in no matter what age, you tell them something to do and then they have got to do it, and I said, it doesn't work like that, kids don't have that. Ok, adults, in the Army or etc but children, you can't say do this and they do it straight away after that, you know, first time. And he really struggled to understand, he is changing a lot in that respect. (Lorna)

Spouse narratives also highlighted that family therapy had helped the veterans to see things from their perspective, which they believed had a positive impact on their relationship. The tone used to describe this within participants' narratives was one of satisfaction and relief.

But he...he was starting to see things from our point...my point of view, our children's point of view, rather than his 'boom, boom, boom' (laughs). (Julie)

The shared narrative of both veterans and spouses highlighted they noticed improvements in their relationship as each person had a shared perspective and increased understanding of some of the difficulties. They perceived their spouse to have a greater understanding of what they had been through, which had a positive impact on their relationship.

It would give her an understanding of what I have been through in my life and what have you. And you know I suppose without that, we wouldn't be in the position that we are in now. (Tommy)

These perceptions of improvement appeared to be an important aspect of both individual stories and the shared narrative. Participants were keen to share this part of their narrative and it seemed important to them that this was reflected.

## **Discussion**

This study aimed to explore ex-military families experience of family therapy through three research questions. Findings will be discussed followed by the strengths, limitations, clinical implications and future research.

### **What stories do individuals tell about being an ex-military family and their experience of family therapy?**

Findings suggested that individuals within an ex-military family each had their own personal experience, articulating and making sense of this differently, through a variety of narrative styles. There was a range of tones both positive and negative within their story, but usually conveying an overarching tone. Each participant had their own position in relation to their experience and aimed to get something different out of telling their story, whether that be attempting to alter the audiences stereotypes of veterans (Martin), to share the experience of being ‘a changed man’ following family therapy (Tommy) or to highlight the sheer difficulty of feeling ‘kicked to the curb’ (Sophie). Generally, narratives were used to communicate the usefulness of family therapy, with a variety of reasons for this experience. All individuals found their own resolution whether that was a positive reflection on their experiences and the changes they have made, or simply accepting that this is a work in progress. The individual stories also highlighted common threads shared among the majority of the stories. Some of these were common to both veterans and spouses, whereas some were group specific, although these threads were told differently and had individual personal nuances. The common threads would be

expected according to Riessman (1993) who recognises the importance of individual stories, whilst acknowledging the likelihood of cultural and societal narratives shaping these stories. Therefore the common threads may highlight some important cultural considerations which will be discussed later.

These findings highlight the importance of attending to individual nuances of each story and can be thought about in terms of person-centred care. Although the participants had similar experiences of family therapy, the way they understood and made sense of these experiences differed, and therefore their hopes and expectations of therapy, their engagement with therapy and outcomes from therapy could also differ. A person-centred approach would be useful in addressing this and can be used within family therapy (O'Leary, 1999).

Although the nuances of individual stories including tones, positioning and genres, can provide useful information about how family therapy may be experienced on an individual basis, common threads creating the shared narrative offer important findings.

### **What meta-narrative occurs about ex-military families' experience of family therapy?**

The shared narrative highlighted that the role of transitioning and lack of support during this time seemed to be the start of some of the difficulties experienced by veterans and their families. This was an important catalyst within the narrative of decision making by participants to access care, particularly family therapy. This seemed to be a significant part of the story that all participants felt they wanted to communicate. It is possible this could provide opportunities for future care and services to provide psychological services at an earlier point in time, which may potentially reduce psychological distress for some families at a later point in time.

Another main finding that also acted as a catalyst to accessing care was noticing changes in the way the veteran behaved and communicated and the impact this had on familial relationships. These are common systemic factors experienced by military and ex-military families as discussed by Everson and Herzog (as cited in Everson & Figley, 2011), which might be part of ‘peripheralisation’ occurring within the family. This is where there is difficulty re-integrating the veteran into the family system after lengthy absences, often involving combat operations, and the couple experience ‘devitalisation’ of their marital quality. This may be experienced as communication difficulties, changes in behaviour (e.g. domestic violence, volatile relationships) and distancing behaviours. These experiences were usually told with sadness by participants as a story of volatile relationships, communication barriers and relationship breakdown emerged. This finding appeared to be accompanied by a turning point in the narratives where hope was offered through family therapy and more significantly, where family therapy had been experienced as helpful by participants, but for different reasons.

The main aspect that was highlighted as helpful, which may differ from generic family therapy with any population, was that of allowing a shared understanding of the difficulties, particularly experiences the veteran may have been subject to during his time in the Armed Forces, and how this might impact his own mental health and relationship difficulties. Benson, McGinn, and Christensen (2012) suggest five key principles in effective family therapy, one of these is ‘changing the view of the relationship’. This basic principle appears to have been important to ex-military families, but with specific reference to how the relationship has changed in light of expectations and culture within the military, which may not be applicable to the family home. This cultural difference may highlight one of the specific needs of veterans and the ex-



military family population; the importance of working with somebody who understands these cultural differences as was highlighted in some individual stories. This might include a variety of aspects of the military culture, for example, the difficulties veterans experience around expressing their emotions for fear of being seen as ‘weak’ or ‘soft’ which, as literature suggests, is thought of as unacceptable in the military (Kings Centre for Military Health Research, [KCMHR], 2010).

Other aspects that were seen as helpful were improved communication and gaining more realistic expectations of the family or veteran. These findings would be expected in other family focused work with adults from the general population with mental health difficulties, however there are specific military aspects that may need to be considered when working with the veteran population. For example, veterans’ expectations of the family prior to family therapy appear to be influenced by the military culture and experiences, such as expecting the family to follow orders, which may be a difference between ex-military families and families within the general population. Epstein and Baucom (2002) suggested that couples therapy can encourage couples to challenge unhelpful beliefs and expectations which may contribute to relationship distress and replace these with alternative, more realistic and neutral expectations (Carr, 2009).

The final main finding from the shared narrative was that of reaching, or working towards, a resolution following family therapy. The qualitative difference between the experience of reaching a resolution between veterans and their spouses seemed relevant. The resolutions within spouse narratives appeared to be acceptance that the work within family therapy was a ‘work in progress’ and that it was likely a new resolution might emerge. Although

there was a sense of acceptance, there was also a negative and possible disappointed tone accompanying this acceptance, which seemed to be aimed at the negative experiences of being an ex-military family and the impact of the military culture. This finding ties in with suggestions by Jervis (2011) who discussed negative views of spouses about their experience of the military and the military culture. Spouses generally spoke favorably about family therapy but wanted to put things right at a societal and cultural level rather than solely for their family. This finding was qualitatively different from the resolutions suggested within the narratives of veterans' who appeared to have a more positive resolution, noticing the positive changes that family therapy had brought within the family and their positive experience of the Armed Forces. It is possible that family therapy has allowed veterans to have feelings of resolution, or start working towards resolution. This along with a more positive view of the military culture may leave the veteran reflecting more positively on their experience than the spouse who may still hold strong negative feelings of being let down by the military.

**What is the perceived impact of the experience of family therapy on familial relationship functioning, as perceived by those in receipt of it?**

The majority of narratives suggested family therapy had improved familial functioning in terms of communication, understanding and more realistic expectations of the family. These findings are in line with aims of family therapy as proposed by Benson, McGinn, and Christensen (2012) in their five key principles, however have elements which are specific to ex-military families such as addressing cultural norms of the military. This highlights the important positive impact that family therapy may have on family functioning and mental health,

supporting suggestions by Everson & Figley (2011) who recommends a systemic approach to working with veterans.

### **Strengths and Limitations of the study**

A narrative approach allowed participants to tell their personal story, emphasizing aspects important to them, whilst ensuring their voices were heard, encouraging rich and complex narratives (Elliott, 2005). Interviewing individually allowed all voices to be heard, whether they would usually be dominant or not, whilst the joint interview allowed for a shared experience to be voiced and related to their experience in family therapy. It is possible that some veterans felt unable to tell negative aspects of their stories due to the potential perception of authority. The military culture requires personnel to adhere to norms whereby authority figures have control. It is possible that the family therapist and researcher were seen as authority figures and therefore in control, making it difficult to question.

Participants were all male veterans and female spouses, which may limit the results as it is possible that female veterans and male spouses would have a different experience and may relate differently to the military culture and family therapy. It should be acknowledged that the length of time served and length of time since leaving the Armed Forces varied significantly. The narrative approach allows for these individual experiences to be spoken about freely however, as services develop, future research might benefit from exploring a particular cohort of veterans, or those that served for a similar amount of time.

A minority of narratives touched on some improvements to family therapy, however these improvements were generally 'glossed over' with a positive statement about how family

therapy had been helpful. It is possible that participants, particularly veterans, did not want to appear ungrateful for the service they received and therefore spoke more positively about it. It is possible that veterans believed offering constructive feedback is not their place, given the military culture does not typically place value on feedback from serving personnel who are expected to follow commands. It is possible their spouse may not have been impacted so much by this culture and therefore more able to offer feedback.

Although all couples had received and completed family therapy, some couples had ended family therapy prematurely due to unforeseen circumstances within the service. This may have impacted their experience and the results.

### **Clinical Implications**

The shared narrative of participants, and individual stories appear to highlight some aspects of family therapy that were helpful. Some participants spoke of wanting this to be widely available to ex-military families and for it to be better advertised so veterans and spouses are aware this is an option for them. Difficulties described in transitioning and the lack of support at this time may give rise to clinical opportunities to offer early support which could potentially lessen psychological distress and relational difficulties experienced later. Spouses spoke of sadness that there were families experiencing the same difficulties that were not offered family therapy. A majority of veterans had experienced individual therapy which had been helpful, however suggested this would be more beneficial alongside family therapy as it allowed their relationships to improve. Spouses agreed, suggesting family therapy might be helpful alongside

individual therapy where the veteran is able to talk about things he is not ready for the family to hear yet.

One of the exceptions from the shared narrative was that several spouses suggested that just having somewhere to ‘offload’ and ‘get things off their chest’ was helpful. This could suggest that spouses may benefit from individual therapy, should family therapy not be available or appropriate for the family.

### **Future Research**

Not all couples were able to participate in a joint interview, either because one half of the couple did not participate, or because of clashing work patterns. This is an area that would warrant further exploration through future research.

Although children were invited to participate in this study, no children took part. It became clear that a minority of families actually involved children in family therapy, with some being perceived as too young. Future research might benefit from exploring how children can participate in and experience family therapy allowing their voices to be heard.

### **Conclusions**

The results of this study, in relation to the research questions outlined, suggested that individuals made sense of their shared or similar experience of family therapy differently, utilising different tones, positions and core narratives. Although these individual nuances and personal reflections were important, the study highlighted that a shared narrative also emerged from common threads running throughout the individual stories. The shared narrative suggested that family therapy was experienced as helpful with an improvement in familial relationships,

improvement in communication and gaining an alternative perspective for both the veteran and spouse.

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**Section C:**

**Appendices**

**Eleanor R. Constant**

### Appendix One – Summary of literature search

Database	Number of Papers (Combined search)	Relevant Title and Abstract	Total Included
ASSIA	81	27	2
Psych Info	147	70	12
Ebscohost	133	31	1
Ovid Medline	307	57	6
KCL, KCMHR	372	33	9

Relevant papers

references were also searched by hand, 14 were included.

## Appendix Two – Extract of Summary of Empirical Papers

Authors	Country	Objective	Sample	Method	Results	Critique
Iverson, Dyson, Smith, Greenberg, Walwyn, Unwin, Hull, Hotopf, Dandeker, Ross & Wessely (2005b)	UK	To describe the frequency and associations of common mental disorders and help-seeking behaviours in a representative sample of UK veterans at high risk of mental health problems	496 'vulnerable' ex-service personnel selected from an existing epidemiological military cohort	Quantitative: Cross-sectional telephone Survey including a modified version of the Primary Care Evaluation of Mental Disorders & PTSD screening & General Health Questionnaire	Depression is more common than post-traumatic stress disorder in UK ex-service personnel. Only about half of those who have a diagnosis are seeking help currently, and few see specialists.	Sample taken from previous cohort study. Included participants from all military forces
Sautter, Lyons, Manguno-Mire, Perry, Han, Sherman, Myers, Landis, & Sullivan, (2006).	America	To identify predictors of treatment engagement of 83 cohabitating female partners of 83 Vietnam theater veterans.	83 cohabitating female partners of 83 Vietnam theater veterans	Telephone survey was conducted to identify predictors of treatment engagement in 83 cohabitating female partners of 83 Vietnam theater veterans with combat-related post-traumatic stress disorder (PTSD). The survey assessed veterans for their trauma history and PTSD symptoms. Partners were assessed for caregiver burden, patient–	Significant predictors of partner PTSD treatment engagement were the couple's income, patient–partner involvement, and partner caregiver burden. These findings have implications for family interventions that may increase partner PTSD treatment engagement and improve PTSD treatment outcome.	Female spouses only

partner involvement, PTSD treatment engagement, self-efficacy relating to PTSD, beliefs about benefits of PTSD treatment, and PTSD treatment barriers

<p>Meis, Barry, Kehle, Erbes, &amp; Polusny, (2010)</p> <p>Doi: 10.1037/a0020925</p>	<p>America</p>	<p>combat-related posttraumatic stress disorder (PTSD) is associated with considerable impairment in relationship adjustment, research has yet to investigate how PTSD symptoms and relationship distress uniquely and jointly predict utilization of a range of mental health services</p>	<p>Participants were drawn from a larger longitudinal project examining risk and resilience among 522 Minnesota NG soldiers deployed to OIF. N=424</p>	<p>Approximately 2–3 months (Time 1) after NG soldiers returned from OIF, participants were mailed self-report surveys using multiple mailings and a \$50 incentive. Eighty-one percent (N=424) responded</p>	<p>PTSD symptom severity, but not relationship adjustment, uniquely predicted greater odds of utilizing individual-oriented mental health services. A significant interaction was found indicating associations between PTSD symptoms and the odds of using services were increased when soldiers reported greater relationship adjustment. For utilization of family-oriented care, greater relationship distress was significantly correlated with greater odds of using services, but associations with PTSD symptoms were non-significant. The association between relationship distress and utilization of family-oriented services did not vary significantly with severity of PTSD symptoms. Results</p>	<p>sample included mostly White, male, National Guard soldiers from the Midwest. Thus, findings may not generalize to ethnically diverse groups, enlisted soldiers, female military members, or samples in other geographic regions with differing availability of services. relied on self-report data, so they cannot speak to how intimate partners' reports of distress or relationship adjustment may influence treatment utilization. survey response rates were</p>
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Forbes, Jones, Greenberg, Jones, Wessely, Iversen & Fear (2013)	England	To compare attitudes to mental illness in the U.K. military and in the general population in England.	Using data from a cross-sectional survey of 821 U.K. military personnel and a separate cross-sectional survey of 1,729 members of the general	821 U.K. military personnel, 1,729 members of the general population in England	suggest supportive intimate relationships facilitate mental health treatment utilization for soldiers with PTSD symptoms	Attitudes toward mental illness are comparable in the general population in England and the U.K. military. Differences included the military holding more positive attitudes about the causes of mental illness, but more negative attitudes about job rights of those with mental illness. Strategies aiming to improve attitudes toward mental illness could focus particularly on personnel's concerns around mental illness impacting on their career.	high, there were a number of demographic differences between responders and nonresponders which may have influenced our results, suggesting findings may apply less to demographic groups underrepresented among responders.	The use of two different types of interviewer-administered methods (the military survey was conducted over the telephone, whereas the general population survey used face-to-face interviews) may have compromised the comparability of the results. The authors acknowledge that the
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De Burgh, White, Fear, Iversen, 2011.	England	To review literature relating to the impact of deployment on spouses of military personnel	population in England, levels of agreement with five statements about mental illness were compared in the military and the general population	A review of the literature published between 2001 and 2010 assessing the impact of deployments to Iraq and Afghanistan on spouses of military personnel was conducted	A total of 14 US-based studies were identified which examined psychological morbidity, help seeking, marital dysfunction and stress in spouses. Longer deployments, deployment extensions and PTSD in military personnel were found to be associated with psychological problems for the spouse. The needs of spouses of military personnel remain an important issue with implications for service provision and occupational capability of both partners	study findings relate to a limited number of attitude items, given that as the primary aim of the military study was to assess treatment for mental illness and access to care
Doi:10.3109/ 09540261.20 11.560144						

Greenberg, N.; Thomas, S.; Iversen, A.; Unwin, C.; Hull, L.; Wessely, S. 2003.	England	To investigate the perceived psychological support requirements for service personnel on peacekeeping deployments when they return home from operations and examine their views on the requirement for formal psychological debriefings	1202 UK peacekeepers on return from deployment	Quantitative: A retrospective cohort study examined the perceived psychological needs of 1202 UK peacekeepers on return from deployment. Participants were sent a questionnaire asking about their perceived needs relating to peacekeeping deployments from April 1991 to October 2000.	Results indicate that about two-thirds of peacekeepers spoke about their experiences. Most turned to informal networks, such as peers and family members, for support. Those who were highly distressed reported talking to medical and welfare services. Overall, speaking about experiences was associated with less psychological distress. Additionally, two thirds of the sample was in favour of a formalised psychological debriefing on return to the UK.	This study was undertaken in 2001 and examined peacekeeping operations back to 1991. possibility of recall bias in mind. Cannot determine causality, e.g if talking decreased scored.
Newby, E., McCarroll, Ursano, Fan, Shigemura & Tucker-Harris, Y. (2005)	America	To determined the perception by 951 U.S. Army soldiers of positive and negative consequences of a peacekeeping deployment to Bosnia	951 U.S. Army soldiers 419 married 532 single soldiers	Quantitative surveys administered in person	Seventy-seven percent reported some positive consequences, 63% reported a negative consequence, and 47% reported both. Written comments were also provided. 15% of married service members reported that deployment has meant missing important family events and 11% reported worsened marital relationships	Self report tools and written comments. No family perspective taken.  No follow up to determine long term effect on family functioning

Riggs D. S., Byrne C. A., Weathers, F. W., & Litz, B. T. (1998)	America	This study examined the quality of the intimate relationships of male Vietnam veterans	Heterosexual couples in which the veteran had posttraumatic stress disorder (PTSD; n = 26) were compared to couples in which the veteran did not have PTSD (n = 24).	The DAS (Spanier, 1976) is a 32-item self-report questionnaire that has been used widely to assess relationship satisfaction. The MSI (Weiss & Cerreto, 1980) is a 14-item true/false questionnaire that assesses likelihood of separation and divorce. The PCL-M (Weathers, Litz, Herman, Huska, & Keane, 1993) is 17-item self-report questionnaire. Items on the PCL-M correspond to the DSM-IV diagnostic criteria for PTSD and include five reexperiencing symptoms, seven avoidance/numbing symptoms, and five hyperarousal symptoms. Fear of Intimacy Scale (FIS). The FIS (Descutner & Thelen, 1991) is a 35-item self-report measure designed to assess a person's anxiety about close relationships with another.	Over 70% of the PTSD veterans and their partners reported clinically significant levels of relationship distress compared to only about 30% of the non-PTSD couples. Relationship difficulties appeared to encompass a wide range of areas, with PTSD veterans and their partners reporting that they had more problems in their relationships, more difficulties with intimacy, and had taken more steps toward separation and divorce than the non-PTSD veterans and their partners.	This was a thorough quantitative study of male American veterans and their spouses. As all participants were volunteers it is possible that there is an over-representation of help-seeking couples which may contribute to the results. It is also noted that the sole use of self-report tools may be problematic. It is also unknown how generalisable findings maybe to veterans of other combat eras
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Relationship Problems Scale (RPS). The RPS (Riggs, 1993) is a 32-item questionnaire that assesses the severity of problems within relationships.

Murray-Swank, A., Glynn, S., Cohen, Amy. N., Sherman, M., Medoff, D. P., Fang, L. J., Drapalski, A., Dixon, L. B. (2007)	America	This study examined views about family relationships and family participation in care	69 consumers with serious mental illness receiving treatment within the Department of Veterans Affairs healthcare system.	Quantitative: Participants met with research staff for a 60- to 90-minute assessment. The assessment included a detailed series of questions that identified participants' family support system. Participants were first asked, "Do you have family or others that you consider to be 'like family'?" If they responded affirmatively, they were asked to generate a list of primary individuals in their family support system. Following these questions, assessors verbally administered standardized measures designed to assess participants' experience of the family environment, their views about family	We found that younger consumers and those with higher levels of psychiatric symptoms were more likely to report family conflict and distress. Of participating consumers, 67% wanted family participation in their psychiatric treatment and those with at least weekly contact with family were more likely to want family participation. Consumers endorsed a number of barriers to family participation in their mental health treatment, including their own concerns about privacy and burdening family and skepticism that family involvement would be helpful	Standardised measures. Attempted to capture a broad range of participants by recruiting across a range of clinical programs (inpatient, outpatient, partial hospitalization), implementing a more comprehensive and representative sampling strategy was not feasible. A majority of our participants was African American, reflecting the demographic characteristics of the study setting. Family relationships and
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Renshaw and Caska (2012)	America	Partners of combat veterans with posttraumatic stress disorder report elevated relationship and psychological distress, but little is known about the mechanisms by which such distress develops	The first sample consisted of 258 partners of Operation Enduring- and Iraqi Freedom-era veterans who completed questionnaires. The second sample consisted of 465 partners of Vietnam-era veterans who completed	participation in care, as well as demographic and clinical characteristics	Two studies included measures quantitative data on outcome measures including PTSD, psychological distress and relationship distress. Path analyses conducted on both samples.	In both samples, path analyses revealed that, when examined simultaneously, partners' perceptions of withdrawal/numbing symptoms were associated with greater distress, but perceptions of reexperiencing symptoms were unrelated to psychological distress and significantly associated with lower levels of relationship distress. the pattern is consistent with an attributional model of partner distress, whereby partners are less distressed when symptoms are more overtly related to an uncontrollable mental illness.	views about family involvement in treatment may vary by consumer age and sex, as well as other characteristics	data collected was cross-sectional and therefore no conclusions of causality could be made
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interviews  
as part of  
the National  
Vietnam  
Veterans  
Readjustme  
nt Study

<p>Browne, T., Hull, L., Horn, O., Jones, M., Murphy, D., Fear, N.T., Greenberg, N., French, C., Rona, R.J., Wessely, S., &amp; Hotopf, M. (2007).</p>	<p>UK</p>	<p>To investigate reasons for the excess of ill health in reservists</p>	<p>We obtained completed questionnair es for 786 of 1400 (56%) TELIC reservists, 3936 of 6295 (63%) TELIC regulars, 800 of 1811 (44%) era reservists and 4750 of 8192 (58%) era regulars. Non- participatio n was</p>	<p>UK personnel who were deployed to the 2003 Iraq War completed a health survey about experiences on deployment to Iraq. Health status was measured using self-report of common mental disorders, post-traumatic stress disorder (PTSD), fatigue, physical symptoms and well-being.</p>	<p>Reservists were older and of higher rank than the regular forces. They reported higher exposure to traumatic experiences, lower unit cohesion, more problems adjusting to homecoming and lower marital satisfaction. Most health outcomes could be explained by role, experience of traumatic events or unit cohesion in theatre. PTSD symptoms were the one exception and were paradoxically most powerfully affected by differences in problems at home rather than events in Iraq.</p>	<p>largest health study ever undertaken in the UK reserve armed forces and is representative of all three branches of service, including serving and ex-serving personnel. Participation was incomplete, with a total participation rate (adjusted for individuals whose address details were unknown) of 61%. The study is cross- sectional, and therefore it is impossible to determine the direction of causation for the associations we report.</p>
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associated with reservist status, lower rank, younger age, not deploying on TELIC and male gender.

This may apply particularly to the more subjective measures regarding comradeship and problems at home, which are likely to be affected by current mood. Some of the measures, for example of deployment-related experiences, have not previously been validated.

<p>Evans L1, Cowlshaw S, Forbes D, Parslow R, Lewis V. (2010)</p>	<p>Australia</p>	<p>This study evaluated the relations between posttraumatic stress disorder (PTSD) symptoms and poor family functioning in veterans and their partners.</p>	<p>Data were collected from Caucasian veterans with PTSD (N = 1,822) and their partners (N = 702); mean age = 53.9 years, SD = 7.36.</p>	<p>Veterans completed the Posttraumatic Checklist Military Version (PCL-M) and, along with their partners, completed the McMaster Family Assessment Device (FAD-12). Assessments were conducted at intake into a treatment program at 3 months and 9 months posttreatment.</p>	<p>Structural equation models (SEMs) were developed for veterans as well as for veterans and their partners. Poor family functioning for veterans at intake predicted intrusion (<math>\beta = .08</math>), hyperarousal (<math>\beta = .07</math>), and avoidance (<math>\beta = .09</math>) at 3 months posttreatment. At 3 months posttreatment, family functioning predicted hyperarousal (<math>\beta = .09</math>) and avoidance (<math>\beta = .10</math>) at 9 months. For veterans and their partners, family functioning at intake</p>	<p>Only participants in treatment for PTSD symptoms were included in this study, the association between family distress and PTSD symptoms might be different for veterans with non-clinical levels of PTSD symptomology or those not in treatment. In addition, participants were</p>
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					predicted avoidance ( $\beta = .07$ ) at 3 months, and poor family functioning at 3 months predicted intrusion ( $\beta = .09$ ) and hyperarousal ( $\beta = .14$ ) at 9 months. The reverse pathways, with PTSD symptoms predicting poor family functioning, were only evident with avoidance ( $\beta = .06$ ).	veterans of the Australian military and primarily Caucasian; as such, findings may not generalize to U.S. military Service members. Without a comparison group it is unclear if these results would hold among veterans without a formal PTSD diagnosis
Glynn et al. (1999)	America	Study tested a family-based skills-building intervention in veterans with chronic combat-related posttraumatic stress disorder (PTSD)	42 vietnam veterans with PTSD recruited from Los Angeles	Veterans and a family member were randomly assigned to 1 of 3 conditions: (a) waiting list, (b) 18 sessions of twice-weekly exposure therapy, or (c) 18 sessions of twice-weekly exposure therapy followed by 16 sessions of behavioral family therapy (BFT).	Participation in exposure therapy reduced PTSD positive symptoms (e.g., reexperiencing and hyperarousal) but not PTSD negative symptoms. Positive symptom gains were maintained at 6-month follow-up. However, participation in BFT had no additional impact on PTSD symptoms.	Limited sample size
Fischer, Sherman, Han & Owen, 2013	America	This study examined the impact of participation in REACH	One hundred veterans and 96 family	Data were collected to measure changes over time in the knowledge and skill domains directly and explicitly targeted by	Study results suggest that multifamily group psychoeducation is useful in treatment of PTSD, leading to increases in targeted PTSD	participation. The study has several limitations. Most notably, because we had

(Reaching out to Educate and Assist Caring, Healthy Families), an adaptation of the multifamily group psychoeducation program tailored for delivery to veterans with PTSD and their family members.

members took part in a longitudinal evaluation of the program. They received the intervention between 2006 and 2010, which involved three phases over a nine-month period.

REACH. Data were also collected to assess changes over time in more distal outcomes expected to be affected by changes in REACH-targeted knowledge and skills, that is, relationship distress/satisfaction, This document is copyrighted by the American Psychological Association or one of its allied publishers. This article is intended solely for the personal use of the individual user and is not to be disseminated broadly. social support, symptom status, and, for veterans only, overall quality of life and use of VA mental health services.

knowledge and skills, as well as improving family functioning and symptom status for both veterans and family members.

no comparison group and veterans continued their usual care during REACH participation, we cannot rule out the possibility that observed improvements were attributable to something other than program participation. Second, our symptom measure is not specific to PTSD and does not have a PTSD subscale

Monson, Schnurr, Stevens and Guthrie (2004)

America

Initial investigation of Cognitive-Behavioral Couple's Treatment

Pilot study with seven couples where the male veteran had

independent clinician assessment and partner report

They found that CBCT for PTSD resulted in a significant decrease in symptoms as rated by both the partner and clinician, while there was also an increase in partner satisfaction levels

Small sample size

Renshaw, Rodrigues, and Jones (2008)	America	(CBCT) for posttraumatic stress disorder (PTSD) To examine spouses of National Guard soldiers recently returned from deployments in Iraq.	a diagnosis of PTSD 49 National Guard soldiers from Utah and their wives	Wives and soldiers completed questionnaires three months after the soldier returned from deployment to Iraq. The questionnaires included a PTSD checklist, Center for Epidemiologic Studies—Depression Scale, Relationship Assessment Scale, Combat Exposure Scale and the Spouse Perception Questionnaire.	They found that wives' marital satisfaction was negatively associated with the severity of their husbands Post Traumatic Stress symptoms when they perceived they had experienced low levels of combat exposure	This study used a variety of standardized measures with a robust statistical analysis undertaken however a limited sample was available. This suggests there was a low power to detect interactions and large bands of error, which makes the strength of results and conclusions limited, although the results do support the importance of interactions in the area
Sautter Glynn, Thompson, & Franklin, 2009	America	Feasibility and efficacy of a novel couple-based treatment, named Strategic	Six male Vietnam combat veterans diagnosed	Self-report, clinician ratings, and partner ratings of PTSD symptoms were obtained before the first session and after the tenth session of	Veterans reported statistically significant reductions in self-reported, clinician-rated, and partner-rated effortful avoidance, emotional numbing,	A variety of sources offering ratings of PTSD symptoms.

Approach  
Therapy (SAT),  
for reducing  
avoidance  
symptoms of  
posttraumatic  
stress disorder  
(PTSD)

with PTSD  
and their  
cohabitating  
marital  
partners  
participated  
in 10 weeks  
of SAT  
treatment

and overall PTSD severity

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### **Appendix Three – Ethical NHS Approval and R&D Approval Letters**

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**Appendix Four – Information Pack**

Ref: 13/LO/0262 Version 1 22.11.12

**Invitation to participate****Ex-Military families' experience of systemic family therapy.**

Dear \_\_\_\_\_

My name is Eleanor Taylor and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study titled 'Ex-military families' experience of family therapy'. Before you decide whether to participate, it is important that you understand why the research is being done and what it would involve for you. Please take a moment to read the enclosed information sheet, which will explain what the study is about and what you can expect from the study. You might find it useful to discuss this study with your family or others and decide together if you wish to take part.

Please contact me on xxxxxxxxxxxxxxxxxxxx if you would like to participate or if you have any questions about the study.

Yours sincerely,

Eleanor Taylor  
(Trainee Clinical Psychologist)

## Adult Information Sheet



Ref: 13/LO/0262 Version 3 20.11.12

### Information about the research

#### Ex-Military families' experience of systemic family therapy.

My name is Eleanor Taylor and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to participate, it is important that you understand why the research is being done and what it would involve for you.

You might find it useful to discuss this study with your family or others and decide together if you wish to take part.

#### What is the purpose of the study?

With the increasing number of military personnel leaving the Armed Forces or being removed from deployment due to Government plans, there is likely to be a greater need for psychological therapies for common mental health difficulties. Veterans and their families have reported how mental health difficulties can impact on their relationships and have expressed a desire for family involvement in therapy. Family therapy is not currently a common intervention for military veterans and it is therefore important to provide research in this area to add to the evidence to further develop guidelines for possible therapies. In order to do this it is important to try and understand your individual experience, and your family's experience of systemic family therapy as a treatment. It is also important to try to understand if these experiences change throughout your experience of family therapy. Finally, it is also important to understand how the military culture might relate to your experience of family therapy.

#### Why have I been invited?

You and your family have been invited to take part in this study as you have experienced family therapy in the Military Veterans' IAPT Service. Approximately eight families will be invited to participate in this study and share their experiences of family therapy.

#### Do I have to take part?

This study is entirely voluntary and it is up to you and your family to decide if you want to take part. If you agree to participate, I will then ask you to sign a consent form. You are free to withdraw from the research study at any time, without giving a reason. This would not affect the standard of care you receive now or in the future.

#### What will happen to me if I take part?

Should you choose to take part in the study you and your family (those who participated in family therapy) will be asked to meet with me individually to discuss your experiences of mental health difficulties, family therapy and how this relates to the military culture. In order to gather some context to support a semi-structured interview, confidential material from your notes held by the Military Veterans' IAPT Service may be read, and anonymised and unidentifiable references may be made in the final write up. The interview will be designed to ensure a variety of topics are discussed to include the experiences of all members of your

family. The conversation will be audio-recorded and transcribed following our meeting. The interview should last between 45-75 minutes and this may be followed up with a family interview or a telephone conversation as it can be useful to have the opportunity to add any additional thoughts or questions you may have had following the initial interview.

All personal information and identifying data will be removed when transcribing the conversations and it will be kept confidential. Quotes may be taken from our discussions and published in the final report and peer-reviewed journal but these will be anonymous. The interviews will be analysed to attempt to draw out the meaning of your individual and family experience of therapy.

### **Expenses**

Any travel expenses incurred to meet with me will be reimbursed to you, up to the value of £10 per participant.

### **What are the possible disadvantages and risks of taking part?**

You and your family may experience the interview as touching on sensitive topics, which you may find distressing. Although much care has been taken to avoid causing any distress, if you feel like you would rather not answer a specific question we can move on to continue with the remaining questions or alternatively you may withdraw at any time.

### **What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study will help us to understand your experience of family therapy as a treatment for mental health difficulties within a military context. This may not directly influence future service but will add to the evidence base currently available.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed.

### **What will happen if I don't want to carry on with the study?**

If you withdraw from the study we would like to use the data collected up to your withdrawal.

### **Complaints**

*If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions [Eleanor.taylor2@nhs.net]. If you remain unhappy and wish to complain formally, you can do this by contacting Dr Alan Barrett, Principle Clinical Psychologist and Clinical Lead, Military Veterans' IAPT Service, alanbarrett@nhs.net, 0161 253 6638,*

### **Will my taking part in this study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence, however if you tell us something which makes us concerned about your safety, or the safety of other people, this will need to be discussed with the team and risk procedures will be followed. If this happens, we will discuss this with you before discussion with the team. Our discussions will be audiotaped and then stored on a password protected USB stick with all information kept anonymous and coded. This data will not be used for any other study. All information which is collected about you during the course of the research will be



kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised. You have the right to check the accuracy of data held about you and correct any errors. Data is required to be kept for ten years following the study, however this will be kept in a locked filing cabinet and will remain confidential, while audio files will be destroyed following transcription.

**What will happen to the results of the research study?**

Results from this study may be published in a journal, however there will be no identifying information within the reports. It is hoped that results, and anonymous quotes, may be used to develop a short headline brief for families accessing the services in the future. Results will also be presented to staff working in the service.

**Who is organising and funding the research?**

This research project is funded by Canterbury Christ Church University.

**Who has reviewed the study?**

*All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NHS Research Ethics Committee.*

*You should keep this information sheet and you will be provided with a signed consent form to keep.*

*Date:                      Version*

**Further information and contact details**

*If you would like to speak to me and find out more about the study or have questions about it answered, you can e-mail me on [Eleanor.taylor2@nhs.net](mailto:Eleanor.taylor2@nhs.net) and leave a contact number so that I can get back to you.*

You should discuss your participation with your family and decide together whether you would like to participate.

## Young Person Information Sheet



Ref: 13/LO/0262 Version 2 20.11.12

### **Information about the research**

#### **Ex-Military families' experience of systemic family therapy.**

My name is Eleanor Taylor and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to participate, it is important that you understand why the research is being done and what it would involve for you.

You might find it useful to discuss this study with your family or others and decide together if you wish to take part.

#### **What do we want to find out?**

We would like to try and understand your experience, and your family's experience of family therapy.

#### **Why have I been invited?**

You and your family have been invited to take part in this study as you have experienced family therapy in the Military Veterans' IAPT Service. Approximately eight families will be invited to take part in this study and share their experiences of family therapy.

#### **Do I have to take part?**

No. If you do not want to take part you do not have to. If you are not sure about taking part, take your time to decide. You might find it helpful to talk to your parents.

#### **What will happen to me if I take part?**

I will ask you to talk to me about your experience of family therapy. It will take about an hour and I might want to meet with you on two different days. There are no right or wrong answers to any questions, I am just interested in what you have to say. I hope you will find it interesting taking part.

#### **What if you start to feel upset?**

I will try to make you feel comfortable with the questions I ask you. If there is anything you do not want to answer, you do not have to. If you feel upset you should tell me or your family.

#### **Can you change your mind about taking part?**

You can change your mind at any time. If you no longer want to take part you can just let me or your parents know.

#### **Will we tell anyone what you say?**

No names will be used when the report is written so nobody will be able to know what you have said; but if you say anything that might make me think that you or another child is at

risk of being harmed, I will have to talk to someone about it to make sure that you are safe. If this happens, I will talk to you first and explain what will happen.

**What happens when the research ends?**

You will be sent a summary of a written report.

If you would like more information please email me at [Eleanor.taylor2@nhs.net](mailto:Eleanor.taylor2@nhs.net)

**Consent Form**



Ref: 13/LO/0262 Version 2 20.11.12

Centre Number:  
 Study Number:  
 Participant Identification Number for this study:

**CONSENT FORM**

Title of Project: Ex-Military families' experience of systemic family therapy.  
 Name of Researcher: Eleanor Taylor

**Please tick box**

- 1. I confirm that I have read and understand the information sheet dated.....  
 (version.....) for the above study. I have had the opportunity to consider the  
 information, ask questions and have had these answered satisfactorily.
  
- 2. I understand that my participation is voluntary and that I am free to withdraw at any  
 time without giving any reason, without my medical care or legal rights being affected.  
 Any data collected up to the point of withdrawal may still be used unless I ask for this to  
 be destroyed.]
  
- 3. I understand that Eleanor Taylor, Dr Alan Barrett and Dr Michael Maltby  
 (Supervisors), may look at relevant sections of confidential material and data collected  
 during the study. I give permission for these individuals to have access to my data.
  
- 4. I agree to interviews being audiotaped.
  
- 5. I agree to my audiotape being transcribed by an independent person bound by a  
 confidentiality agreement.
  
- 6. I agree that anonymous quotes from my interview may be used in published reports of  
 the study findings.
  
- 7. I agree to take part in the above study.
  
- 8. I agree for my child to participate in the above study.

Name of Veteran \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Name of Family Member \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Name of Person taking consent \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

## Appendix Five – Narrative Interview Guide



Salomons Campus at Tunbridge Wells

Ref: 13/LO/0262 Version 1 15.7.12

### Semi-Structured Interview Schedule

I would like to speak with you about your experience of being in the military and how you manage this within your family. I would also like to ask you about your experience of family therapy.

- Can you tell me about your family?
  - Can you tell me about the roles in the family?
  - How have your relationships developed throughout your military experience?
  - Have you noticed any changes within your relationships since leaving the military?
  
- Can you tell me about the difficulties your family experienced?
  - How would you describe the difficulties?
  - How do you think these difficulties started?
  - How did your family manage these difficulties prior to family therapy?
  
- How did you decide to access family therapy?
  - What were your views about accessing family therapy?
  - What were the views of other family members ?
  - How, if at all, were these views thought about and discussed?
  
- What were your expectations of family therapy?
  - Did you have any hopes or fears?
  
- Can you tell me about your experience of family therapy?
  - When did you start therapy?
  - How long did you receive family therapy?
  - Has family therapy brought about any changes within your family?
    - If so, what changes have you noticed?
  - Was there anything you found helpful?
  - Was there anything you found unhelpful?
  
- How was the military culture addressed within family therapy, if at all?
  - Did family therapy fit in with your cultural beliefs of being an ex-military family?
    - If so how, if not why not?
  
- Is there anything you would like to tell me about your experience of being an ex-military family receiving family therapy that I have not asked you

### Appendix Six – Participant Outcome Measures

Veteran Outcome Measures Pre and Post Intervention

<b>Participant</b>	<b>PHQ-9 Scores Pre- intervention</b>	<b>PHQ-9 Scores Post- intervention</b>	<b>Statistically Reliable Change (<math>\geq 6</math>)?</b>	<b>GAD-7 Scores pre- intervention</b>	<b>GAD-7 Scores Post- intervention</b>	<b>Statistically Reliable Change (<math>\geq 4</math>)?</b>
Tim	16 (Caseness)	10	Yes	17 (Caseness)	5	Yes
Jack	21 (Caseness)	10	Yes	16 (Caseness)	14 (Caseness)	No
Martin	22 (Caseness)	15 (Caseness)	Yes	15 (Caseness)	9 (Caseness)	Yes
David	12 (Caseness)	9	No	10 (Caseness)	7	No
Tommy	19 (Caseness)	3	Yes	17 (Caseness)	1	Yes

## Spouse Outcome Measures Pre and Post Intervention

<b>Participant</b>	<b>PHQ-9 Scores Pre- intervention</b>	<b>PHQ-9 Scores Post- intervention</b>	<b>Statistically Reliable Change (<math>\geq 6</math>)?</b>	<b>GAD-7 Scores pre-intervention</b>	<b>GAD-7 Scores Post- intervention</b>	<b>Statistically Reliable Change (<math>\geq 4</math>)?</b>
Julie	11 (Caseness)	17 (Caseness)	No	13 (Caseness)	12 (Caseness)	No
Sharon	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Lorna	6	Unknown	Unknown	7	Unknown	Unknown
Sophie	8	3	No	4	3	No

## **Appendix Seven –Example of Data Analysis**

### **Labov's Structure and Code Development**

The following structure from Labov (1972) was implemented for each transcript and used to highlight important relevant aspects of the narrative for each research question.

Abstract (A) – A brief summary of the narrative

Orientalton (O) – Provides detail such as who, when, where (usually near the beginning)

Complicated Action (CA) – The core narrative of the story

Coda (C) – Signals coming to the end of a story, or turning point.

Resolution (R) – The end of the narrative



vets start with time served?

MARTIN

Participant 005 19<sup>th</sup> July 2013

I: Erm, Okay so I would just like it please if you could just tell me about your experience of being an ex-military family, okay, and your experience of family therapy. So that is all of the events that have been important to you up to now really.

005: Okay

I: Erm, you can begin wherever you like and take your time, we have got as much time as you would like. First of all I will just be listening so I won't interrupt you...

005: Okay

I: ...at all. I might take a few notes which I might ask you about after you have told me about your experiences if that's okay.

005: Okay

I: So yeah, just start wherever you're happy...

I: Erm... I served for twenty-two years in the Army, in the British Army, erm, when I came out of the Army everything was fine although I was quite stressed about coming out, er, no job, no house, er, five children, erm...but I eventually I got sorted, I got a job, I got a good job, I got erm, I got a nice house and everything else. Erm, but I started experiencing problems with my family life, erm, that eventually led to the break up of the marriage, erm, three of the children were still quite young when I started experiencing problems, issues and everything else, erm, I don't know, I thought there was something wrong with me or something like that, I don't know really, and then you know, I've seen a program once and I've seen some advertisements and other things about the veterans service, and er, I thought, I wonder if it was my Army service that you

Long service history  
stressed leaving Army.  
No job/house, dependent children.  
Eventually got job/house.  
family problems.  
marriage/relationship breakdown.  
Young dependent children.  
Something wrong with me.  
Adverts for veteran service.  
Linked service to problems.

MARTIN

A know, had caused, you know, a factor in my marriage breaking up. Erm...so I went to seek some help eventually, it took a long time, probably ten years after I came out the Army. Er, I went, I got some counseling from the veterans service, a feila called (Clinical Psychologist Name) Dr (Clinical Psychologist Name) and er, I had counseling for twelve months and that helped tremendously, but erm, the issues I was having, I was a single parent by this time, erm, my wife was from Northern Ireland, I met her over there, I did ten years service in Northern Ireland altogether, erm, and er, I met her when I was over there, so the five children I had with the same lady, and er, then my marriage split up, my wife went back to live in Northern Ireland and I was, I was, I had the five children, you know they're my children, I looked after them, I was still working full time, erm, there were a few issues and arguments and one of my older daughters, she went to live with her mother and then some of the younger children went to their mother, some came back, it was backwards and forwards, it was just chaotic to be honest with you, it was awful. Erm...and er...I sought some help like I said, I went to see (Clinical Psychologist Name) from the veterans service, and had some counseling for the best part of twelve months really, and I found that really really helpful, you know, some strategies put in place, erm...but that was sort of centred on me and my issues, some from childhood, really that had manifested itself I suppose, I don't know...erm...I mean I enjoyed my life in the Army, I had an absolutely great time, you know there were some bad times but you don't seem to remember them] but it was a way of life for twenty-two years and er, and then I struggled you know when I came out, I would get stressed out and things like that. Erm, I maintained...I tried to maintain this happy sort of, you know, tough...not tough guy, you know but I can deal with anything sort of approach

Service linked to relationship breakdown.  
 Long time to eat for help.  
 Individual therapy helpful.  
 Single parent  
 Met wife while deployed.  
 Relationship breakdown.  
 Located after dependent children.  
 Arguments with daughter.  
 Chaotic family.  
 Individual therapy helpful.  
 Centred on individual issues.  
 Enjoyed time in Service.  
 Way of life  
 Struggle leaving Army.  
 Army tough guy perception/front

and er...er...really struggled with the marriage breakup, I come from a very loving family myself, you know very strong sort of...family...orientated erm ...you know family comes first, you know and it has always been like that with me but erm, so when my marriage broke up I really took it hard. And er, I struggled, I struggled with the children and the family life, erm, with my children, they tend to be suffering as well, especially with one of my girls, erm, my girl who lives with me now she is sixteen, she was suffering at school, erm, and I had all this counseling with (Clinical Psychologist Name) and erm, from the veterans service, and I asked (Clinical Psychologist Name) if there is anything, any help I could get for families, you know and he said yeah, and he referred me to one of the family therapists, and erm, so we went alone, myself and my daughter, my sixteen year old and my twenty two year old, my eldest daughter, she lives with me as well, came along with us just for support really because Holly was very apprehensive about going, as I was you know...

I: Mmmmm  
005: ...erm...and er we had, erm, some sessions with the family therapist and the therapist herself was lovely and I thought she was really good, but there was some issues I wasn't totally happy with. Erm...erm...it wasn't as regular as I would have liked it, and some of that was down to me because I missed a couple of appointments...

I: Right  
005: ...erm...and erm...the place where we had it, it wasn't ideal I didn't think, it was in a Doctors...in my own Doctors surgery but it was right next to the waiting room so I was very conscious, you know when you went in there were people there...

Family background/raising family family comes first.  
Hard marriage breakdown  
struggled with children + family life.  
Children suffering.

Asked for help for family

Veteran and two daughters

Daughter + veteran apprehensive about going.

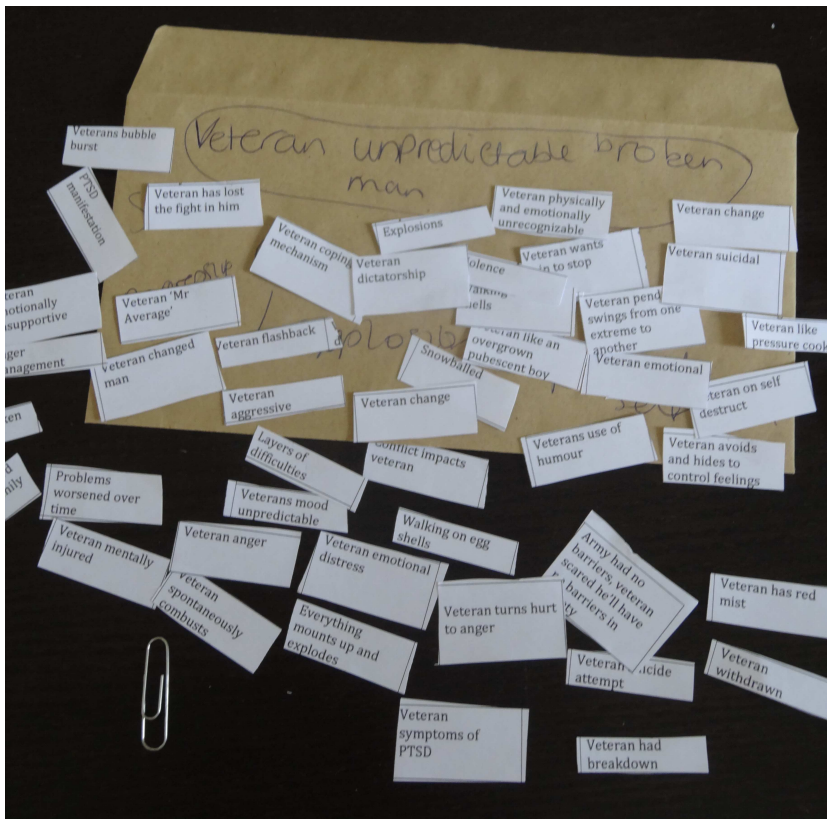
Family therapist helpful/nice.

Some things unhappy with.  
- Not regular sessions.  
missed appointments / share blame.

Location of therapy unhelpful.

conscious of confidentiality.

## Theme Development



**Appendix Eight – Literary Narrative Data (Adapted from Colbert, 2010)**

<b>Participant</b>	<b>Characters</b>	<b>Tone</b>	<b>Core Narrative (Summary)</b>	<b>Genre</b>	<b>Positioning Participant's hope for telling the story</b>	<b>Turning point</b>
Julie (Spouse)	<ol style="list-style-type: none"> <li>1. Julie (Victim)</li> <li>2. Julie (Outsider)</li> <li>3. The Old Tim</li> <li>4. Tim - overgrown pubescent boy</li> <li>5. Children</li> <li>6. Depression</li> </ol>	<p>Tired/Exhausted            Hopeless            Disappointed            Fed Up            Deflated</p>	<p>Felt like single parent caring for an extra child. Family therapy helpful to open conversation. Disappointed ended prematurely</p>	Tragedy	Emphasize difficulty for the family living with veteran.	<p>Engaging with family therapy.            Family therapy ending prematurely.</p>
Tim (Veteran)	<ol style="list-style-type: none"> <li>1. Tim (old self)</li> <li>2. Tim (changed man)</li> <li>3. Julie (Heroin)</li> <li>4. Elephant in the room</li> <li>5. Harry</li> <li>6. Suicide</li> </ol>	<p>Matter of fact            Regretful            Darkness            Vulnerability</p>	<p>Everyone needs help at some point, its part of team work. Family therapy helpful to see others views</p>	Romance	<p>Help audience realise asking for help is not weak.            Importance/uniqueness of ex-service personnel</p>	<p>Starting to see changes.            Therapy ending prematurely.</p>
Julie & Tim	<ol style="list-style-type: none"> <li>1. Family therapy</li> </ol>	Quietly positive	Family therapy	Romance	Tim: family therapy is	Being able to talk to

Jack	<ol style="list-style-type: none"> <li>1. Jack (old self)</li> <li>2. Jack (changed man)</li> <li>3. Sharon (breadwinner)</li> <li>4. Sarah (family therapist)</li> </ol>	<p>Mixture of ashamed and hopeful</p> <p>Passionate</p>	<p>Conflict of emotions from violence towards partner, dissociation.</p> <p>Encouraged because of improvement so far.</p>	Tragedy	<p>Hopeful things are changing for the positive.</p> <p>Trying to understand his violence although unable to remember.</p> <p>Trying to convince audience he is not at fault – e.g. violence &amp; unemployment.</p>	<p>Accessing veterans services</p> <p>Getting short term work.</p> <p>Seeing small improvements in self</p>
Sharon	<ol style="list-style-type: none"> <li>1. Invisible Sharon</li> <li>2. Strong Sharon</li> <li>3. Changed Jack</li> <li>4. Violent Jack</li> <li>5. Bull</li> <li>6. Sarah (family therapist)</li> </ol>	<p>Insidious</p> <p>Disappointed</p> <p>Angry</p> <p>Upset</p>	<p>Families are forgotten about. You don't know what goes on behind closed doors.</p> <p>Services turn you away.</p>	Tragedy	<p>Trying to encourage audience to remember the families.</p> <p>Hoping for services to take note of families.</p>	<p>Veteran agreeing to access veteran service and seek help.</p>
Jack & Sharon	<ol style="list-style-type: none"> <li>1. Military</li> <li>2. Public</li> <li>3. Ex-military friends</li> <li>4. Old Jack</li> <li>5. Old Sharon</li> </ol>	<p>Disappointed</p> <p>Determined</p> <p>Insistent</p>	<p>Lack of support coupled with stigma which is a big problem</p>	Tragic Romance	<p>Highlighting the lack of support for veterans and families. Highlighting the need to educate public to reduce stigma</p>	<p>Spouse being turned away when asking for support from military colleagues.</p>

Martin	<ol style="list-style-type: none"> <li>1. Martin</li> <li>2. Holly (youngest daughter)</li> <li>3. Lisa (eldest daughter)</li> <li>4. Sarah (helpful)</li> <li>5. Sarah (unhelpful)</li> </ol>	<p>Positive Reflective Controlled Evaluative</p>	<p>Family therapy helpful although needs to be more regular and in better location. Family benefitted from therapy and have noticeable changes. Military culture is brutalizing</p>	Romance	<p>Trying to change stereotype of soldier/ex-military. Overcome the stigma of seeking help. Improve the nuances of therapy.</p>	Deciding to seek help.
Lorna	<ol style="list-style-type: none"> <li>1. Lorna the hard taskmaster</li> <li>2. David</li> <li>3. Death</li> <li>4. Children</li> <li>5. Military</li> </ol>	<p>Independent Resilient Survivor</p>	<p>Determined and resilient. Will not give up on David. Hard taskmaster for him to encourage change.</p>	<p>Epic Adventure</p>	<p>Wants audience to know veteran struggles and the impact this has on the family with no support</p>	David starting to advise others from what he has learnt in family therapy.
David	<ol style="list-style-type: none"> <li>1. Lorna</li> <li>2. Suicidal David</li> <li>3. Emotional David</li> </ol>	<p>Sadness Shame Deflated</p>	<p>Feels bad for the impact his behaviour has on Lorna and the family.</p>	<p>Sorrowful Tragedy</p>	<p>Wants audience to know the difficulties he experiences and the lack of support available.</p>	Getting a job.
Tommy	<ol style="list-style-type: none"> <li>1. Anger</li> <li>2. Sarah</li> <li>3. Old Tommy</li> <li>4. New Tommy</li> <li>5. Father</li> </ol>	<p>Excited Unbelievable Insistent</p>	<p>I'm a changed man since family therapy</p>	<p>Romance Adventure</p>	<p>Wants audience to know he is grateful for family therapy for helping him get away from anger</p>	Accessing family therapy and being discharged.

Sophie	1. Veteran (changed man) 2. Children (protection)	Angry Upset Let Down	Family has been let down by the military and 'kicked to the curb'	Sorrowful Tragedy	Wants audience to know that families of veterans are forgotten about and highlight that help is available but it needs to be better advertised.	Finding out help was available.
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## **Appendix Nine – Bracketing Interview Summary (Pre and Post Research)**

How did the research area arise?

A variety of aspects informed my decision to carry out research into ex-military families' experience of family therapy. Firstly the research fair highlighted the different research topics available, which were all interesting however I wanted to do something more personal and interesting to me. I spent time thinking about my other interests along side psychology and how these could be incorporated into a clinical psychology research project. I kept thinking about my involvement in the Air Training Corps, which has included personal experiences of friends joining the military and visits to military bases, working closely with military personnel. Joining the Armed Forces was an alternative route I was previously considering taking myself. One of the reasons I did not want to join the Armed Forces was my close relationship with my family and the impact of deployment and having a career in the military on my family. This led me to think what experiences families of military veterans may have, particularly those veterans who experience psychological distress.

I am aware of recent documentaries and media portrayal of veterans, deployment, military wives, and life after the armed forces including homelessness, criminality and suicide. I am interested to watch these but am cautious when thinking about these, particularly in relation to my project, because of the potential misrepresentation by the media or biased views. I was mindful that I did not want this to influence my views of various aspects of this project, including what it might be like for a veteran or their family, but wanted to be aware of the importance of conducting research in this area.

One area that may have been influenced by the media was my expectation that PTSD would be more prevalent in the veteran population. I was surprised to learn through doing the literature review that psychological difficulties experienced by veterans mirrors that of UK population. This had led me to think about any other assumptions I may have.

One assumption I had was that relationships were likely to have formed prior to joining the forces or during the service personnel's early career rather than forming a relationship after leaving the Armed Forces. This led me to notice my assumption that any changes in relationship would be due to the family having to adjust to military life and reintegration rather than only adjustment to leaving the military.

I expected the majority of participants would be male but hoped to have a mixed group for the research project.

I was unsure how much of the veterans military experience would be shared during interviews and if veterans would share graphic detail about their time on deployment. This tied in with my expectation, and possibly a stereotype, that military veterans would be unlikely to demonstrate much emotion and I wondered how this might influence the narratives.

My initial thoughts when thinking about the research area was that family therapy probably would be experienced as helpful but I was interested in the unique military aspect. I wanted

to ensure that my expectations of family therapy probably being experienced as helpful did not influence my interpretation of results and narratives and therefore thought of ways to overcome this. One was keeping a reflective diary and being aware of my expectations, along with involving independent second coders to help discuss and develop themes. The independent coder and my supervisor did not have any direct knowledge or experience of the military culture and therefore were able to offer an independent perspective during discussion of codes and themes.

How has my personal experience of forces influenced my research? In some respects it has been helpful because of the military language/jargon used, which I could understand and therefore did not have to interrupt narratives. I think having an understanding of the military culture and experience of this culture has enabled me to connect a little more with participants and their experience. A direct experience of some of the stereotypical views and beliefs within the military has allowed me to remain mindful of the culture, whilst ensuring it did not influence my interpretation of narratives.

## **Appendix Ten – Reflective Research Diary Extracts**

### *December 2011 – Research Fair*

The research fair was really interesting, it is incredible to see the range of research opportunities available and the passion some of the supervisors have. This has really inspired me to pursue an area that really interests me, I think this would be very important to keep me focused and interested throughout the three years. Slightly overwhelmed as to where to begin when picking the topic area, particularly as it is so early on in the training.

### *May 2012 – MRP Proposal Submission*

Completing the MRP proposal has been slightly more challenging than I had anticipated. Trying to articulate the research question, which I have composed from a brief reading of some relevant literature, has been difficult but I got there with the support of my supervisor. Although I feel confident with the topic area, I am not sure I feel confident enough to discuss the analysis method at this point at the review panel.

### *June 2012 – MRP Proposal Review*

The review board was the most challenging part of the course so far. It really highlighted to me just how much in depth understanding of the area I needed before I actually started the research. I found it particularly difficult to answer questions about the analysis and approach. During discussion we realized this was because IPA was not an appropriate method for the research question I had proposed. Although this was a very helpful experience, it was also very difficult and the thought of having to resubmit my proposal was unnerving at this early stage. Through discussion with my supervisor, this was reworked and resubmitted. The relief when it was approved was a welcome feeling.

### *October 2012 – Literature Search*

The start of the literature review felt daunting. The challenge of working out which databases to search, ensuring the search terms were appropriate and that papers were stored and documented clearly were just some of the difficulties I faced. I soon realized organization was a key aspect of this part of the research project to ensure no relevant papers were missed and all were referenced correctly. I took a ‘little but often’ approach to this section in order to maintain my focus, notice some progress and not lose track of what I had done. This appeared to be helpful and kept my mind fresh on the research project. This was an aspect of the project I knew would run throughout.

### *December 2012 – Ethics Committee Panel*

Finally, the date for the ethics panel arrived. I had struggled to make progress with the online ethics form, which seemed excessively long and repetitive. I found myself putting off completing the ethics form for several weeks and soon realized this was not going to be a helpful approach and that it was only myself I was potentially causing a problem for. When I finally focused to complete the form it was a long and arduous process but nowhere near as difficult as I had made out. My supervisors were encouraging in this process. I decided to attend the ethics panel in person as I thought it would be a good learning experience. I had not expected to be greeted by over twenty-two members of the panel and found this a little daunting. I was soon made to feel at ease and the questions the panel asked seemed reasonable. It was a thought provoking discussion throughout the meeting. I noticed my confidence increase throughout the meeting and felt encouraged that I was able to discuss the project in depth and answer their questions. I was pleased that there were just minor amendments prior to the approval being given.

### *June/July/August 2013 – Data Collection*

My first trip away for data collection and I have mixed feelings. As I sat waiting for the first participants to arrive I noticed myself becoming very nervous and doubting the narrative guide I had put together. I reviewed it and re-read some of the narrative interview literature whilst waiting which reassured me. I felt organized with everything else, like ensuring I had spare batteries for the audio-recorder and the consent forms and information sheet were ready. When the participants arrived I explained how the individual interviews would take place followed by the family interview. Proceeding with the interviews was a relief to actually have some data collected. I noticed myself finding it difficult not to interrupt initially but persevered and allowed the participant to tell their story before asking them follow up questions. The first participant found it difficult to continue telling their story freely and asked for a little more structure, whereas the second participant did not have any problems with telling their story. The couple interview was very short and the couple found it difficult to think of anything else to add from their individual interviews. I was slightly concerned at this point that the rest of the couple interviews would be similar and wondered what I could do to extend this.

Although there were seven participants lined up for this week, by the end of the week only five were completed, as two participants did not turn up to their scheduled interviews. I found this both frustrating and concerning. I had travelled a long way to complete the interviews and they had been arranged for some time and confirmed. Although I understood that this could happen and that participation was entirely voluntary, it was frustrating that they had not cancelled in advance.

The second trip felt more comfortable. Although I was eager to gather data for the rest of the participants, I had a better idea of how the interviews were likely to run and the sorts of questions to be asking. I recall being struck by each and every narrative I heard throughout the data collection, over the two visits. These stories were filled with emotion and were real life experiences, not an edited documentary or television series but real life. I was struck by the amount of emotion in each story and I recall being a little surprised when some of the veterans showed their emotion. Their stories were so moving and understandably emotional, however the way many of them spoke about having to be ‘the tough guy’ or ‘big and strong’ made me believe it was unlikely that much emotion would be shared. This experience really highlighted how wrong assumptions can be and reminded me of my bracketing interview, which enabled me to remain mindful.

It was helpful to stay away for the data collection as it allowed me to get a head start on the transcribing. I used the time in the evenings and between interviews to transcribe and listen to previous interviews.

### *September/October 2013 - Transcribing*

Although I had started the transcribing whilst away completing data collection, this took a significant amount of time, far longer than I had anticipated and therefore needed to be continued. I adopted the ‘little but often’ approach to this task too in order to again maintain focus and see progress. I ensured I had an up to date timeline in order to make sure I had enough time to then analyse the data and complete the write up. Although this task took a long time, it was a helpful way to immerse myself in the data and really get to know the participants stories.

*October 2013 – ‘Voices of Veterans’ Conference.*

I attended a conference/work shop presented by military veterans working for a charity. The conference was extremely emotive with very personal stories being shared. One of the presenters frequently became upset during his presentations, however ensured us that he had come to terms with showing his emotions and felt comfortable doing this in front of other people, where in the past he had not. This led me to think about my assumptions prior to setting out on the research project about whether military veterans would be likely to share their emotions. It has led me to think about the various stages a veteran may be at during their life which at times may involve feeling able to share their emotions, and at other times being unable to. This conference encompassed various debates about the mental health of veterans and I found my confidence increase, as I was able to take a position in some of these debates based on my experience of interviewing veterans and spouses, as well as completing a literature search. I noticed myself at times feeling uneasy about sharing my views as many of the delegates were also military veterans and had a much more direct experience.

*January 2014 - Analysis*

I found this aspect of the research difficult to get started. I was fearful that I might do something wrong and therefore continued to read and re-read literature about narrative analysis. I had numerous conversations with my supervisor throughout the lead up to analysis where we discussed the creativity involved in the analysis process and the importance of having some confidence in what I was going to do. Once I had decided the process of analysis and got started, the flow of analysis kept me going. I immersed myself in the data and decided to do the analysis by hand. This allowed me to move things around and compile the codes into relevant themes. Initially I found it difficult to implement Labov's structure to the narratives but this soon became easier with practice and proved useful for later parts of the analysis and working out which aspects of their stories formed the core narrative.

*February/March 2014 – The write up*

Once the analysis was complete I started writing up the research project. Although I had been looking forward to this I was also apprehensive. When I started writing I was pleased the flow continued and allowed me to get a draft of the write up completed ready to send to supervisors for feedback. This stage was a big relief and satisfying although also a little overwhelming. The end of the research project was fast approaching and although this was exciting it was also quite anxiety provoking.

**Appendix Eleven – Sample Transcript**

*This has been removed from the electronic copy*

## Appendix Twelve – Summary Report to NHS Ethics Committee

### DECLARATION OF THE END OF A STUDY

(For all studies except clinical trials of investigational medicinal products)

*To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research (“the main REC”) within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.*

#### 1. Details of Chief Investigator

Name:	Eleanor Taylor
Address:	
Telephone:	xxxxxxx
Email:	Ert8@canterbury.ac.uk
Fax:	

#### 2. Details of study

Full title of study:	Ex-military families’ experiences of family therapy: A narrative approach
Research sponsor:	Canterbury Christ Church University
Name of main REC:	xxxxx NHS Trust
Main REC reference number:	xxxxxxxxxx

#### 3. Study duration

Date study commenced:	18 <sup>th</sup> May 2013
Date study ended:	28th March 2014
Did this study terminate prematurely?	<b>No</b> <i>If yes please complete sections 4, 5 &amp; 6, if no please go direct to section 7.</i>

#### 4. Recruitment

Number of participants recruited	9
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Proposed number of participants to be recruited at the start of the study	12
If different, please state the reason for this	Several potential participants did not want to participate. Some potential participants were difficult to contact and therefore were unable to be recruited.

### 5. Circumstances of early termination

What is the justification for this early termination?	This was not early termination, the pool of participants were exhausted and sufficient data had been collected.
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### 6. Temporary halt

Is this a temporary halt to the study?	<i>No</i>
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

### 7. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	None.
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### 8. Final report on the research

Is a summary of the final report on the research enclosed with this form?	<i>Yes</i> <i>If no, please forward within 12 months of the end of the study.</i>
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### 9. Declaration

Signature of Chief Investigator:	
Print name:	
Date of submission:	



## **End of Study Summary Report**

The above study was completed on the 28<sup>th</sup> March 2014 and I write to you with a summary.

The study aimed to explore ex-military families' experience of family therapy through the following research questions.

1. What stories do individuals in an ex-military family tell about their experience of family therapy?
2. What meta-narrative occurs from ex-military families' experience of family therapy?
3. What is the perceived impact of the experience of family therapy on familial relationship functioning?

A literature review highlighted a lack of research into the experiences of military veterans and their families of family therapy.

A narrative methodology was used for both the data collection and data analysis allowing for participants to share their individual experience of family therapy whilst exploring the cultural context of being an ex-military family.

Approval for this research was sought from the NHS research ethics committee and the local Research and Development committee. The British Psychological Society 'Code of Ethics and Conduct' (2009) was also adhered to. Participants were recruited using purposive sampling from a Military Veterans Increasing Access to Psychological Therapies (MVIAPT) service which is a pilot service offering psychological therapies specifically for military veterans and their families. Veterans who had received and completed family therapy were sent an invitation to participate and an information pack.

Narrative interviews were conducted with five veterans and four spouses, with two couple interviews following individual interviews. The majority of interviews lasted between 25 minutes and 140 minutes.

Interviews were transcribed verbatim and read several times whilst the audio recordings were listened to. Once each transcript had been analysed individually, the veteran transcripts were analysed together to highlight dominant themes, the spouse transcripts were analysed together to highlight dominant themes and couple interviews were analysed together. This allowed the researcher to understand the individual experiences as well as the experiences of the veterans as a group and the spouses as a group to see if there were any similarities or differences in the narratives.

Main findings included the shared narrative suggesting family therapy was experienced as helpful with an improvement in familial relationships, improvement in communication and gaining an alternative perspective for both the veteran and spouse.

The sample of participants were all male veterans and female spouses which may limit the results as it is possible that female veterans and male spouses would have a different experience and may relate differently to the various aspects of military culture, beliefs and family therapy. It should also be acknowledged that the length of time served and length of time since leaving the Armed Forces varied significantly.

A minority of narratives touched on some improvements that could be made to family therapy, however these improvements were generally 'glossed over' with a more positive statement about how family therapy had been helpful. It is possible that participants, and particularly veterans, did not want to appear ungrateful for the service they received and therefore wanted to speak more positively about it. It is also possible that veterans believed offering constructive feedback or criticism is inappropriate, or not their place, given that the military culture does not typically place value on constructive feedback from serving personnel who are expected to follow commands. It is possible their spouse may not have been impacted so much by this culture and therefore more able to offer this feedback.

A majority of the veterans had experienced individual therapy which they thought had been helpful, however suggested that this would be more beneficial alongside the family therapy as it allowed their relationships to improve. This is something that spouses agreed with, suggesting that family therapy might be helpful alongside individual therapy where the veteran is able to talk about things he is not ready for the family to hear yet.

Please feel free to contact me if you require any additional information.

Yours sincerely,

Eleanor Taylor  
(Trainee Clinical Psychologist)

## Appendix Thirteen - Participant Summary

Dear Participant,

I would like to thank you for participating in the 'ex-military families' experience of systemic family therapy' project. Your participation was greatly appreciated and I would like to inform you of the findings of this study.

The study aimed to explore ex-military families' experience of family therapy through the following research questions.

1. What stories do individuals in an ex-military family tell about their experience of family therapy?
2. What meta-narrative occurs from ex-military families' experience of family therapy?
3. What is the perceived impact of the experience of family therapy on familial relationship functioning?

A key finding from the study was that veterans, spouses and couples all spoke about family therapy being helpful for them and their family but for a variety of reasons including improved communication, having a safe environment to talk and gaining a shared perspective and understanding. All groups felt like there was a lack of support from the military, NHS, tertiary services and their social network.

All groups also spoke about the military culture, for the veteran group, the military culture appeared to be a way of understanding their current beliefs, attitudes and behaviours. They also spoke more positively about their experience of the military culture, experiencing it as a way of life and frequently describing the military as their extended family. The spouse group appeared to describe the military culture as a more negative part of their narrative as they talk about the way the military culture can be brought into, and negatively impact on, their home life.

Main findings included the shared narrative suggesting family therapy was experienced as helpful with an improvement in familial relationships, improvement in communication and gaining an alternative perspective for both the veteran and spouse.

A minority of narratives touched on some improvements that could be made to family therapy, however these improvements were generally 'glossed over' with a more positive statement about how family therapy had been helpful.

Please feel free to contact me if you would like any additional information or to discuss these findings further.

Yours sincerely,

Eleanor Taylor

(Trainee Clinical Psychologist)

## Appendix Fourteen – Submission Guidelines for Journal of Family Psychology

Journal of Family Psychology® offers cutting-edge, groundbreaking, state-of-the-art, and innovative empirical research with real-world applicability in the field of family psychology. This premiere family research journal is devoted to the study of the family system, broadly defined, from multiple perspectives and to the application of psychological methods to advance knowledge related to family research, patterns and processes, and assessment and intervention, as well as to policies relevant to advancing the quality of life for families. Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

### Submission

Please submit manuscripts electronically, either using Microsoft Word (.doc) or Rich Text Format (.rtf) via the Manuscript Submission Portal.

If you encounter difficulties with submission, please email Larisa Niles-Carnes at the Editorial Office or call 404-616-2897.

General correspondence with the journal should be addressed to:

Nadine J. Kaslow, PhD, ABPP Editor, Journal of Family Psychology Emory University  
School of Medicine Department of Psychiatry and Behavioral Sciences Grady Health  
System Room 13D018 80 Jesse Hill Jr. Drive NE Atlanta, GA 30303

In addition to addresses and phone numbers, please supply fax numbers and email addresses for potential use by the editorial office, and later by the production office.

Keep a copy of the manuscript to guard against loss.

### Article Requirements

For general guidelines to style, authors should study articles previously published in the journal.

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

The manuscript title should be accurate, fully explanatory, and preferably no longer than 12 words. The title should reflect the content and population studied (e.g., "family therapy for depression in children"). If the paper reports a randomized clinical trial, this should be indicated in the title, and the CONSORT criteria must be used for reporting purposes.

Research manuscripts and review and theoretical manuscripts that provide creative and integrative summaries of an area of work relevant to family psychology should not exceed 30–35 pages, all inclusive (including cover page, abstract, text, references, tables, figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, figures, etc.) must be double spaced. References should not exceed 8 pages.

Brief reports are encouraged for innovative work that may be premature for publication as a full research report because of small sample size, novel methodologies, etc. Brief reports also are an appropriate format for replications and for clinical case studies. Authors of brief reports should indicate in the cover letter that the full report is not under consideration for publication elsewhere. Brief reports should be designated as such and should not exceed a total of 20 pages, all inclusive. References should not exceed 8 pages.

Manuscripts exceeding the space requirement will be returned to the author for shortening prior to peer review.

All research involving human participants must describe oversight of the research process by the relevant Institutional Review Boards and should describe consent and assent procedures briefly in the Method section.

It is important to highlight the significance and novel contribution of the work. The translation of research into practice must be evidenced in all manuscripts. Authors should incorporate a meaningful discussion of the clinical and/or policy implications of their work throughout the manuscript, rather than simply providing a separate section for this material.

#### Masked Review

The *Journal of Family Psychology*<sup>®</sup> uses a masked reviewing system for all submissions. The cover letter should include all authors' names and institutional affiliations. However, in order to permit anonymous review, the first page of text should omit this information. This cover page should only include the title of the manuscript and the date it is submitted.

Please make every effort to see that the manuscript itself contains no clues to the authors' identities.

Please ensure that the final version for production includes a byline and full author note for typesetting.

#### Cover Letter

Authors should indicate in their cover letter that the work has not been published previously and is not under consideration for publication elsewhere. The relationship of the submitted manuscript with other publications and/or submissions of the author, if any, should be explained.

The cover letter should include a statement indicating that the manuscript has been seen and reviewed by all authors and that all authors have contributed to it in a meaningful way.

The cover letter must include the full mailing address, telephone, fax, and email address for the corresponding author.

#### CONSORT Criteria

The *Journal of Family Psychology* requires the use of the CONSORT reporting standards (i.e., a checklist and flow diagram) for randomized clinical trials, consistent with the policy established by the Publications and Communications Board of the American Psychological Association.

CONSORT (Consolidated Standards of Reporting Trials) offers a standard way to improve the quality of such reports and to ensure that readers have the information necessary to evaluate the quality of a clinical trial. Manuscripts that report randomized clinical trials are required to include a flow diagram of the progress through the phases of the trial and a checklist that identifies where in the manuscript the various criteria are addressed. The checklist should be placed in an Appendix of the manuscript for review purposes.

When a study is not fully consistent with the CONSORT statement, the limitations should be acknowledged and discussed in the text of the manuscript. For follow-up studies of previously published clinical trials, authors should submit a flow diagram of the progress through the phases of the trial and follow-up. The above checklist information should be completed to the extent possible, especially for the Results and Discussion sections of the manuscript.

Visit the CONSORT Statement Web site for more details and resources.

#### Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6<sup>th</sup> edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Below are additional instructions regarding the preparation of display equations, computer code, and tables.

#### Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

#### Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

**In Online Supplemental Material** We request that runnable source code be included as supplemental material to the article. For more information, visit [Supplementing Your Article With Online Material](#).

**In the Text of the Article** If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

#### Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table

will create problems when the table is typeset and may result in errors.

#### Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

#### Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

#### References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

**Journal Article:** Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151. <http://dx.doi.org/10.1037/a0028566>

**Authored Book:** Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.

**Chapter in an Edited Book:** Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

#### Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

\$900 for one figure

An additional \$600 for the second figure

An additional \$450 for each subsequent figure

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Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

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unknown.

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See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

Authors of accepted manuscripts are required to transfer the copyright to APA.

### Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.