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PARENTING EXPERIENCES OF MILITARY VETERANS DIAGNOSED WITH POST-TRAUMATIC STRESS DISORDER

Section A: The impact of post-traumatic stress symptoms on parenting amongst ex-military service parents: A systematic review
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Section B: A qualitative exploration of the parenting experiences of ex-military fathers diagnosed with post-traumatic stress disorder (PTSD)
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In memory of my wonderful Dad who was always there for me, teaching me so much about life as we went along; I so wish I could have told you about all of this.

Summary of the Major Research Project

Section A: This section describes a systematic review of the literature exploring the impact of post-traumatic stress symptoms (PTSS) on parenting amongst ex-military service parents. A search of four databases identified 14 studies meeting the inclusion criteria. The literature was synthesised and described within the following areas of parenting; caregiving, satisfaction, competence, stress, mentalising, and the parent-child relationship, with individual and contextual factors reported within these. Methodological critiques, as well as clinical and research implications are discussed.

Section B: This section presents an empirical paper exploring the experience of parenting in ex-military fathers who have received a diagnosis of post-traumatic stress disorder (PTSD). Ten semi-structured interviews were conducted and analysed using interpretative phenomenological analysis (IPA). The analysis resulted in four themes and 10 subthemes relating to the perceived impact of PTSD symptoms on parenting and perception of the self as a parent, a need to protect children from distress and harm, the importance of developing insights and understanding, and the protective influence of children on well-being. Findings are discussed in relation to the extant literature, and clinical and research implications are outlined.

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Section A: Literature Review Paper

The impact of post-traumatic stress symptoms on parenting amongst ex-military service parents: A systematic review

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Abstract

Background: Parental mental health plays a significant role in children's development. There has been growing interest in the impact of parental trauma experiences on parenting and the parent-child relationship. Research suggests that ex-military personnel may be at increased risk of developing post-traumatic stress disorder (PTSD).

Aims: The aims of this review were to explore the impact of post-traumatic stress symptoms (PTSS) on parenting amongst ex-military parents.

Method: Four databases, ASSIA, PsycINFO, PTSDpubs, and Web of Science Core Collection, were systematically searched for studies published between 2016 and present. This date was selected due to recent proliferation of research in this area.

Results: Fourteen studies were included which were critically appraised. A narrative synthesis reported findings under the following parenting domains; caregiving, satisfaction, competence, stress, mentalising, and parent-child relationships. Adverse impacts of PTSS were reported, with PTSS having a direct and indirect effect on parenting. Individual and contextual factors were found to influence this association.

Implications: Clinical implications focus on clinicians supporting and initiating conversations about parenting with ex-service personnel and the potential benefits of systemically informed interventions. A need for qualitative research is highlighted, as well as obtaining the views of children of ex-service parents with PTSD, and further exploration of protective factors.

Keywords: parenting, trauma, ex-military, PTSD, systematic review

Introduction

Parental Mental Health

Being a parent is a multifaceted role influenced by various individual and contextual factors such as culture, community, family, and socioeconomic status (Kotchick & Forehand, 2002). An evolving body of literature has shed light on the significant role that parents and the parent-child relationship play in children's development (van Ee et al., 2016), and within this there has been a growing focus on parental mental health. Current figures indicate that approximately 68% of women and 57% of men experiencing mental health difficulties in the United Kingdom (UK) are parents (Public Health England, 2021).

Over time, the association between parental mental health and adverse child emotional, social, and behavioural outcomes have been well documented (Smith, 2004). Several mechanisms by which parental mental health might impact children have been proposed, including the influence of genetic factors, direct exposure to symptoms, as well as disrupted parenting; for example, parental mental health difficulties have been associated with reduced emotional availability, responsiveness, and stigma (Leinonen et al., 2003; Reupert & Maybery, 2016). Notwithstanding these results, not all children experience adverse outcomes, thus highlighting the role of individual differences as well as protective factors such as social support (Gatsou et al., 2017). Additionally, parenthood has also been described as providing a sense of purpose and motivating engagement in treatment (Evenson et al., 2008).

Trauma and Post-Traumatic Stress

The impact of parental trauma-related distress has garnered much attention in the research literature. Responses to traumatic experiences are thought to be related to how individuals process, appraise, and give meaning to the traumatic experience (see Bisson, 2009, for a comprehensive review). Additionally, responses are influenced by a range of factors including ethnicity, childhood experiences and attachment, past trauma experiences, and social

support (Carlson et al., 2016). For many, trauma experiences can be assimilated without the experience of ongoing distress; however, for others this is more difficult.

Post-traumatic stress disorder (PTSD) is a diagnosis defined by the development of clusters of symptoms related to re-experiencing, avoidance of trauma-related stimuli, negative changes in cognition and mood, and heightened arousal and reactivity, in response to experiencing a traumatic event (American Psychiatric Association, 2013). Symptoms of PTSD can manifest as several psychological and behavioural difficulties, the experience of which is known to vary from person to person. These experiences may include flashbacks, hypervigilance to threat stimuli, feelings of guilt or shame, withdrawal, and irritability or aggressive behaviour (Schnurr et al., 2009).

PTSD is generally considered in relation to the experience of single event trauma (American Psychological Association, 2013), whilst the diagnostic term Complex PTSD (CPTSD) is related to the experience of multiple or chronic traumas. CPTSD encompasses the symptom clusters associated with PTSD, as well as three additional clusters relating to 'disturbances in self-organisation' (DSO; Maercker et al., 2013) namely interpersonal difficulties, affect dysregulation, and negative self-concept.

Relational Impact of Trauma

The controversies surrounding the validity and usefulness of diagnoses as socially constructed phenomenon (Pai et al., 2017), and the risk of diagnoses pathologising human responses to experiences, are held in mind. Nevertheless, trauma sequalae can permeate many aspects of an individual's life, as well as the lives of those around them, and impact functioning in several areas, including family and parental functioning (Christie et al., 2019).

The cognitive-behavioural interpersonal theory of PTSD (C-BIT; Dekel & Monson, 2010) has been applied when considering the influence of PTSD on interpersonal functioning

and relationships. Within this model behavioural avoidance is thought to result in less engagement and shared enjoyment with close others, which in turn results in decreased satisfaction in the relationship. A reinforcing effect may also be experienced when children modify their own behaviour to accommodate, and in turn facilitate, avoidance symptoms. Difficulties with expressing emotions within the relationship are also thought to have a deleterious effect on the closeness of the relationship. Additionally, the model emphasises the role of cognitive processes such as attentional bias towards threat resulting in 'overprotective' behaviours to ensure safety.

The intergenerational impact of parental trauma has also been widely studied. A recent systematic review of outcomes for military children reported that parental PTSD was associated with increased risk of behavioural problems, emotional distress, and the development of children's own post-traumatic stress symptoms (PTSS; Banneyer et al., 2017). Several theories have been proposed to explain this association. The concept of intergenerational transmission refers to the notion that children can be directly or indirectly affected by their parent's trauma through parental over-disclosure, re-enactment, identification, and silence (Ancharoff et al., 1998). The theory of secondary traumatisation (Figley, 1986) posits that as a child offers support by attempting to understand the experiences and feelings of the traumatised parent, they may internalise these experiences and feelings as their own, consequently developing their own trauma symptoms.

Ex-Military Service Parents

The majority of individuals who have served in the military successfully transition to civilian life; however, a proportion leave with, or subsequently develop mental health difficulties, with the prevalence of PTSD reported to be higher in ex-service personnel compared with the general population (Rhead et al., 2022). This finding is considered in relation to research which suggests that it is common for ex-military personnel to have been

exposed to multiple combat stressors as well as pre-military stressors including adverse childhood experiences (Murphy et al., 2019).

In a study by Janke-Stedronsky et al. (2015), veterans with dependent children were found to be 40% more likely to receive a diagnosis of PTSD, even after controlling for demographic variables and other mental health difficulties. The reasons for these findings remain somewhat unclear; however, it has been hypothesised that concerns about family relationship disruption during military service and deployment may be linked with increased PTSS.

Existing Literature Reviews

To date there have been two reviews which have explored the impact of PTSD on parenting amongst parents generally (Christie et al., 2019; van Ee et al., 2016). There have been three reviews exploring the impact of parental PTSD with solely military populations. These reviews have focused on specific conflicts, for example, Creech and Misca (2017) drew samples from parents who had served in post-September 11 conflicts only, or trauma exposures, for example, in their meta-analysis Kritikos et al. (2019) focused on combat exposure and PTSD. A synthesis of the scant qualitative literature exploring the experiences of parental PTSD in military families from the perspectives of the parents themselves, partners, and children was completed by McGaw et al. (2019). The samples of studies reported on in these three reviews included either solely actively serving military parents or combination of active and ex-service parents. It is noted that all reviews reported on the negative impact of PTSD on parenting, with the qualitative reviews also highlighting family strengths including the family being a ‘team’ and the valued role of the parent despite the challenges of a PTSD diagnosis.

Rationale and Review Aims

There has been a proliferation of research exploring the impact PTSS / PTSD in military families in recent years, thus much of this research will not have been captured by the previous reviews. Furthermore, no previous reviews have specifically focused on ex-service parents, with research highlighting that these parents may have unique needs and experiences in comparison to actively serving military parents due to the process of transitioning to civilian life and no longer receiving the same support or structure as they would have had in the military (Creech & Misca, 2017). These findings, together with previous research outlining the potentially deleterious effect of parental PTSS / PTSD on parenting and child outcomes, support the completion of an up-to-date review synthesising the recent literature for ex-military parents. This review therefore aims to answer the following question: what impact does experiencing PTSS / PTSD have on parenting amongst ex-military service parents?

Method

Literature Search

Literature searching and assessment of studies for inclusion in the review were undertaken in line with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) guidelines. Four electronic databases, Applied Social Sciences Index and Abstracts (ASSIA), PsycINFO, PTSDpubs, and Web of Science Core Collection were searched on 15th February 2022 using the search terms outlined in Table 1. These terms were informed by initial internet searches and reading of the existing literature in this area.

Table 1

Combination of Terms Used in the Literature Search

parent* OR mother* OR maternal OR father* OR paternal OR filial
AND
veteran* OR “ex-service*” OR military OR armed forces OR “service member”

AND trauma* OR "post-traumatic stress disorder" OR "posttraumatic stress disorder" OR PTSD OR CPTSD

Initially, no date limits were applied to the search. However, the progression of the literature search revealed a proliferation of relevant research over the previous five to six years, and as such, a decision was made to only include studies that had been published since 2016. This date was also selected as a previous review by Creech and Misca (2017) included literature published up to this date.

After excluding duplicates, titles and then abstracts of the retrieved papers were reviewed against the inclusion and exclusion criteria outlined in Table 2 below. This process was repeated for the resulting full-text papers. Additionally, the reference lists of retrieved relevant review and full-text papers were hand searched to identify any additional papers. This search strategy, as outlined in Figure 1, resulted in 14 studies being included in the review.

Table 2

Study Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
• Qualitative or quantitative peer reviewed empirical studies written in English. • Samples included ex-service personnel (i.e., those no longer serving in the military) who were parents (biological, non-biological, or 'step-parent'). No limits were set on the age of the child as it is acknowledged that the parenting role	• Studies including actively serving personnel. Studies including a mixed sample were included only if results included stratified analysis by ex-service status. • Outcomes focused on 'family' more generally and not specifically related to parenting or the parent child relationship. In line with this, studies with outcomes only measuring the

continues beyond the offspring's childhood and into their adulthood (Holt et al., 2018). In studies where the service status of the parent was ambiguous, the author of the review contacted study authors to confirm ex-service status.

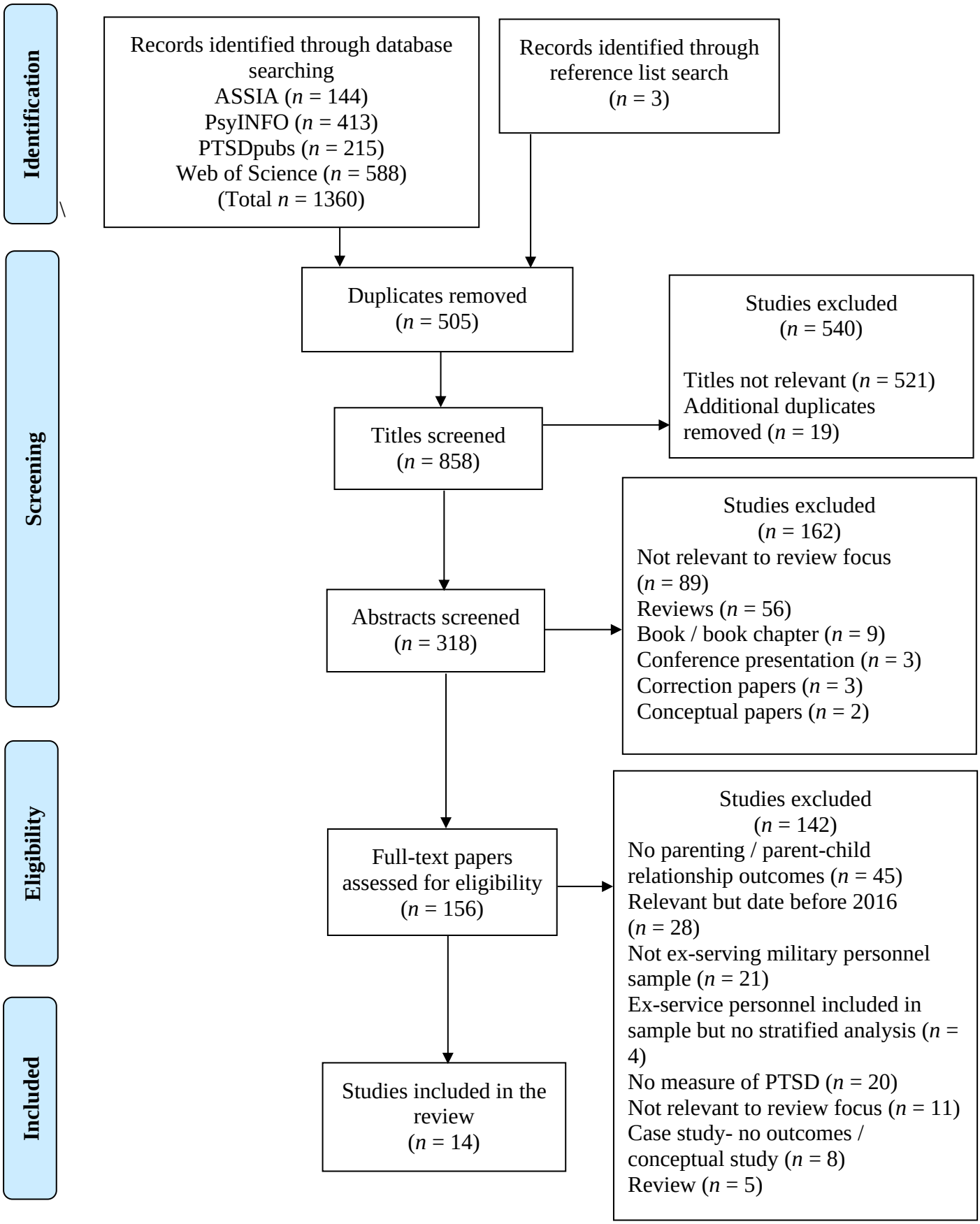
- Studies reporting outcomes related to parenting, including parenting behaviours, experiences of parenting, attachment, and the parent-child relationship, or in the case of qualitative studies, the focus was on parenting. A broad definition was applied here as it is acknowledged that parenting is a multifaceted construct (Christie et al., 2019).
- Studies using a well-established measure of PTSD, such as validated measures, and / or DSM-5 and ICD-10 / ICD-11 criteria.
- Date of publication of studies between 2016 (inclusive) and present.

psychopathology of the ex-service member or their family were also excluded.

- Studies including a description of traumatic experiences but no measure of PTSD. This delineation was made as, though a diagnosis of PTSD is considered a significant psychopathological consequence of trauma exposure, not all individuals who experience trauma go on to develop post-traumatic stress symptoms (Shalev et al., 2019).
- Book chapters, theses, or conference presentations were excluded due to lack of peer-review. Review papers were also excluded.

Figure 1

PRISMA Diagram Summarising the Literature Search



Critical Appraisal

The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was used to guide the quality assessment of the studies included in the review, though it is noted that the critiques presented are not limited to its findings. The MMAT was selected as it was developed for use in systematic reviews which include studies employing various designs, as was the case in this review. Available research indicates that the MMAT is a valid and reliable tool (Hong et al., 2019; Pace et al., 2012). Calculating an overall score is discouraged and instead details in relation to each of the criteria were used to inform quality appraisal. The appraisal process is outlined in Table 3 (see Appendix A).

Structure of the Review

A summary of the 14 included studies is provided in Table 4, with study characteristics described qualitatively below. A narrative synthesis was employed given the heterogeneity of the included studies. Findings are synthesised in terms of parenting domains, grouped together by measures used and qualitative themes described. Methodological and conceptual critiques are presented throughout, and critical evaluation across studies is discussed in further detail in the ‘critique’ section of the review. Finally, clinical and research implications are presented in the discussion.

Table 4

Summary of Included Studies

Study	Country	Aims	Participants	Design	PTSD Measures	Parenting Measures	Key Findings
Bachem et al. (2021)	Israel	To explore the implications of world assumptions (WAs) and post-traumatic stress disorder (PTSD) on marital and parenting relationships in a sample of veterans and their spouses.	*N* = 213 male Israeli combat veterans of the 1973 Yom Kippur War, some of whom were also prisoners of war (*M* age = 57.90) and their wives (*M* age = 58.8). The couples had been married an average of 34.20 years and had an average of 3.23 adult children.	Cross-sectional Utilised data from 2008-2010 data collection stage of a multicohort longitudinal study of Yom Kippur War veterans and their female spouses.	PTSD Inventory (PTSD-I; Solomon et al., 1993) – 17-item self-report measure based on PTSD diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).	Adapted Caregiving Questionnaire (Kunce & Shaver, 1994) – 31-item self-report measure adapted to explore veterans' relationships with their adult children, in particular proximity to them, sensitivity to their needs, co-operation versus controlling caregiving, and overinvolvement in caregiving.	Veterans' PTSD significantly negatively correlated with parenting. World Benevolence Model (WB; belief that world is kind and people are caring): - Veterans' lower scores on WB scale were associated with higher PTSS scores. - Indirect effect of PTSS on parenting via marital adjustment. - Higher post-traumatic stress symptoms (PTSS) were associated with lower positive parenting scores in veterans. This result was not found for wives.

							Self-Worth Model (evaluation of self as good and capable): - Veterans' lower scores on self-worth scale were associated with higher PTSS scores. - Indirect effect of PTSS on parenting via marital adjustment. - Higher post-traumatic stress symptoms (PTSS) were associated with lower positive parenting scores in veterans. This result was not found for wives. No significant effects reported within the Meaningfulness (world is meaningful and just) model.
Creech et al. (2016)	USA	To examine associations between combat exposure, PTSD symptoms,	*N* = 134 female veterans, of which 47.8% (*n* = 64) were mothers, who	Cross-sectional Prospective participants received a	PTSD Checklist (PCL; Weathers et al., 1993) – 17-item self-report measure	Parenting Sense of Competence Scale (PSCS; Gibaud-Wallston & Wandersman,	No significant correlations between PTSD symptom severity and parenting confidence or satisfaction.

		alcohol misuse, and family and relationship functioning.	had been involved in operations in Afghanistan and Iraq (*M* age = 37.11, *n* = 109 White, *n* = 21 Black, *n* = 2 Asian, *n* = 2 Multiracial, *n* = 3 Native American, *n* = 6 Other). Of these, 47.8% (*n* = 64) were a parent / primary caregiver to a child under the age of 18, and 40.3% (*n* = 54) had a child living with them.	letter containing a link to the survey website.	assessing symptoms of PTSD based on the DSM-IV.	1978) – 17-item measure assessing parents' self-reported self-efficacy and satisfaction in their parenting role.	No significant associations in the model examining whether PTSD symptoms accounted for indirect effects between combat exposure and parenting confidence and satisfaction. However, post-hoc analyses suggested mediation models were underpowered and null findings should be interpreted with caution. Instead, increased PTSD symptom severity was significantly associated with decreased family functioning (communication and closeness); however, this measure does not explore parenting specifically.
Creech et al. (2021)	USA	To examine associations between military sexual trauma, stress during pregnancy, PTSD and	*N* = 697 female veterans accessing Veterans Health Administration maternity care benefits. *M* age = 32.3 years,	Cross-sectional Surveys completed via telephone 12 weeks postpartum.	History of PTSD was based on electronic health records and recorded diagnosis using ICD-9 code 309.81	Postpartum Bonding Questionnaire (Brockington et al., 2006) – 25-item self-report measure assessing a mother's	32% (*n* = 223) had been diagnosed with PTSD according to their records. Neither PTSD nor military sexual trauma had direct associations with maternal bonding.

		mother-infant bonding.	59.3% (*n* = 413) white, 39.3% (*n* = 274) non-white, 19.9% (*n* = 139) Hispanic, 67.1% (*n* = 468) married.		(posttraumatic stress disorder) and ICD-10 code (post-traumatic stress disorder)	feelings and attitudes towards her baby in the following areas: impaired bonding, rejection and anger, anxiety about care, and risk of abuse.	Presence of PTSD diagnosis did have a significant indirect association with maternal bonding through the mediation of maternal depression.
Feingold & Zerach (2021)	Israel	To explore whether parental reflective functioning and parental sense of competence moderated the association between post-traumatic stress symptoms (PTSS) and alcohol use disorder (AUD).	*N* = 189 male Israel Defence Forces (IDF) combat veteran fathers (*M* age = 30.03). *M* number of children = 1.86. Eligibility criteria: - Minimum age 20 - Served in combat troops and were released from military service within the previous 20 years.	Cross-sectional Participants responded to an advert about the study. They then received a link to the online survey.	Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2013) – 20-item self-report measure assessing symptoms of PTSD in line with the DSM-5.	Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017) – 18-item self-report measure assessing the parent's mentalising capacity in relation to their child's mental states. Parenting Sense of Competence Scale (PSCS; Gibaud-Wallston & Wandersman, 1978) – 17-item measure assessing	8.9% (*n* = 14) of veterans exceeded the cut-off score of 33 on the PCL-5 for a diagnosis of PTSD. 12.5% (*n* = 20) veterans self-reported fully symptomatic probable PTSD according to DSM-5 criteria. Higher PTSS was significantly associated with pre-mentalising modes, i.e., more difficulty understanding and interpreting their child's experiences and internal world. PTSS was not significantly associated with certainty about child's mental states,

			- Parent of at least one child.			parents' self-reported self-efficacy and satisfaction in their parenting role.	nor interest and curiosity in their child's mental states. Higher PTSS was significantly correlated with lower levels of parental sense of competence.
Franz et al. (2021)	USA	To examine the relationship between neighbourhood cohesion, PTSD, and perceived parental functioning.	*N* = 563 veteran parents (*n* = 94 single black veterans, 73% female; *n* = 87 dual household black veterans, 57% female; *n* = 67 single white veterans, 56% female; *n* = 315 dual household white veterans, 47% female) Age range 22-50 (*M* = 38.92) *M* number of children for whole sample = 2.43	Longitudinal Participants drawn from longitudinal study investigating gender, health, and trauma. Participants received measures in the post and sent these back. Data was collected at Time one (baseline) and Time two (4 months later).	Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2013) – 20 item self-report measure assessing symptoms of PTSD in line with the DSM-5.	Parental functioning scale of the Well-Being Inventory (Vogt et al., 2019) – 5-item self-report measure of perception of functioning as a parent (an example is given of 'effectively disciplining your child') over the previous month.	Dual household white parents reported the lowest PTSD symptom severity when compared with single white parent households and single and dual black parent households. Across groups there was no significant differences in parental functioning. For single black parents, higher PTSD symptom severity was associated with poorer parental functioning, measured 4 months later. These results were not reported for dual household black parents, dual household white parents, nor single white parent households.

			Eligibility criteria: - Completed questionnaires on parenting (administered to parents of children under 18) and PTSD (administered to those identifying a traumatic event) - Identified as black and / or white.				
Goger et al. (2021)	USA	To examine the influence of psychopathology during pregnancy and postpartum on parenting stress and bonding difficulties in women veterans.	*N* = 28 pregnant females initially recruited (*M* age = 31.6, 46.4% Caucasian / white, 17.9% Hispanic, 7.1% African American black, 3.6% Asian American, 25% more than one race/ethnicity)	Longitudinal Measures completed during the third trimester of pregnancy and approximately six weeks postpartum.	Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2013) – 20 item self-report measure assessing symptoms of PTSD in line with the DSM-5.	Postpartum Bonding Questionnaire (Brockington et al., 2006) – 25-item self-report measure assessing a mother's feelings and attitudes towards her baby in the following areas: impaired bonding, rejection and anger, anxiety	Participants did not score in the clinically significant range for PTSD either during pregnancy or postpartum. PTSD was associated with pre- and postpartum psychopathology, but was not associated with parenting stress or bonding difficulties. Instead, postpartum depression was associated with parenting stress and impaired bonding.

	N = 23 mothers took part postpartum (*M* age = 31.3, 47.8% Caucasian/white, 21.7% Hispanic, 21.7% African American black, 0% Asian American, 26.1% more than one race/ethnicity)		about care, and risk of abuse.
	Eligibility criteria: - Pregnant women (up to 38 weeks pregnant). - 18 years old or older. - Completed military service. - Sought healthcare at the Department of Veterans Affairs San Diego		Parenting Stress Index-Short Form (PSI-SF; Haskett et al., 2006) – 36-item self-report measure comprised of three subscales: parental distress, parent-child dysfunctional interaction, and difficult child.

			Healthcare System.				
Levin et al. (2017)	Israel	To explore the reciprocal relationship between both spouses PTSS and marital adjustment, and the impact this has on parental functioning.	*N* = 225 Israeli combat veterans of the 1973 Yom Kippur War (*M* age = 58.62) and their wives (*M* age = 58.28).	Longitudinal Utilised data from 2003 (Time one) and 2008-2010 (Time two) data collection stages of a longitudinal study of Yom Kippur War veterans and their female spouses.	PTSD Inventory (PTSD-I; Solomon et al., 1993) – 17-item self-report measure based on PTSD diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).	Positive parenting measured using the adapted Caregiving in Couple Relationships Questionnaire (Kunce & Shaver, 1994) – 31-item self-report measure adapted to explore veterans' relationships with their adult children, in particular proximity to them, sensitivity to their needs, co-operation versus controlling caregiving, and overinvolvement in caregiving.	Veterans post-traumatic stress symptoms (PTSS) at Time 1 and Time 2 significantly negatively correlated with positive parenting. Veterans PTSS at Time 2, but not Time 1, significantly positively correlate with overinvolvement. Veterans PTSS had no direct effects on positive parenting, but did have an indirect effect via Time 1 marital adjustment, i.e., higher Time 1 PTSS predicted lower Time 1 marital adjustment, which was associated was decreased positive parenting at Time 2.
McGaw et al. (2018)	Australia	To investigate experiences of parenting and	*N* = 11 Australian ex-military veterans	Qualitative	Posttraumatic Stress Disorder Checklist for	N/A – qualitative study.	Five primary themes identified:

family life from the perspective of the veteran parent with PTSD.	(*n* = 9 male, *n* = 2 female, *M* age = 43 years, *n* = 10 Caucasian, *n* = 1 indigenous). Overall, participants were raising one to four children, all with at least one child under 18 living at home.	Each participant engaged in a semi-structured interview with transcripts analysed using thematic content analysis.	DSM-5 (PCL-5; Weathers et al., 2013) – 20 item self-report measure assessing symptoms of PTSD in line with the DSM-5.	Disconnectedness – described a sense of feeling disconnected from family, from parent role, and from community. Transgenerational effects: "Parented by someone with PTSD" – described concerns about the impact of PTSD on children and inappropriate role modelling. "A strong sense of family" – described the family as a team and close knit, sometimes at the exclusion of others, and the strength of partners. PTSD: an umbrella effect – described the pervasive impact of PTSD on all aspects of life, balancing PTSD effects with parenting obligations, and being overprotective and hypervigilant. Services and resources – described what is and is not

							working with access and engagement with services, and what veterans and their families would like.
O'Toole et al. (2018)	Australia	To explore the relationship between veterans' mental health and the emotional climate of the family during their offspring's childhood.	*N* = 197 Australian veteran fathers who had been posted to Vietnam between 1962-1972 and their partners and mother of their child(ren) (*n* = 135). Data was collected from their adult children *n* = 315; of these 57.2% were daughters (*n* = 180, *M* age = 38.2 years) and 42.8% were sons (*n* = 135, *M* age = 38.4 years).	Longitudinal Utilised data from a cohort study of male Australian Vietnam veterans who were interviewed twice, 22 (wave one) and 36 years (wave two) after returning to Australia following being posted to Vietnam between 1962-1972. Data for this study also came from adult children interviewed between 2012-2014.	In wave one: Structured Clinical Interview for DSM-III (SCID; Spitzer et al., 1987) – utilises a semi-structured interview guide for making diagnoses according to the DSM. Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane et al., 1988) – 35-item self-report measure assessing combat-related PTSD in line	Five Minute Speech Sample (FMSS; Gottschalk & Gleser, 1969) – assesses parent-child relationship by asking person to speak about their relative for five uninterrupted minutes. Speech was coded using the Family Affective Attitude Rating Scale (FAARS; Bullock & Dishion, 2004) which consists of both positive (e.g., warmth) and negative (e.g., criticism) attitudes relevant to the parent-child relationship.	PTSD symptoms significantly higher in inconsistent fathers and lowest in warm fathers. FAARS scores from daughters: More ambivalent in their feelings towards their father when the father had PTSD. Father's numbing and avoidance scores significantly positively associated with negative relationship score and significantly negatively associated with daughter's positive perception of them. FAARS scores from sons: No correlations between relationship scores and father's PTSD scores. Attachment: For sons and daughters secure attachment saw the

					with DSM-III criteria. In wave two: Clinician-administered PTSD Scale (CAPS-4; Weathers et al., 2001) – a 30-item structured interview with questions corresponding to the DSM-5 criteria for PTSD.	Childhood attachment measured using a questionnaire developed by Hazan & Shaver (1987) which asked respondents to rate the extent three descriptions – which mapped onto childhood attachment styles of secure, anxious, and avoidant – most resembled their parents' attitudes, feelings, and behaviours towards them growing up.	lowest numbing/avoidance, hyperarousal, and total symptoms. These symptoms were highest in the inconsistent category for sons and highest in the cold and distant category for daughters. For sons, father's PTSD was associated with reduced perceptions of father as warm and responsive, and increased perception of father as inconsistent. For daughters, father's PTSD diagnosis was associated with lower positive relationships scores.
O'Toole (2022)	Australia	To explore the relationship between veterans' mental health and the emotional climate of the family during their offspring's	*N* = 181 Australian veteran fathers who had been posted to Vietnam between 1962-1972. Data was collected from	Longitudinal Utilised data from a cohort study of male Australian Vietnam veterans who were	In wave one: Structured Clinical Interview for DSM-III (SCID; Spitzer et al., 1987) – utilises a semi-structured	Five Minute Speech Sample (FMSS; Gottschalk & Gleser, 1969) – assesses parent-child relationship by asking person to speak about	FAARS scores from daughters: - Father's numbing/avoidance symptoms negatively associated with positive relationship scores.

childhood and whether there were any differences between sons and daughters.	their adult children *n* = 283; of these 57.6% were daughters (*n* = 163, *M* age = 38.2 years) and 42.4% were sons (*n* = 120, *M* age = 38.4 years).	interviewed twice, 22 (wave one) and 36 years (wave two) after returning to Australia following being posted to Vietnam between 1962-1972. Offspring data collected between 2012 and 2014.	interview guide for making diagnoses according to the DSM. Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane et al., 1988) – 35-item self-report measure assessing combat-related PTSD in line with DSM-III criteria. In wave two: Clinician-administered PTSD Scale (CAPS-4; Weathers et al., 2001) – a 30-item structured interview with questions corresponding to the DSM-5	their relative for five uninterrupted minutes. Speech was coded using the Family Affective Attitude Rating Scale (FAARS; Bullock & Dishion, 2004) which consists of both positive (e.g., warmth) and negative (e.g., criticism) attitudes relevant to the parent-child relationship.	- Father's numbing/avoidance and hyperarousal positively associated with negative relationship scores. No significant correlations were reported for FAARS scores from sons.	

					criteria for PTSD.		
Sherman et al. (2016)	USA	To investigate veteran parents' perceptions of the impact of PTSD on their parenting and children.	*N* = 19 veterans (*n* = 17 male, *n* = 2 female, *M* age = 39.1, range 27 – 52, *n* = 16 (84.2%) Caucasian, *n* = 4 (21.1%) African America, *n* = 3 (15.8%) Native American, *n* = 1 (5.3%) Hispanic / Latino, *n* = 1 (5.3%) Asian, *n* = 10 (52.6%) married or living with partner. All had at least one child aged 4 – 18 living in the home at least half of the time.	Mixed methods Participants recruited via staff referrals at the Veterans Affairs centre, recruitment letters, and presentations to PTSD groups. Interested individuals then contacted the research team. Seven individual semi-structured interviews and three focus groups were conducted, and data analysed inductively	PTSD Checklist (PCL; Weathers et al., 1993) – 17-item self-report measure assessing symptoms of PTSD based on the DSM-IV.	Five-item 'over-reactivity' subscale of the Parenting Scale (Arnold et al., 1993) – assesses parents' emotional and disciplinary behaviours towards their children over the previous 2 months.	Mean PCL score was 68.7. 95% (*n* = 18) of participants scored above the diagnostic cut-off score of 50. With regards to responses on the parenting scale, 58% (*n* = 11) of participants exceeded the clinical cut-off score on the 'over-reactivity' subscale. Two overarching themes emerged from the qualitative analysis: Impact of PTSD symptoms on parenting – participants described parenting difficulties associated with three of the PTSD symptoms clusters; avoidance, negative cognitions and mood, and arousal and reactivity. For example, avoiding certain activities with children, 'numbing' of emotions, and irritable or aggressive behaviour.

				using a developed codebook. Participants also completed questionnaires.			Children's emotional and behavioural reactions to parental PTSD – This theme encapsulated veteran's perceptions of their children's emotional responses, such as sadness, confusion, self-blame, fear, and behavioural responses, such physically withdrawing, excluding the veteran, providing emotional and practical support.
Smith et al. (2017)	USA	To examine relationships between deployment stressors and post-military work and family satisfaction and functioning.	*N* = 522 veterans, of which 61.4% (*n* = 321) were parents (*n* = 153 mothers, *n* = 168 fathers). Of the overall sample, 54% were female, 46% male, 70% white / Caucasian, 13% multiracial, 11% black/African	Longitudinal Data collected at Time 1 and Time 2 (3.5 years later)	PTSD Checklist-Military Version (PCL-M; Weathers et al., 1993) - 17-item self-report measure assessing symptoms of PTSD based on the DSM-IV, with wording specific to military experiences).	Parenting scale of the Inventory of Psychosocial Functioning (IPF; McQuaid et al., 2012) – 10-item self-report measure assessing impairments in parenting role over the previous six months. Parental Satisfaction Scale (Wickrama et al.,	For mothers: - PTSD symptom severity mediated the link between greater warfare exposure and parental functional impairment. - PTSD symptom severity and depression symptom severity mediated the link between sexual harassment and parental

	American, 4% Hispanic, 2% other race / ethnicity). 54% of women and 70% of men had been in a parenting role within the previous 6 months. Eligibility criteria: - Post-military service veterans - Returned from a deployment to Iraq or Afghanistan within the previous 2 years (2008-2010).	1995) – 4-item self-report measure of a parent's satisfaction in their relationship with their child(ren) over the previous six months.	functional impairment. - Of the health constructs measured at Time 1, only PTSD was related to parental impairment at Time 2. For fathers: - PTSD symptom severity mediated the link between greater warfare exposure and parental functional impairment. - PTSD symptom severity mediated the link between family stressors and parental impairment. - Of the health constructs measured at Time 1, only PTSD was related to parental impairment at Time 2. For both:

							Significant correlation between PTSD and parental functioning and satisfaction.
Vogt et al. (2016)	USA	To evaluate the gender-specific impact of PTSD on post-military family and work quality of life.	*N* = 524 veterans of which 61.6% *(n* = 323) were parents (*n* = 167 mothers, *n* = 156 fathers). Of the whole sample, 53.8% were women (*n* = 282) of whom 64.4% were white, 14.6% multiracial, 13.5% black, 2.5% Hispanic, 5% other, 57.8% aged 18-34, 33.2% aged 35-54, 9% aged 55-65+ and *n* = 240 men, of whom were 76.1% white, 10.1% multiracial, 7.6% black, 5% Hispanic, 1.2% other, 51.7%	Longitudinal Data collected at time 1 and time 2 (3.5 years later)	PTSD Checklist-Military Version (PCL-M; Weathers et al., 1993) - 17-item self-report measure assessing symptoms of PTSD based on the DSM-IV, with wording specific to military experiences).	Parenting scale of the Inventory of Psychosocial Functioning (IPF; McQuaid et al., 2012) – 10-item self-report measure assessing impairments in parenting role. Parental Satisfaction Scale (Wickrama et al., 1995) – 4-item self-report measure of a parent's satisfaction in their relationship with their child(ren).	Fathers with probable PTSD: - Equally likely as those without probable PTSD to be fathers. - More likely to report impaired parental functioning (compared to fathers without PTSD). No longer significant after accounting for covariates. Depression was the only significant predictor. - 30% less likely to report feeling satisfied in parenting role. Remained significant after accounting for covariates. Mothers with probable PTSD:

			aged 18-34, 34.8% aged 35-54, 13.4% aged 55-65). Eligibility criteria: - Post-military service veterans - Returned from a deployment to Iraq or Afghanistan within the previous 2 years (2008-2010).				Equally likely as those without PTSD to be mothers. - Five times more likely to report often or always experiencing impairment in parental functioning (compared to mothers without PTSD). - 20% more likely to be dissatisfied with parenting experiences. - Findings about functioning and satisfaction no longer significant after account for covariates. - Depression was a significant predictor of functioning and satisfaction.
Zerach & Solomon (2016)	Israel	To explore the relationships between veteran fathers' PTSD symptoms,	*N* = 134 Israeli father-adult offspring dyads, with the fathers being veterans	Longitudinal This study was part of a larger longitudinal	PTSD Inventory (PTSD-I; Solomon et al., 1993) – 17-item self-report	Parental caregiving practices measured using the adapted	Fathers' PTSS negatively associated with proximity to children and sensitivity to their needs, which in turn

paternal parenting, adult offspring's attachment insecurities and adult offspring's PTSS.	of the Yom Kippur War having served with the Israel Defence Forces. Sample was divided into two groups. *N* = 80 dyads where the father was an ex-prisoner of war (ex-POW; father's *M* age = 57.7 years, *n* = 43 daughters, *n* = 35 sons, *M* offspring age = 35.1 years) and *N* = 44 dyads where the father was not an ex-POW but fought on the same fronts (father's M age = 56.6 years, *n* = 20 daughters and *n* = 24 sons, *M* offspring age = 34.8 years).	study exploring the psychosocial impact of war captivity on veterans of the Yom Kippur war. Data collected from fathers in 1991 (Time 1), 2003 (Time 2), and 2008 (Time 3) and from adult offspring between 2013-2014 (Time 4).	measure based on PTSD diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).	Caregiving Questionnaire (Kunce & Shaver, 1994) – 31-item self-report measure adapted to explore veterans' relationships with their adult children, in particular proximity to them, sensitivity to their needs, co-operation versus controlling caregiving, and overinvolvement in caregiving.	were negatively associated with attachment insecurities. War captivity increased PTSS at Time 2 and 3, which in turn decreased positive parenting at Time 3. Fathers' Time 3 total PTSS, intrusion, avoidance, hyperarousal significantly negatively associated with Time 3 proximity, sensitivity, cooperation, and positively associated with overinvolvement.

Review

Study Characteristics

Sample

The number of ex-service personnel participants in the studies ranged from 11 to 697, with a total of 3037. Fifty-eight per cent were male (n = 1761) and 42% female (n = 1276), with mean reported ages ranging from 30.03 – 58.62 years. Five studies collected data from both male and female ex-service personnel (Franz et al., 2021; McGaw et al., 2018; Sherman et al., 2016, Smith et al., 2017; Vogt et al., 2017), three collected data from females only (Creech et al., 2016; Creech et al., 2021; Goger et al., 2021), and one from males only (Feingold & Zerach, 2021). Three studies (Bachem et al., 2021; Levin et al., 2017; O'Toole et al., 2018) collected data from male ex-service personnel and their wives (total n = 635), and three studies (O'Toole et al., 2018; O'Toole, 2022; Zerach & Solomon, 2016) collected data from male ex-service personnel and their adult children (total n = 732, M age ranging between 34.98 and 38.31).

Setting

Seven of the included studies were conducted in the United States of America (USA; Creech et al., 2016; Creech et al., 2021; Franz et al., 2021; Goger et al., 2021; Sherman et al., 2016; Smith et al., 2017; Vogt et al., 2017), four studies were undertaken in Israel (Bachem et al., 2021; Feingold & Zerach, 2021; Levin et al., 2017; Zerach & Solomon, 2016), and three in Australia (McGaw et al., 2018; O'Toole et al., 2018; O'Toole, 2022).

Design

Eight studies utilised a longitudinal design (Franz et al., 2021; Goger et al., 2021; Levin et al., 2017; O'Toole et al., 2018; O'Toole, 2022; Smith et al., 2017; Vogt et al., 2017; Zerach & Solomon, 2016). A cross-sectional design was used by four studies (Bachem et al., 2021; Creech et al., 2016; Creech et al., 2021; Feingold & Zerach, 2021). One study utilised a

qualitative approach (McGaw et al., 2018) and one used mixed methods (Sherman et al., 2016), though the authors note the emphasis on the qualitative component.

Measures of Post-Traumatic Stress Symptoms (PTSS)

Self-report measures were commonly used to assess for presence of PTSS and were used solely by 11 studies (Bachem et al., 2021; Creech et al., 2016; Feingold & Zerach, 2021; Franz et al., 2021; Goger et al., 2021; Levin et al., 2016; McGaw et al., 2018; Sherman et al., 2016; Smith et al., 2017; Vogt et al., 2017; Zerach & Solomon, 2016). Two studies (O'Toole et al., 2018; O'Toole, 2022) used a combination of self-report measures and structured clinician facilitated clinical interview, and one study (Creech et al., 2021) referred to ICD-9 and ICD-10 diagnostic codes recorded in the participants' records.

Impact of PTSS / PTSD on Parenting

Parenting Behaviours and Caregiving

Nine studies in the review reported outcomes or themes related to caregiving practices.

Parental Functioning. Four studies used measures of parental functioning, a term used to describe the use of supportive and effective parenting practices (Vogt et al., 2019). In two studies by Vogt et al. (2017) and Smith et al. (2017), PTSD was measured at Time 1 and parental functioning was measured three and a half years later (Time 2). Vogt and colleagues (2017) found that both men and women with PTSD were more likely to report often or always experiencing impairments in their parental functioning compared to parents without PTSD (17.4% versus 1.6% for fathers and 13.2% versus 3.8% for mothers). Correlational analyses undertaken by Smith and colleagues (2017) also revealed that higher PTSS scores were moderately associated with impairments in parental functioning for both men and women.

Further analyses indicated that the negative impact of PTSS on both men's and women's parental functioning did not remain significant after accounting for covariates including depression, alcohol misuse, age, ethnicity, education, and income. Instead,

depression was found to be a significant predictor of functioning for both parents (Vogt et al., 2017). Additional models predicting parental functioning showed that PTSD was a significant mediator between greater warfare exposure, sexual harassment, and family stressors and impaired functioning for both mothers and fathers. For mothers only, depression was also found to be a significant mediator in the association between these variables (Smith et al., 2017).

Strengths of the studies by Vogt et al. (2016) and Smith et al. (2017) include larger sample sizes (n = 323 and n = 321 respectively) and a relatively even distribution of mothers and fathers in the samples. However, it is noted that there was a lack of racial diversity within the samples with both comprising majority White individuals. In addition, Vogt et al. (2017) highlight that drawing firm conclusions regarding the relative severity of impairments in parental functioning is precluded by the lack of cut-off or normed scores for the Inventory of Psychosocial Functioning (IPF; McQuaid et al., 2012).

In another longitudinal study conducted in the USA, Franz et al. (2021) found that increased PTSS scores were associated with more impaired parental functioning four months later among single Black parents. This significant association remained even when covariates including income, neighbourhood crime rates, and sex, were controlled for. For single Black parents, the deleterious effects of PTSD were buffered by neighbourhood cohesion to the extent that there was no significant association between PTSD and impaired parental functioning when neighbourhood cohesion was reported to be high. The results for single Black parents were not reported for dual household Black parents, dual household White parents, nor single White parents, with no significant associations between PTSD, parenting, and neighbourhood cohesion reported for these groups. It is of note that these findings may have been influenced by the lower endorsement of PTSS symptoms in these three groups compared to single Black parents. The authors also acknowledge the adverse impacts of discrimination and racism sadly

experienced by many Black families, in particular single parent families, but note that this was not measured or accounted for in this study.

Physical and Emotional Involvement. The adapted Caregiving Questionnaire (Kunce & Shaver, 1994), measuring parents' physical and emotional proximity to their child(ren), sensitivity to their needs, co-operative versus controlling caregiving, and overinvolvement, was utilised in three studies which all used samples of Israeli ex-service fathers who had served in the Yom Kippur War of 1973 (Bachem et al., 2021; Levin et al., 2017; Zerach & Solomon, 2016). Increased PTSS, as measured 30 years after the war (2003) was significantly correlated with father's reduced proximity and sensitivity to their adult children five to seven years (2008-2010) later (Levin et al., 2017; Zerach & Solomon). Furthermore, when measured 35 to 37 years after the war (2008-2010) increased PTSS was also significantly associated with reduced proximity, sensitivity, co-operation, and increased overinvolvement measured at this time (2008-2010; Levin et al., 2017; Zerach & Solomon). Though not parenting specific, it is of note that father's PTSS as measured 30 (2003) and 35 (2008) years after the war was significantly associated with adult offspring's attachment anxieties and insecurities, and their own PTSS, as measured 35 years after the war (Zerach & Solomon, 2016).

Zerach and Solomon (2016) also explored the impact of war captivity and PTSD, and found that war captivity increased father's PTSS as measured at Time 2 (2003) and Time 3 (2008), decreased father's parenting at Time 3, which in turn was associated with increased offspring' attachment avoidance (though not specially attachment to the parent) at Time 4 (2013-2014), which was further significantly associated with higher offspring PTSS. Analysis of data collected at Time 2 indicated that war captivity was found to increase father's avoidance symptoms, which decreased the level of parenting, which in turn was associated with increased offspring' attachment avoidance at Time 4. It is of note that data from Time 1 (1991) was not

included in the analysis as there was no significant correlation between father's PTSS at this time and offspring's PTSS at Time 4 (2013-2014).

In further analyses completed by Levin and colleagues (2017), PTSS did not have a direct effect on 'positive parenting', i.e., proximity, sensitivity, or co-operation. However, there was an indirect effect in that higher PTSS at Time 1 (2008) predicted lower marital adjustment at Time 1, which was associated with lower levels of positive parenting at Time 2 (2013). The role of marital adjustment was also discussed in a cross-sectional study by Bachem et al. (2021) Increased PTSS was significantly associated with reduced 'positive parenting' for fathers, and was also indirectly associated with parenting by the mediating role of reduced marital adjustment in models exploring the impact of world benevolence and self-worth schemas, both of which were significantly negatively correlated with fathers' PTSS. Additionally, within the self-worth model, ex-service members' PTSS scores negatively impacted their wives parenting scores via wives' lower marital adjustment scores, thus indicating a spill-over effect. Notwithstanding these findings, it is of note that lower scores on measures of world benevolence and self-worth also impacted parenting for both spouses beyond the impact of either partner's PTSS.

Findings from the two qualitative studies also reported the impact of PTSD on parental caregiving and engagement with children. In a mixed-methods study of 19 ex-service members accessing Veterans Affairs Healthcare across three states in the USA, who were parents to children aged four to 18 (Sherman et al., 2016), qualitative accounts revealed a theme encompassing parenting difficulties related to three PTSD symptoms: avoidance, negative alterations in cognition and mood, and changes in arousal and reactivity. Many of the participants described a conflict between wanting to be present and do things with their children but also wanting to avoid potential triggers or trauma-related reminders. A similar conflict was reported by McGaw et al. (2018) within the theme of 'PTSD: an umbrella effect' which

described the pervasive impact of PTSD on parenting in a sample of 11 Australian ex-service members with children aged zero to 18. Within this theme, parents reflected on how they felt "caught between a rock and hard place" (p. 259) in managing their parenting obligations against the impact of PTSD; for example, some reported avoiding family outings or not taking medication in order to feel more alert.

Interactions and activities with children were also noted to be negatively impacted by overprotectiveness and hypervigilance (McGaw et al., 2018; Sherman et al., 2016), as well as experiences of 'feeling alienated from others' (Sherman et al., 2016) and 'disconnection' (McGaw et al., 2018). Within these experiences of detachment, parents described going through the motions or "faking it" when with their children (McGaw et al., 2018, p. 258), or needing to take themselves away when symptoms felt particularly distressing (Sherman et al., 2016).

Discipline. One study in the review measured parents' enforcement of discipline. In the quantitative component of their mixed-methods study, Sherman et al. (2016) found that 58% (n = 11) scored over the cut-off on the five-item 'over-reactivity' subscale of the Parenting Scale (Arnold et al., 1993) which measures harsh or emotion laden discipline over the previous two months. The finding that the remaining eight participants did not score over the cut-off suggests variability in how PTSS affects parents' use of discipline. Furthermore, the data were not statistically analysed and were only reported descriptively from a small sample so further investigation is warranted.

Threatened or Actual Harm Towards Children. In qualitative accounts of how alterations in arousal and reactivity impact parenting for participants in the study by Sherman et al. (2016), irritability and aggressive behaviour were implicated in parenting challenges. Concerningly, these included threats of and actual violence towards their children, with one father reflecting: "I can't stand disrespect…I almost put my son through a window…I said 'if

you ever walk up on me again when I'm talking to you…I'll kill you'…I looked at him and he started crying." (p. 405).

Satisfaction with the Parenting Role

Parenting satisfaction refers to the sense of enjoyment and fulfilment felt within the parenting role, and the extent to which experiences as a parent are aligned with individual expectations (Cohen et al., 2011). Vogt and colleagues (2017) found that men with PTSD were 30% more likely to report dissatisfaction with their parenting experiences measured three and a half years later (Time 2), compared to those without PTSD. A similar trend was reported for women, with those with PTSD being 20% more likely to report dissatisfaction at Time 2. The effect of PTSD on parenting satisfaction remained significant for both men and women even after controlling for covariates including depression, alcohol misuse, age, ethnicity, education, and income. Whilst the study's focus was on PTSD, it is noteworthy that depression was also a significant predictor of parental satisfaction for women.

Smith and colleagues (2017) also found that PTSD was significantly negatively correlated with parenting satisfaction three and a half years later for both men and women. However, the final model predicting parenting-related quality of life reported no direct or indirect effect of PTSD on parenting satisfaction for men or women. Instead, depression was found to be a significant direct and indirect predictor of parenting satisfaction.

Parenting Competence

A concept linked with parental satisfaction is parenting sense of competence (PSOC). Creech et al. (2016) found no significant associations between PTSS and sense of competence in their study of mothers in the USA who had previously deployed to the conflicts in Iraq and Afghanistan. Conversely, Feingold and Zerach (2021) reported that fathers who had served with the Israeli Defence Force who were experiencing higher levels of PTSS reported decreased sense of competence. These findings may reflect the differing experiences of

mothers versus fathers; however, it is also of note that the study by Creech et al. (2016) included a relatively small sample (n = 64), and the authors highlighted that the analyses may have been underpowered and so the results were interpreted tentatively.

Feingold and Zerach (2021) posited that decreased PSOC may be influenced by negative alterations in cognitions and mood associated with PTSD. This idea is supported qualitatively in a study by Sherman et al. (2016) whereby 'negative beliefs and expectations about the self and the world' and 'negative trauma-related emotions' were described as being associated with negative parental self-evaluation, with one participant commenting "I screwed everything up you know or I'm going to mess everything up" (p. 405).

Experience of Stress in Parenting

One study (Goger et al., 2021) in the review explored the impact of PTSD on parenting stress, a concept typically defined as an aversive reaction to the parenting role and influenced by a number of child and parent characteristics (Deater-Deckard, 1998). In a sample of female ex-service members who completed measures during their third trimester of pregnancy and approximately six weeks postpartum, PTSD was not associated with parenting stress, despite PTSD being significantly associated with pregnancy-related anxiety and depression. Instead, parenting stress was significantly positively associated with postpartum depression (Goger et al., 2021). The authors recognised that attrition, small sample size (n = 28 during pregnancy, n = 23 postpartum), and the fact that data were gathered from only one Veteran's Affairs medical facility, limited the generalisability of the findings. Furthermore, regarding PTSD symptoms, it is of note that the women did not score in the clinically significant range during pregnancy or postpartum, which may have potentially diluted the effects.

Parental Mentalising

A type of mentalising known as parental reflective functioning refers to the parent's capacity to reflect upon and understand their own mental states as well as those of their child

(Camoirano, 2017). One study explored the association between PTSS and parental reflective functioning in a sample of 189 Israeli Defence Forces combat veterans (Feingold & Zerach, 2021). No significant correlations were reported between PTSS and certainty about mental states or interest or curiosity in mental states; however, increased PTSS were significantly associated with pre-mentalising modes i.e., increased difficulties in understanding and interpreting their child's mental state and internal world. The authors hypothesised that this finding may have been influenced by insufficient mental representation of the men's own trauma experiences disrupting their parental mentalisation ability. However, research exploring reflective functioning in ex-service parents remains in its infancy and the authors acknowledge that this requires further exploration.

Parent-Child Relationships

Maternal-Infant Bonding. Two studies explored bonding in the postpartum period with samples of ex-service mothers. Goger et al. (2021) found that PTSD symptoms during pregnancy and postpartum were not significantly associated with bonding difficulties. Instead, impaired bonding was associated with postpartum depression. These results are built upon by Creech et al. (2021) who reported that women with a recorded diagnosis of PTSD (32% of the sample, n = 223) reported significantly greater bonding difficulties. Further analysis using structural equation modelling revealed no direct associations between PTSD and bonding, but rather that PTSD was indirectly significantly associated with impaired bonding via the mediating role of maternal depression. The larger sample size is noted as a strength of this study; however, the sample was limited in terms of representativeness given the relative lack of participants from Black and Asian backgrounds.

Father-Child Relationships and Attachment. O'Toole et al. (2018) and O'Toole (2022) drew samples from a cohort study of male Australian Vietnam veterans to assess associations between paternal mental health, parent and family relationships, and offspring

psychopathology. A total of 315 adult offspring (*n* = 180 daughters and *n* = 135 sons) participated in the 2018 study by O'Toole and colleagues. Correlations between father's PTSD scores and parent-child relationship scores approximately 17 years later (Time 2) showed that for daughters, father's numbing / avoidance symptoms were significantly associated with a more negative (critical, reports of anger or conflict) relationship score and decreased positive perceptions of their fathers. No significant correlations were reported for sons. Furthermore, daughters were more likely to hold ambivalent feelings towards their fathers if the father had a diagnosis of PTSD, whereas for sons, fewer perceptions of the father as warm and responsive, and more perceptions of him as inconsistent, were associated with their father's PTSD diagnosis. For both sons and daughters, a father's diagnosis of PTSD was related to childhood attachment to the father but not to the mother. PTSD scores were lowest in secure attachments for both sons and daughters, and highest in inconsistent attachment scores for sons and in the cold and distant scores for daughters. These results together suggest that father's PTSD may have an influence on both sons and daughters through attachment impairments, and further on daughters through a less positive relationship.

Comparable results were reported by the more recent study by O'Toole (2022) employing a similar methodology with 283 adult children (*n* = 163 daughters and *n* = 120 sons). Father's numbing / avoidance symptoms were significantly associated with a more negative relationship from the perspective of daughters, as were father's hyperarousal symptoms, as measured 17 years later. Again, no significant correlations were reported for sons. Though not the focus of this review, it is of note that family emotional climate, as measured using the FMSS and FAARS, was a significant intervening variable between father's PTSD and daughters', but not sons', PTSS.

The findings by O'Toole et al. (2018) and O'Toole (2022) suggest that father's PTSD impacts relationships with sons and daughters differently; however, this warrants further

exploration as, though the sample sizes were relatively large, there was a poorer response rate amongst sons in these studies which may have biased the results. Additionally, attachment was only assessed using a brief measure with adult children reporting retrospectively on their childhood. The validity of retrospective reporting has been explored and debated widely within the literature with many studies highlighting the risk of bias and 'false negatives' (Baldwin et al., 2019).

Relational Concerns and Disconnection. In their qualitative study, Sherman et al. (2016) described how 'constricted affect' was associated with parental experience of the parent-child relationship, with one father reflecting: "There are times when I'll be with my son and I'll just be watching him. And…I don't feel anything. I look at him like he's 'a' child. I don't look at him like he's 'my' child." (p. 405). Similar findings were reported by McGaw et al. (2018) who described a theme of 'disconnectedness' which encompassed a sense of parental detachment from their children and their role as a parent.

A second theme of 'transgenerational effects: parented by someone with PTSD' described parental concern about the intergenerational impact of PTSD and inappropriate role modelling (McGaw et al., 2018), with one participant reflecting: "…what an important role model I am and I'm really aware of that and you know I still just worry what I'm doing to them." (p. 258). Within this, parents also described noticing 'symptoms' in their own children including sensitivity to loud noises and anxiety, and reflected on the influence of PTSD within the parent-child relationship. The parents in the study by Sherman et al. (2016) also expressed concerns about their children's emotional and behavioural reactions to them such as confusion, frustration, resentment, and fear of the parent, as well as behavioural reactions including children physically withdrawing from, or ignoring, the parent. Though both qualitative studies included a mixed sample of mothers and fathers, it is of note that fathers made up over 80% of the samples in each which may have introduced bias.

Children as a Source of Significant Support. Despite the relational concerns described above, Sherman et al. (2016) also reported subthemes related to children 'providing support' which was acknowledged and appreciated by parents. This included emotional support such as checking in and expressing love during difficult times, support with grounding, and practical support such as reminding parents about their appointments. Interestingly, no concerns about possible role reversal were reported by the parents, which is in contrast to research in which adolescent children of military personnel affected by PTSD described the burden of 'parentification' (Harrison et al., 2014).

Critique

Sample

The majority of studies drew their sample from wider studies exploring the mental health and well-being of ex-service personnel; however, sampling strategies were not always clear and details with regards to characteristics of the target population were lacking, making it difficult to adequately assess how representative the samples were. An area in which samples were not deemed to be representative was race and ethnicity. All studies reported data from majority White individuals, with lack of racial diversity frequently cited as a limitation, and only one study explored the role of race and ethnicity in the context of parenting with PTSD (Franz et al., 2021). Furthermore, the study by Franz and colleagues (2021) was the only study to investigate the impact of PTSD on parenting for single versus dual parent households, and other studies lacked details with regards to relationship status or parent sexuality.

Not all studies conducted further analysis of missing data or differences between responders and non-responders, but when this was completed differences were noted and results indicated that responses were not missing completely at random. To reduce the impact of bias, methods for handling missing data, such as listwise deletion and maximum likelihood, were used in most, but not all, of the studies.

Design

Four studies in the review used a cross-sectional design (Bachem et al., 2021; Creech et al., 2016; Creech et al., 2021; Feingold & Zerach, 2021). It is commonly recognised that cross-sectional designs provide a 'snapshot' of the data; however, since each datum is only collected at one time, the ability to ascertain the directionality of the relationship between PTSD and parenting is limited.

The use of a longitudinal design in eight of the studies (Franz et al., 2021; Goger et al., 2021; Levin et al., 2017; O'Toole et al., 2018; O'Toole, 2022; Smith et al., 2017; Vogt et al., 2017; Zerach & Solomon, 2016) allowed for a more comprehensive exploration of the directionality and degree of association between PTSD and parenting over time. Nevertheless, all studies utilising this design described attrition of participants, a common methodological concern of longitudinal studies which is associated with response bias and threats to the generalisability of results.

Is it noted that there were measures taken to minimise bias in the qualitative study by McGaw et al. (2018) and the qualitative component of the study by Sherman et al. (2016), including following pre-determined analysis guidelines and coding procedures and utilising inter-rater review of codes and themes. McGaw and colleagues (2018) also evidenced reflexivity, which supports transparency and coherence in qualitative research (Yardley, 2000), with the lead author acknowledging potential biases related to their personal and professional exposure to military families; however, this was not discussed by Sherman and colleagues (2016).

Measures

The reliability and validity of the measures used to assess for PTSS / PTSD and parenting outcomes in the studies ranged from acceptable to very good, except for novel the use of the FAARS in the studies by O'Toole et al. (2018) and O'Toole (2022), for which

Cronbach alpha statistics were below those reported in other research that utilised this measure, thus highlighting potential reliability issues.

Other than the FAARS which was coded by the research team, all other measures were self-report, the majority of which were completed by the ex-service personnel parents. An advantage of using self-report measures is that several outcomes can be measured relatively easily with a large sample; however, they are also susceptible to response biases including socially desirable responding (Paulus, 2017). Furthermore, parental PTSD has been associated with a subjective sense of relationship difficulties (Schechter et al., 2015) which may also influence responses, and potentially over-estimate relationships between PTSD and parenting difficulties.

Analysis

The analyses used in each of the studies was deemed to be appropriate and relevant. It was noted that many of the studies reported results following correlational analyses. Though the use of correlational research supports high ecological validity and exploration of the often complex relationships between variables, it is widely acknowledged that correlation does not imply causation and as such cause and effect inferences cannot be made.

Discussion

This review synthesised the up-to-date literature exploring the impact of PTSS and PTSD on parenting amongst ex-military service parents. Many of the findings support the results of previous reviews reporting on the deleterious effects of PTSS on parenting in several domains; however, individual differences and the influence of a variety of contextual factors are also considered, thus emphasising the complexities of the association. These are also considered in relation to a number of methodological limitations.

PTSS were associated with decreased parental functioning and satisfaction for both mothers and fathers. However, this association did not remain significant after accounting for

covariates such as age, education, income, and ethnicity. The findings reported by Franz et al. (2021) also support the importance of recognising the intersection of race and being a single parent in the context of PTSD and parental functioning, as well as the protective role of neighbourhood support and connectedness. This is in line with research documenting risk and protective factors for parental mental health such as poverty and social support (Gupta et al., 2014).

Parental PTSS was also associated with reduced emotional and physical involvement with both younger and adult children, thus demonstrating potential long-lasting effects. The experience of symptoms of avoidance, low mood, and hyperarousal were implicated in these findings and can be considered in relation to the C-BIT mode (Dekel & Monson, 2010). For example, Creech and Misca (2017) described that behavioural avoidance negatively impacted engagement with children and cognitive appraisals of situations as threatening were associated with more negative perceptions of children's behaviour and concerns for their safety. The findings that marital adjustment mediated the link between PTSS and parental involvement also emphasise the importance of family relationships in line with family systems theory which posits that interactions between family members influence other family member's behaviours (Minuchin, 1985).

Perceived competence in the parenting role has previously been shown to mediate the link between PTSD symptoms and problematic family functioning in a sample of mixed active and ex-service personnel (Laifer et al., 2019). In this review there appeared to be gender differences in the experience of parental competence, with higher levels of PTSS associated with reduced parental competence in fathers but not mothers. This contrasts with the extant literature which reports low maternal parental competence in the context of mental health difficulties such as depression (Bugental & Johnston, 2000). Additionally, Goger et al. (2021) found that PTSS were not associated with parenting stress for ex-service mothers as measured

six weeks postpartum. Previous studies have reported an association between PTSS and parenting stress in ex-service fathers of children aged 13 and under (Tomassetti-Long et al., 2015), thus suggesting that the age of the child and gender of the parent may play a role in the in the experience of parental competence and stress. Given the small sample sizes included in the studies in this review, conclusions are drawn tentatively and warrant further investigation.

A parenting domain not reported on in previous reviews is parental mentalising. Feingold and Zerach (2021) reported that PTSS were associated with increased difficulties in understanding and interpreting their child's mental state and internal world. As this was the only study to report on mentalising in the review, conclusions are drawn with caution. Nevertheless, these findings are important to consider in the context of previous research indicating that parental reflective functioning plays a significant role in fostering mentalising capabilities in offspring, which in turn are associated with the development of emotion regulation, sense of agency, and secure attachments (Slade, 2005).

There were mixed findings with regards to mother-infant bonding. No direct effects of PTSS were reported, however, indirect effects via maternal depression were noted. Research suggests that the experience of depression may disrupt the responsivity of the parent (Shaw et al., 2006). This is a pertinent consideration in the context of attachment theory and the central role responsive caregivers are considered to play in the formation of secure attachments (Bowlby, 1979). The experience of depression was also described as a mediating factor, or predicting factor in its own right, in the domains of parental functioning, involvement, and stress. Here, depression and PTSD are considered as distinct diagnostic constructs; however, considering that 'negative alterations in mood' are described in the context of PTSD, it is perhaps more helpful to consider the experience of low mood and 'depression' as significant parts of a wider, more complex emotional response to traumatic stress.

The findings by Sherman et al. (2016) highlighted that parents valued the support of their children. However, reports from other studies suggested that children, including adult children, of ex-service parents can be impacted negatively by their parents PTSS, with adverse outcomes noted for how children perceive their fathers and quality of attachments (O'Toole, 2022; O'Toole et al., 2018). Differences between the experiences of sons and daughters suggest that mechanisms of impact may be different and indicate the need for further research in this area. Furthermore, though only one study (Sherman et al., 2016) reported accounts of threatened or actual harm towards children, the significant detrimental impact of child maltreatment attests to the need to remain mindful of the potential for experiences of irritability and anger in the context of PTSD to manifest as aggressive behaviour directed towards children.

Limitations of this Review

The focus on parenting meant that it was not within the scope of this review to discuss all of the findings reported by the studies included. For example, results relating to reported child and partner psychopathology and general family functioning have not been discussed here, though it is acknowledged they are also important considerations.

Synthesising the results by parenting domains was chosen as it was deemed the most appropriate way of collating the studies in relation to the review question. However, it is noted that there was variability within the studies described under each domain, for example, with regards to where the study took place, the age / gender of the ex-service parents, and the age of the children, thus making it difficult to draw complete comparisons between the studies.

Exposure to military related trauma was not specified in the inclusion and exclusion criteria for the review as preliminary reading of the literature indicated that this was not specified in all studies. In addition, research suggests that ex-service personnel are likely to

have been exposed to chronic and multiple forms of trauma (Murphy et al., 2019). As such the conclusions drawn in this review cannot be considered in the context of military trauma only.

There were four studies excluded from the review due to the samples being mixed serving and ex-service parents and no stratified analysis by ex-service status. It is recognised that the decision to exclude these studies means that some relevant findings have not been reviewed; however, given the lack of stratified analysis it would not have been clear whether the findings described came from ex-service parents only.

The use of diagnostic categories in research can offer a pragmatic 'shared language' (First et al., 2015); however, illness models of distress are criticised for being reductionist, with diagnoses reported to lack reliability and validity due to heterogeneity within diagnostic categories (Allsopp et al., 2019). Limiting the review to studies only incorporating measures / diagnosis of PTSD focuses findings on 'symptoms', rather than individual presentations, thus potentially obscuring nuance and excluding the exploration of other responses to trauma and the impact these may have on parenting in veteran populations.

Clinical Implications

These findings emphasise the importance of professionals remaining cognizant of the potential parenting difficulties experienced by ex-service personnel, both in terms of links with adverse child outcomes, but also the potential for difficulties to compound parental distress. Practically, it may be beneficial for clinicians to initiate and support conversations about parenthood and family life whilst acknowledging strengths. The finding that many of the participants included in the studies in this review did not meet clinical cut-offs for PTSD measures also suggests that there may be many parents experiencing difficulties, but do not have an 'official' diagnosis of PTSD, thus emphasising the need for formulation and continued discussions about the experience of parenting with ex-service personnel.

Though further research is warranted, the findings of this review suggest that there are factors that may influence the relationship between PTSS and parenting. These include gender, ethnicity, marital relationships, neighbourhood cohesion, and age of the child. It is therefore important for professionals to keep in mind individual and contextual factors when working with ex-service parents experiencing PTSS. Furthermore, a focus on building supportive relationships may be beneficial for ex-service parents. This could include support with integration into the community, but also more personally, support with building and maintaining family relationships. The incorporation of more family focused interventions or practical support with explaining PTSD to children may support with this.

The potential adverse impacts on children, including adult children, highlight the need for professionals also to remain aware of the potential impact of parental distress when working with children and adults whose parents have served in the military.

Research Implications

The majority of studies in this review utilised quantitative study designs. Though quantitative methods allow for the testing of hypotheses with larger samples, qualitative accounts allow for a more detailed exploration of a participant's lived experience, thus elucidating some of the nuances of experience which may not have been explored via the use of pre-determined measures. Only two studies in this review reported qualitative data from the perspective of ex-service personnel parents, indicating that further qualitative research is warranted in this area.

The reliance on self-report measures in the quantitative studies and the potential for self-report to be susceptible to bias suggests that future research may also benefit from incorporating other measures of parenting. These may include direct observation or further incorporation of the perspectives of partners and children via the collection of both quantitative

and qualitative data. Within this, further research could continue to explore any differences between the experiences of sons and daughters.

Following on from the acknowledged limitations with regards to sample representativeness, there is a need to further explore the experiences of ex-service parents from minoritised ethnic backgrounds and from the LGBTQ+ community.

The studies in this review were conducted in three countries only: Australia, USA, and Israel. Though deemed 'Western' cultures, they remain distinct sociocultural contexts. The authors of the studies conducted in Israel recommend caution with generalising to other contexts, and highlight that status as a parent is considered significant and holds value both societally and religiously in Israel, with a culture of familism prevailing perhaps more than in other Western societies (Shenkman et al., 2021). As such, the current literature could be expanded upon by research conducted with ex-service parents in other countries.

As the literature in this area evolves there is a need to build upon research exploring what impact PTSD has on parenting, but also research exploring how and why there is an impact. Investigating relevant risk and protective factors, through the incorporation of mediating and moderating factors and covariates into analyses, may illuminate some of the 'hows' and 'whys', thus enhancing the understanding of the relationship between PTSD and parenting for ex-service members and highlighting areas for intervention.

Conclusions

There has been a proliferation of research exploring the impact of PTSD on military family functioning and parenting in recent years. The aim of this review was to synthesise the recent literature in response to the question: what impact does experiencing PTSS / PTSD have on parenting amongst ex-military parents? A systematic search resulted in 14 studies being included for review. The results indicated that, generally, PTSS / PTSS had an adverse impact on a number of parenting domains including caregiving, satisfaction, competence, stress,

mentalising, and the parent-child relationship. However, negative associations were not always reported or were reportedly differently for different groups (for example, mothers and fathers), thus emphasising the role of individual and contextual factors such as gender, ethnicity, social support, and family relationships. Many studies also reported the role of depression either as a mediating factor or a predictor over and above PTSD. These findings are considered in the context of methodological limitations. There were a number of implications including; the need for clinicians to remain cognizant of parenting difficulties experienced by ex-service parents diagnosed with PTSD in terms of parental distress as well as the potential impact on military children (including adult children), developing parenting focused adjunct interventions and / or the use of more systemically informed interventions, and developments in research including further qualitative studies and studies incorporating observations as well as the perspectives of partners and children in order to provide a more holistic understanding.

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Section B: Empirical Paper

A qualitative exploration of the parenting experiences of ex-military fathers diagnosed with post-traumatic stress disorder (PTSD)

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Abstract

The experience of post-traumatic stress has been implicated in adverse outcomes for trauma-exposed parents and their children. The aim of this qualitative study was to explore how ex-military service (veteran) parents who had received a diagnosis of post-traumatic stress disorder (PTSD) experience and make sense of parenthood, their role as a parent, and the parent-child relationship. Ten ex-military fathers from the UK who had been diagnosed with PTSD engaged in interviews which were analysed using Interpretative Phenomenological Analysis (IPA). The analysis resulted in four themes; 'Not always being the father I want to be', 'Striving to protect', 'Developing insight and understanding', and 'Protective influence of children'. These themes captured participants' experiences of the perceived negative impact of PTSD symptoms on parenting and an evolving view of the self as a parent in relation to this, taking action to protect children from distress and harm, the importance of developing insights and understanding both personally and within parent-child relationships, and the distracting and motivating influence of children and enjoyment of the parenting role despite the challenges experienced in the context of a PTSD diagnosis. Findings are discussed in relation to the extant literature, and clinical and research implications are outlined.

Keywords: parent, father, veteran, trauma, PTSD

Introduction

It is estimated that there are approximately two million ex-military service members currently residing in the UK (Ministry of Defence, 2019). Many veterans will not experience mental health difficulties; however, research indicates that those who have served report increased levels of anxiety, depression, alcohol misuse, and post-traumatic stress disorder (PTSD) in comparison to the general population (Rhead et al., 2022). A high percentage of ex-service personnel are also reported to have experienced multiple traumas including combat-related trauma and adverse childhood experiences (Murphy et al., 2019).

A recent study by Murphy and colleagues (2020) reported that 71% of a sample of treatment seeking veterans met the criteria for a diagnosis of PTSD or complex PTSD. PTSD is a diagnosis characterised by ongoing difficulties related to re-experiencing, avoidance, arousal and reactivity, and mood and cognition, in response to experiencing a traumatic event (American Psychiatric Association, 2013). The experience of multiple or chronic stressors is associated with complex PTSD (CPTSD), a diagnosis characterised by the experience of symptoms related to PTSD as well as 'disturbances in self-organisation' namely affective dysregulation, negative self-concept, and disturbances in relationships (Maercker et al., 2013).

The severity and chronicity of the psychological and behavioural experiences associated with a PTSD diagnosis will vary between individuals. For some, this may include positive psychological change accompanied by new insights, a concept known as post-traumatic growth (Tedeschi & Calhoun, 2004). Nevertheless, the experience of flashbacks, feeling emotionally detached, hypervigilance, and irritability can have a significant detrimental impact on a person's quality of life and relationships (Schnurr et al., 2009).

The cognitive-behavioural interpersonal theory of PTSD (C-BIT; Dekel & Monson, 2010) posits that there are three processes which maintain symptomology and negatively impact relationship functioning: behavioural avoidance and accommodation, cognitive

processes and thematic content, and emotional disturbances. An example is that behavioural avoidance may have a deleterious impact on relationship satisfaction due to interfering with engagement in shared activities and with affective expression, impacting both physical and emotional closeness. Creech and Misca (2017) applied the C-BIT to parent-child relationships in military families and support for the bi-directional nature of the model was demonstrated; for example, it was noted that children may modify their own behaviour to accommodate, and in turn facilitate, avoidance symptoms, thus creating a circular reinforcing effect.

The effects of parental post-traumatic stress symptoms (PTSS) on children are well documented. In a review focused on military children, including adult children, predominantly negative outcomes were reported related to altered physiological stress responses, behavioural and conduct difficulties, and increased reporting of feeling anxious and depressed (Banneyer et al., 2017). Additional research reports a medium effect size of the association between parental PTSD and child PTSD-related symptoms (Morris et al., 2012), even when the offspring have not suffered the named traumatic event themselves, thus suggesting a transference of symptoms via the parent-child interaction. Proposed mechanisms of intergenerational transmission of trauma include silence, over-disclosure, identification, and re-enactment (Ancharoff et al., 1998). Additionally, theories of secondary or vicarious traumatisation posit that as a child offers support by attempting to understand the experiences of the traumatised person, they may internalise these experiences and feelings, consequently developing their own trauma symptoms (Figley, 1986).

In light of these findings there has been growing interest in the impact and experience of a PTSD diagnosis on parenting. Post-traumatic stress symptoms (PTSS) experienced by ex-service members are associated with increased parenting stress, reduced confidence and satisfaction in the parenting role, poorer parent-child communication, reduced affective involvement, and problem-solving (Christie et al., 2019; Creech & Misca, 2017), as well as the

use of more inconsistent discipline, and reports of aggression directed towards children (Sherman et al., 2016).

In a recent systematic review, McGaw and colleagues (2019) drew together the extant qualitative literature exploring the experience of parental PTSD from the perspectives of veteran parents, their children, and partners. This yielded only 11 studies with themes relating to the fragility of the home environment, disconnection, but also the importance of family. Only two studies in this review explored the experiences of ex-service parents. These qualitative results described barriers to communicating with children about PTSD, the impact of specific PTSD symptoms clusters on parenting effectiveness, and the behavioural and emotional reactions of their children (Sherman et al., 2015; Sherman et al., 2016). A more recent qualitative study by McGaw et al. (2018) exploring parenting and family life conducted in Australia also described experiences of disconnection, a sense of a pervasive impact of PTSD on family life, but despite this, a strong sense of family.

The experience of parenthood is complex and multifaceted. Research with ex-service parents indicates that being a parent increases the likelihood of receiving a diagnosis of PTSD (Janke-Stedronsky et al., 2015); however, parenthood has also been cited as a source of strength and motivation to engage in treatment (Evenson et al., 2008). Considering these findings together with the results of research highlighting both the intra- and interpersonal deleterious effects of post-traumatic stress symptoms, it is argued that it is important to further understand the experience of ex-service parents diagnosed with PTSD.

Furthermore, much of the research to date has used quantitative methodologies with mixed samples of active and ex-service parents. It has been argued that the needs and experiences of ex-service personnel are likely to be different given that they have navigated the transition to civilian life and no longer have the same structures and supports in place as those still serving (Creech & Misca, 2017). The existing qualitative literature is scant and has

focused on communication about PTSD, the impact of symptoms, and family life more generally. To date there has been no research conducted in this area with former members of the UK armed forces. The overarching aims of this research therefore were to gain an in-depth understanding of how ex-service parents who had received a diagnosis of post-traumatic stress disorder (PTSD) experience and make sense of parenthood, their role as a parent, and the parent child relationship.

Method

Design

Semi-structured interviews were used to gather data in this qualitative study which utilised Interpretative Phenomenological Analysis (IPA). IPA is theoretically underpinned by the principles of phenomenology, an approach to understanding subjective lived experience, and hermeneutics, which refers to the theory of interpretation. IPA recognises a 'double hermeneutic' as the researcher interprets the participant making sense of their own lived experience (Smith et al., 2009). Other qualitative methodologies were considered, however, as the research questions were focused on exploring experiences, rather than seeking to develop an explanatory theory for example, the phenomenological focus of IPA felt best suited to this.

Participants

A purposive sampling strategy was used to recruit participants. In line with the idiographic focus of IPA, this sampling strategy was favoured as it supports the recruitment of a homogenous sample (Smith et al., 2009). Participants were recruited from a group of treatment seeking veterans who had received support from a national charity which offers support for veterans experiencing complex mental health problems. A total of 10 participants, a sample size deemed appropriate for doctoral level research utilising IPA (Smith & Nizza, 2021), were recruited in line with the inclusion and exclusion criteria outlined in Table 1.

Table 1

Study Participation Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Aged 18+ • Male, female, or non-binary gender UK veteran. • A parent / guardian to biological and / or non-biological child / children of any age. • Currently have regular contact with their child / children. • Received a diagnosis / met diagnostic cut off for PTSD. • English speaking.	• Individuals who have children but no longer have contact with them of any kind. • Individuals who had sustained a brain injury that resulted in neurological damage that significantly impaired their memory and / or concentration. • Individuals who were experiencing active psychosis or were actively suicidal.

These criteria were informed by the inclusion and exclusion criteria outlined by the charity. Individuals experiencing active psychosis or active suicidal ideation are initially supported by the charity to engage in local or more specialist services to manage risk and provide initial intervention.

Participant demographics are outlined in Table 2. All participants had previously met the criteria for a diagnosis of PTSD using the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) and had engaged with the charity for support with symptoms of PTSD during 2019. Though the study was open to both mothers and fathers, all participants were male. Nine participants identified as white British, and one participant identified as white European, though discussed growing up in the UK. Participants ranged in age from 40 to 68 (M = 56.9 years) and their children's ages ranged from 3 to 48 (M = 25.25 years). No limits were specified on the age of the child as the parenting role continues beyond childhood (Holt et al., 2018).

With regards to their time in the military, this ranged from 9 to 25 years (*M* = 19 years), with the time since leaving the military ranging from 5 to 42 years (*M* = 20.4 years).

Table 2

Participant Demographics

Pseudonym	Age bracket	Armed force served in	Marital status	Child and Contact Information	International Trauma Questionnaire interpretation
Ben	40-44	Army	Separated	Son & daughter (<18 years old) Stay every other weekend	CPTSD
Oliver	40-44	Army	Married	Two daughters (<18) Live at home	Scores did not meet diagnostic cut offs
Adam	45-49	Navy	Divorced	Two daughters (one <18 and one >18) Sees when can, regular phone calls / messages	Scores did not meet diagnostic cut offs
Jason	50-54	Air Force	Divorced	Son (<18) Stays each weekend	CPTSD
Richard	55-59	Army	Married	Daughter (>18) Sees once per month plus regular calls and messages	CPTSD
Shaun	60-64	Air Force	Cohabiting	Daughter (>18) Sees every couple of weeks plus regular calls and messages	CPTSD
Chris	65-69	Navy	Married	Son & daughter (>18) Sees weekly plus regular calls and messages	CPTSD

Jonathan	65-69	Army	Married	Daughter (>18) Visits regularly plus regular calls and texts	PTSD
Keith	65-69	Army	Married	Two sons & two daughters (>18) Sees every few months plus regular calls and messages	CPTSD
Tim	65-69	Army	Married	Three sons & one daughter (>18) Youngest son lives at home, no contact with eldest son, regular contact with middle children	CPTSD

Materials

Trauma Experiences Measure

Prior to the interview, participants completed the International Trauma Questionnaire (ITQ; Cloitre et al., 2018, see Appendix B). The ITQ is an 18-item self-report measure, which has been validated with community and UK veteran samples (Murphy et al., 2020), and assesses PTSD and CPTSD symptoms. If an individual meets the criteria for a diagnosis of CPTSD, as outlined below in Table 3, then they cannot also receive a diagnosis of PTSD.

Table 3

Diagnostic Criteria for the International Trauma Questionnaire (ITQ; Cloitre et al., 2018)

Diagnosis	Criteria
PTSD	• A score of ≥2 (‘moderately’) for at least one of two symptoms from the clusters of re-experiencing, avoidance, or sense of threat. • A score of ≥2 for at least one indicator of functional impairment related to these PTSD symptoms.
Complex PTSD	• A score of ≥2 (‘moderately’) for at least one of two symptoms from the clusters of re-experiencing, avoidance, or sense of threat. • A score of ≥2 for at least one of two symptoms from the clusters of affect dysregulation, negative self-concept, and disturbances in relationships. • A score of ≥2 for at least one indicator of functional impairment related to the PTSD symptoms AND at least one indicator of functional impairment related to the DSO symptoms.

Participants scores were used to describe the sample and give an indication of their experiences at the time of engaging in the study. As all participants had previously met the criteria for PTSD diagnosis they were not excluded based on their ITQ scores.

Interview Schedule

An interview schedule (Appendix C) was developed keeping in mind the aims of the study whilst also remaining consistent with IPA methodology. The schedule was informed by reading relevant literature and consulting with the research supervisors as well as four veterans who worked for or were associated with the charity through which participants were recruited.

Procedure

Ethical approval for the project was granted by the Salomons Ethics Panel (Appendix D). An email (Appendix E) was composed by the researcher and sent via the charity's research team to 200 veterans who had previously taken part in a study exploring the health and well-being of veterans and had given consent to be contacted about future research. Interested individuals contacted the researcher, and following receipt of an information sheet (Appendix F), those eligible and willing to take part also completed a consent form (Appendix G). Sixteen individuals initially expressed an interest in participating; four individuals did not respond to initial correspondence, and two individuals planned to meet with the researcher but later withdrew citing deterioration in their mental health.

The researcher met with participants on two separate occasions via Zoom (n = 9) or telephone (n = 1). The ITQ (Cloitre et al., 2018) was completed and demographic information (Appendix H) was collected during the first meeting. Participants engaged in the semi-structured interview during the second meeting. Interviews lasted between 35 and 100 minutes. These were recorded using a Dictaphone and transcribed verbatim by the researcher, with personal or identifiable information removed or changed. The audio files, anonymised transcripts, as well as demographic information and ITQ questionnaires, were stored on a password-protected storage device.

Data Analysis

Transcripts were analysed according to the analytical process in IPA outlined by Smith et al. (2009) and Smith and Nizza (2021) who discuss updated terminology which is used here. Each transcript was analysed individually before moving onto the next. Transcripts were initially read twice, whilst also listening to part of the recording to recall the participant's voice, to support familiarisation with the data. Exploratory notes were made noting descriptive, linguistic, and conceptual comments. These notes were used to inform experiential statements which offered a concise summary of the experiences of the participant throughout the transcript, and these statements were then grouped together into personal experiential themes. Patterns and idiosyncrasies across the personal experiential themes for all participants were explored and collated, resulting in group experiential themes and subthemes. Analysis was iterative in that transcripts were repeatedly reviewed throughout the process.

Ethical Considerations

The study was proposed and undertaken keeping in mind the values of compassion, respect, and dignity (valuing each person and seeking to understand their experiences) as outlined in the National Health Service (NHS) Constitution (Health Education England, n.d.). To maintain confidentiality and anonymity the participants created unique identifier codes and pseudonyms were created which have been used in this report. At the start of both meetings, each participant was reminded that their participation was voluntary and that they could withdraw their data without giving a reason up to two working days following the meeting. Additionally, participants were reminded that the researcher was not affiliated with the charity, and that any support from the charity would not be impacted by their decision to take part or not.

Any verbal and non-verbal signs of distress were attended to by the researcher by 'checking-in' with the participants where appropriate, and participants were reminded that they could take breaks or stop at any time. At the end of both meetings participants were offered space to discuss their experiences of being involved in the research. Though no participants reported distress, signposting to sources of support was also provided. Participants were verbally debriefed about the aims of the study at the end of the second meeting and a written debrief (Appendix I) was also emailed to them following participation.

Quality Assurance and Reflexivity

Principles that guide high quality qualitative research outlined by Yardley (2000) were followed throughout. Sensitivity to context was achieved via reading relevant existing literature, consulting with veterans about the design of the study, and remaining mindful of ethical considerations. Furthermore, reflexivity was supported by the use of a bracketing interview undertaken with a trainee clinical psychologist colleague prior to conducting the first interview (Appendix J) and a diary (Appendix K) which was kept throughout the research process noting thoughts, emotional response, and reflections. The bracketing interview allowed a space for the researcher to reflect on and bring to awareness their own assumptions, biases, motivations, and expectations (Alase, 2017). These included assumptions that parenting was both a positive and challenging role, that those in the military may be exposed to more 'masculine' narratives which may hinder their ability to talk about their emotions, and that trauma can have devastating impacts but can also result in growth in some people. These personal responses are informed by the researcher's positioning as a white British female trainee clinical psychologist who professionally has worked with individuals who have experienced trauma, and personally as someone who is not yet a parent, but whose father served in the Royal Air Force. Additionally, at the time of undertaking this project, the researcher's partner was in the process of transitioning out of the military.

Methodological rigour was achieved by following the guidelines for the analytical process in IPA (Smith et al., 2009; Smith & Nizza, 2021). Annotated transcripts and themes were also shared with the lead supervisor. Furthermore, the researcher continually compared experiential themes with the transcripts to ensure that they were grounded in the data. In line with demonstrating transparency, the process of theme development is included in the appendices (see Appendix L, M, and N).

Results

Data from the ITQ (Cloitre et al., 2018) were used for descriptive purposes and not analysed; however, it was noted that when asked to identify an experience that troubled the participants most, all described an experience of combat related trauma whilst on operational deployments.

Analysis of all interview transcripts resulted in the development of four group experiential themes and 10 subthemes. These are outlined in Table 4 below. Additional participant quotes are included in Appendix O.

Table 4

Group Experiential Themes and Subthemes

Group Experiential Themes	Subthemes	Number of Participants Contributing to Subthemes
Not Always Being the Dad I Want to Be	Disconnected and Disrupted Parenting	10
	I Haven't Fulfilled my Parental Duties	9
	Maybe I am a Good Enough Dad?	8
Striving to Protect	Shielding Children from the Realities of Distress	7

	I Can't Let Anything Happen to Them	5
	Breaking the Family Cycle	4
Developing Insight and Understanding	Understanding Supports Connection	10
	How do I Explain it? (If I Want to Explain)	5
Protective Influence of Children	Keeping Going for Them	8
	The Joy of Fatherhood	5

Not Always Being the Dad I Want to Be

This group experiential theme captures how participants make sense of themselves as parents in the context of PTSD symptoms negatively impacting parenting. There is an emphasis on the word 'always' in the title of the group experiential theme; this reflects the participants' evolving view of themselves as parents, as well as their experiences of reconciling the challenges of being a parent diagnosed with PTSD, feelings of guilt, and a sense that they are doing / have done a good enough job as a dad.

Disconnected and Disrupted Parenting

This subtheme encapsulates how parenting was negatively affected by the psychological and behavioural manifestations of PTSD. For some participants low mood was experienced as most challenging, whereas for others it was irritability and heightened arousal. Keith and Tim were the only participants to describe engaging in verbal and threatened physical aggression directed towards their children. These reactions appeared to be understood in the context of emotional 'outbursts' related to PTSD, but also in relation to parenting during the 1980s when physically punishing children was more commonplace.

All participants spoke about the variable nature of PTSD, and there was a consensus that parenting felt manageable if mood and behaviour remained relatively consistent and

"under control" (Richard), whereas experiencing a deterioration in mood or behaviour appeared to be overwhelming and present more challenges:

> "Yeah when I'm on a downer I'm more shouty, I'm a bit more shouty with them. Then when I'm in a good mood I'm more cuddly so it's like…yeah…" (Ben)

All participants described feeling disconnected at some point from their role as a father and from their children. The sense made of this varied between participants. Seven participants described becoming avoidant and withdrawn, resulting in physical and emotional detachment. Detrimental impacts both for the self and for children were recognised:

> "Um, I think I lost the love for them. And because I wasn't giving them the love that I'd given before, it wasn't reciprocal they weren't giving me the love." (Chris)

> "You know they started to miss out or I started to miss out because I wouldn't socialise or I didn't want to socialise." (Oliver)

Participants also seemed to feel disempowered as a result of PTSD which resulted in a change to or loss of their usual role as a father:

> "They knew that I was dad and I was in charge. But when I had the breakdown obviously [wife's name] took over the kids. So she was looking after them and she was making the decisions with the children. They all look to her mainly now." (Tim)

For Adam and Shaun, two participants who described experiences on operational tours in which they witnessed the deaths of children, reminders of these traumas encountered during parenting and subsequent avoidance and re-experiencing impacted their ability to be physically present:

> "I don't know how long I sat there staring to be honest and I don't know how I come round and then saw that it was her again, but I wasn't- I physically wasn't sat in my front room holding my daughter, I was physically in a compound holding a dead child." (Adam)

"I thought it must be because it was a child involved in my PTSD and then I had a child the bloody same sex, you know. And it was just, you know, I think if I'd have had a son it wouldn't have been as bad.

I: Why do you think that is?

Shaun: Well because it wouldn't be reminding me of the little girl." (Shaun)

There was a sense that the trauma was 'alive' for Shaun due to it being difficult to separate his daughter, and therefore his role as a father, from his trauma experiences; something that was distressing for him.

I Haven't Fulfilled My Parental Duties

In discussing and reflecting on their experiences of being a parent, nine participants described feeling guilty about their parenting behaviour. The use of the word guilt by most participants suggested a feeling of unhappiness and regret linked to thinking that they had done something wrong, caused harm, or had compromised their own standards of who and what a father should be: "I feel like I haven't fulfilled my parental duties, I've let her down." (Adam) As part of this there was sense that children were an innocent party who did not deserve to suffer as a result of having a father diagnosed with PTSD:

"It's like a punishment for them as well which isn't fair; I did what I did, I volunteered, I joined up in my job. It's not their job, it wasn't their choice." (Shaun)

The experience of guilt was painful for the participants, with these difficult feelings considered as another challenge to deal with on top of PTSD, and further compounding existing low mood or critical perceptions of themselves:

"So that guilt then makes things worse in a way, because you haven't been as playful as you've wanted to be or as you normally are…so you have those thoughts to deal with." (Ben)

"Oh it's horrible that is. Makes me feel even more depressed that does, yeah." (Tim)

For many participants the burden of guilt pervaded, even when children and others shared their reassurances, indicating that these feelings had perhaps become ingrained over time:

> "Some people might see me as a good dad anyway, but it's in my head, I'll never be good enough. If you never think you're not good enough there'll always be…that'll always play a part I suppose." (Ben)
>
> "They're [his children's] response was what I actually anticipated. But er…I still punish myself for it." (Keith)

Maybe I am a Good Enough Dad?

Over the course of the interviews eight of the participants began to acknowledge shared enjoyment with their children, beliefs that their children saw them as reliable or generally "alright", and their own perceptions of doing a good job as a father. An example is articulated by Tim who initially commented "I don't regard myself as a good parent at all" and moved to a place where he was able to recognise doing somethings right: "My son did tell me a few weeks ago that he loved me so [laughs]…yeah so he- there must be some right there." (Tim)

It is of note that these discussions occurred towards the end of the interviews. This may have been related to many of the participants' tendencies to keep things hidden and to just carry on, as discussed in the next theme 'striving to protect'. It is hypothesised that engaging in the interviews perhaps gave the participants space and permission to take a step back and think about their experiences more holistically. Acknowledging the positives and attempting to reconcile that it was "not all bad" seemed to also have a positive impact on how participants felt about themselves:

> "I want to take a bit of the praise and I feel as though I have done something towards it, not as much as the wife, but it takes two of us to model the kids. So yeah I've got it

right. I have. That makes me feel better, I was starting to feel quite down actually, but no, I'm feeling ok." (Chris)

Striving to Protect

This group experiential theme encapsulates the conscious effort made by participants to change and moderate their behaviour in response to an awareness and understanding of the potential detrimental impact of their traumatic experiences on their children and their relationships. Within this, participants described engaging in behaviours that appeared to serve the function of not only trying to protect their children from distress and harm, but also of preserving their children's positive view of them as a father.

Shielding Children from the Realities of Distress

This subtheme encompasses the actions taken by participants to hide their mental health difficulties. Only one participant explicitly described engaging in behaviours that shieled children from the realities of distress in order to protect them:

"I think that you become quite a good liar if I'm honest. I think you become very apt at acting and being able to cover things up quite well. And that's a really sad thing to say, but you do it, I done it to protect my girls." (Oliver)

However, descriptions by other participants in relation to being aware of the concept of intergenerational transmission of trauma, a conscious awareness of children's perceptions, and not wanting their own behaviours to affect their children, suggested that hiding parts of the self served a protective function. Four participants described assuming a mask or 'acting' to hide true feelings:

"It's a mask really. It's more of putting a mask on to say, 'everything's great, there's no problem here', so he doesn't really get to see it." (Jason)

Similarly, Tim described developing a 'skill' in making sure that his son was protected from his mental health difficulties:

> "We've always kept things away, not got him involved with things to do with my mental health and all that lot you know. I suppose it was a skill we developed." (Tim)

These descriptions appeared to emphasise the conscious effort involved in keeping up appearances, with some participants acknowledging that this was exhausting and not possible to continually maintain.

As well as being motivated to protect their children from the ill-effects of trauma, for some participants, hiding difficulties was due to a fear that the parent-child relationship would be negatively affected if children, including adult children, experienced the truth:

> "I really do not want to lumber her with this because she's her own woman she's got her own things to think about and this shouldn't really affect her and shouldn't affect her relationship with me, and I'm frightened that it would." (Chris)

The use of the word lumber here suggested that Chris may experience himself as a heavy burden, one not to placed on someone else, especially his child. Not being seen as weak was also important for some participants, potentially highlighting the influences of norms and narratives surrounding the concept of masculinity:

> "Thing is, my daughter will go 'well my dad was this hard man' – this is my fear – 'this hard bloke this tough man and that, and he couldn't face a problem, and his way out was topping himself…so I've got a problem I'm not big and tough so how am I going to deal with it?'" (Shaun)

A fear of being judged negatively was also experienced by other participants. There seemed to be an understanding that being judged by your own children is particularly painful, and that perhaps it is safer to be more open and honest with 'strangers' not connected to the family, such as professionals:

> "Sometimes it's easier talking to a stranger than it is actually talking to someone you know, because…I don't know whether it's the judging thing?" (Adam)

I Can't Let Anything Happen to Them

This subtheme relates to the more explicit forms of protective behaviour engaged in by participants to ensure safety, such as not letting their children do certain things, being 'on guard', and ensuring preparedness:

> "When you take them out on day trips and places like that, um, there's always that level of heightened awareness when you're out and about with them…a level of protection and preparation that goes into it…going somewhere." (Ben)

Heightened awareness and hypervigilance were also described by other participants, highlighting the increased sensitivity of the participants to their environment and awareness of potential threats. This constant scanning seemed to add an additional layer to the role of dad to that of 'protector', with Shaun drawing parallels with being "like a bodyguard" to his daughter.

For Adam and Shaun, the need to protect their daughters appeared to be impacted not only by potential unknown threats but also by previous experiences on operational tours in which they witnessed, and were unable to prevent, the deaths of children:

> "Because I think…I feel like…I definitely lost people in Afghan, but I feel like I lost people that didn't need to be lost in Afghan, and a lot of mine orientates around children. There are different scenarios with regards to children dying and you know that little girl definitely sits with me because we wouldn't have hit the compound if it wasn't for the target pack." (Adam)

The little girl sitting with him suggests that Adam has retained an awareness of a time when he felt that he should have protected a child but was unable to. His later discussion of "I even went and bought her a tracker" suggested that he was taking control of what he could do to protect his daughter.

The good intentions behind wanting to protect their children from harm were recognised by participants, perhaps aligning them with any other caring and attentive father.

However, good intentions appeared to be quickly outweighed by the extreme nature of the behaviours which became overwhelming for both the participants and their children:

> "I daren't sleep at night in case anyone came in the room. How ridiculous was that? So I went for days not sleeping which made me worse, you know grumpy, sleep deprivation, it was killing me, and just ruined everything for everyone really." (Shaun)

Breaking the Family Cycle

In making sense of themselves as parents, four participants reflected on their childhoods and the relationship with their own father. Awareness of unmet needs and vulnerabilities related to childhood traumas seemed to give rise to a desire to break the cycle of absence, emotional disconnection, fear, and violence. Being a father was viewed as a significant responsibility, with each participant seeming acutely aware of how they do and do not want to parent their children, based on memories of their own childhoods:

> "So when I got married, I said right these are things I'm not going to do: I'll never lay a hand on my wife or family if I have one, I will never keep them short of money, I will never cheat…and these are the sort of ground rules I gave myself." (Jonathan)

For Jason there was also an emphasis on wanting to provide an emotionally and physically close relationship with his son, characterised by talking and showing affection; something he had not experienced in his own relationship with his father:

> "And I didn't want to have that same for him [son]- For me to appear to him in that same way as being emotionally distant or being physically distant or anything of that nature, you know. If he wants a hug fine absolutely, if he doesn't again fine, absolutely not a problem." (Jason)

Developing Insight and Understanding

This group experiential theme relates to how insight and understanding is developed and navigated within relationships. Participants highlighted a need to understand themselves,

with five participants describing feeling confused and unaware of the extent of their difficulties in the aftermath of trauma pre-diagnosis. The reciprocal nature of understanding was also discussed, with participants wanting to reassure their children whilst simultaneously acknowledging the importance of feeling understood and accepted by their children and families.

Understanding Supports Connection

Developing understanding seemed to support interpersonal connection with others, as well as intrapersonal connection, i.e., making sense of the self in relation to previous experiences:

> "My therapist gave me a book and for me that probably was a really good book to make me understand my PTSD and to understand what it was all about…it's really interesting…before I didn't understand what was wrong with me." (Oliver)

Many of the participants also shared detailed accounts of their combat experiences during the interviews. This was interpreted as participants feeling that perhaps the author did not have enough of an understanding and the details were required to gain some insight into what the men had been through and the unique experience of warfare:

> "I find civilians- sorry to be insulting to a civilian, civilians have a very peculiar view of what warfare is like and what it's like to be under fire and to shoot back; like I say, it's both terrifying and amazingly exciting at the same time." (Richard)

This demarcation between combat veteran and civilian was likely acutely experienced in the parent-child relationship, and feelings of frustration around misunderstanding, or concerns about admitting feelings of terror, an admission not aligned with the hegemonic masculinity commonly associated with the military, may have precluded the men from talking to their children about their experiences.

However, partners and children developing an understanding of participants' military experiences and responses to trauma was seen as helpful and supported participants with feeling validated and less alone:

> "They've always been loving and caring and everything, but now I think they saw what I was going through...and they've got a good understanding of it. And not so much the respect is there, but the loyalty, the love, and understanding is there." (Chris)

As well as feeling understood themselves, it was important for some participants to reassure their children what had happened / was happening was not their fault:

> "I want to at some point in time put that across to her which I tried to say you know reinforce that fact that nothing you've done has caused any of the situations that we're in at this present moment in time." (Adam)

Four participants cited the role of professional intervention in supporting the development of new insights, which in turn prompted more open discussions with their families:

> "It [therapy] shows you the change and perceptions. I don't try to be that rufty-tufty soldier anymore to my girls and or to my wife, because I think without talking, you know it's really difficult." (Oliver)

Oliver highlighted how the role he assumed in the military, one characterised by being 'rough and tough', had spilled over into his role as a father. However, with therapeutic support there had been shift away from this role to an awareness that talking and showing more vulnerability supported building connection with his family.

For Ben and Richard, a change in perspective had occurred in response to experiencing combat trauma and subsequent mental health difficulties. The experience of trauma seemed to highlight the fragility of life and not taking life itself or relationships for granted, with these insights facilitating a deeper love for their children:

> "I think it matters now because I've seen how valuable it [life] is. So has it affected my relationship with my daughter? Yes, but because I think I love her properly." (Richard)

An awareness that mental health difficulties were / are experienced in response to trauma also seemed to promote empathy and curiosity with children:

> "When I'm dealing with the children and their behaviour I often think what's going on behind that in their head? So what's the reason for it and… Because of my own experiences with mental health, there's a reason behind it you know, it doesn't just happen, something's going on." (Ben)

How do I Explain? (If I Want to Explain)

This subtheme captures the complexities of explaining experiences to facilitate understanding. Participants referred to the level of explanation being dependent on their children's ages, with young children requiring much less explanation than older children. Some participants felt able to offer a basic explanation to their children, and some were happy to avoid the conversation altogether. For the participants who did want to explain their experiences, responses, and offer reassurances, there was an uncertainty and lack of confidence which appeared to hold them back:

> "All my life I've had to say to my daughter one day you'll understand, which you know, wasn't good enough really." (Shaun)

Five participants seemed to experience a dilemma with regards to whether or not they should explain what was going on. Here, the recognition that supporting children to understand could be helpful was balanced with a fear of getting it wrong or making it worse:

> "I think that can be quite a scary sort of thought about where you go [with explaining] because you know is that helpful or not helpful? Will that have an impact or not have an impact? I don't know really, it's not the easiest thing in the world really to go with." (Adam)

Protective Influence of Children

This group experiential theme describes the ways in which the participants experienced their children as providing a significant and valued source of enjoyment and support in their lives. For many participants, their children and the parent-child relationship provided support, distraction, comfort, and a way of coping with difficulties even when other relationships and activities could not.

Keeping Going for Them

This subtheme captures the experience of children playing an active and significant role in the participants' well-being. This was spoken about by eight participants. For participants with younger children in particular, children were seen as a welcome distraction. Simply being around their children provided solace for some:

> "I used to love just sitting there watching her. I could spend hours just watching her draw and I found that was probably like one of my best therapies you know was doing that and being with her." (Adam)

As well as distracting from difficulties, all participants experienced their children as a motivating force which drove action and engagement during times when this felt more difficult for them. Within this, there was a recognition that the needs of the child took precedence over the participants' own needs and a sense of "doing it for them". Chris and Ben both discussed this in relation to their motivations to seek and continue with treatment:

> "I've sought treatments, help with it, because I want to be…the whole reason is to keep a relationship with my kids, that's why I engage with [the charity] was because I want to get better and be a better dad for them, that's the whole reason behind it." (Ben)
>
> "You know, if it's affecting my family and the tablets stop it affecting my family and my friends, let's do it, you know, I'll keep taking it." (Chris)

Further descriptions of trying to be selfless indicated that this was at times an effortful endeavour on the part of the participants: “I’m fighting on for my daughter and my granddaughter’s sake.” (Shaun) The use of the word ‘fighting’ here appeared to highlight the intensity of this, and perhaps also drew parallels between parenting whilst living with PTSD and military experiences of contending in combat. Despite these challenges, the effort of being selfless seemed to have benefits for both the participant and their children:

> “And yeah it’s just trying to be selfless, and I have to put them first over me, and not in a negative way, because I think it’s a positive thing because actually I end up benefiting from it anyway, so it ends up being fine.” (Oliver)

Furthermore, five participants described how their children had saved them, with the presence of children and the importance of the father-child relationship appearing to play a significant role in protecting against the overwhelming experience of symptoms and suicidal ideation: “Yeah… If it wasn’t for them I might not be here.” (Keith)

The Joy of Fatherhood

Five participants described the general pleasure and happiness they experienced in their role as fathers. These verbal descriptions were accompanied by visible indications of their experience during the video calls; for example, participants smiling and laughing. Two participants focused on the positive impact of the transition to fatherhood. For Ben, positive change as a result of becoming a father seemed particularly pertinent as his son was born at time when he was finding it difficult to cope with his diagnosis of PTSD:

> “And then we started a family together and then my son came along and that was a massive change for the positive for me, that was brilliant you know, that was amazing.” (Ben)

Other participants with older children spoke of the development of special bond over time which has been maintained and is valued:

> "Oh yeah, you know I always look forward to seeing her, always look forward to seeing her. And it makes me feel good when I see her as well. And you know it's- You see it's a source of pleasure, it is, I mean I get pleasure out of talking about her." (Jonathan)

For all participants contributing to this subtheme there was a description of the joy of fatherhood remaining constant, despite this at times being overshadowed by the challenges of parenting in the context of PTSD: "But god they're good fun. That's the thing isn't it, I really enjoy being a dad." (Oliver)

Discussion

The aim of this study was to explore how ex-service parents who had received a diagnosis of post-traumatic stress disorder (PTSD) experience and make sense of parenting. The theme 'not always being the father I want to be' captured participants' experiences of how PTSD symptomology influenced and impeded their parenting. Participants described the impact of low mood, irritability, avoidance, and re-living trauma on their ability to engage with their children physically and emotionally. These findings resonate with previous research identifying symptoms characteristic of PTSD significantly negatively impacting on parenting in veteran populations (Cohen et al., 2011).

In their qualitative study McGaw and colleagues (2018) described participants' experiences of 'disconnectedness', something that was also reported in this study as participants described feeling emotionally detached and avoidant. This mirrors previous quantitative literature in which numbing and avoidance symptoms have been associated with decreased perceived parent-child relationship quality (Ruscio et al., 2002). Additionally, the impact of intrusive traumatic memories on disconnection was noted by a small number of the participants in this study.

In reflecting on their experiences of parenting, the majority of participants described feeling guilty, which was experienced as an additional challenge to manage on top of PTSD.

To the author's knowledge this is the first study to describe feelings of guilt in relation to parenting in a sample of ex-service parents with PTSD. Participants' critical perceptions of themselves as fathers can be understood in the context of research which suggests that trauma can threaten the view of the self, thus contributing to negative self-appraisals (Brown et al., 2016). Towards the end of the interviews there was a shift in some participants being able to recognise their strengths as fathers, which in turn was noted to have a positive impact on the participants mood.

Participants' experiences of taking action to protect their children and the view of themselves as fathers within the parent-child relationship were captured in the theme 'striving to protect'. An awareness of the potential detrimental impact of PTSD on children and an understanding that trauma can be 'transmitted', ideas that have received significant attention in the literature (Ancharoff et al., 1998), appeared to underlie this. Furthermore, the role of hypervigilance can be understood within the C-BIT model (Dekel & Monson, 2010), which posits that attentional bias towards threat is thought to influence concerns about loved ones' safety, which in turn prompts behavioural reactions to ward off anticipated threat. Additionally, references to maintaining the "tough bloke" persona and not showing weakness suggests the influence of societal narratives regarding men being strong and fathers being providers and protectors (Miller, 2011). These constructions of masculinity may have also been reinforced in the male-dominated military environment in which characteristics such as strength and courage are privileged (Eichler, 2017). Participants' descriptions of wanting to break the cycle of abusive or neglectful fathering suggests that they had undergone a process of 'reworking' (Pruett, 2000), whereby a conscious decision is made to be a different and better father to compensate for their own experiences.

The importance of understanding the self as well as shared understanding with children and families was highlighted in the theme 'developing insight and understanding'. Many ex-

service personnel can feel isolated in their experiences, with this isolation exacerbated by the experience of stigma and self-stigma, for example, internalising perceptions that individuals with PTSD are 'crazy' (Mittal et al., 2013). In this study, feeling understood, accepted, and supported by their children and families was important to participants and when present, helped to facilitate connection with them. The role of family support and involvement is well documented, and is associated with decreased symptom severity and improved engagement with treatment (Wilcox, 2010). For some participants insights gained through engaging with treatment prompted more open discussions with their children and families which helped to facilitate understanding. For others, in line with the concept of post-traumatic growth (Tedeschi & Calhoun, 2004), new perspectives had been gained as a result of traumatic experiences which facilitated increased empathy and closeness with their children.

Some participants described experiencing a dilemma with regards to explaining their difficulties to their children. These findings are in line with previous research investigating the challenges and complexities of ex-service parent and child communication about PTSD. Sherman et al. (2015) reported barriers to communication including concerns that children will not understand, fears that children will become distressed, and ex-service members not knowing enough about PTSD themselves. Supporting parents to navigate these dilemmas and barriers may be particularly pertinent considering research which suggests that silence contributes to the intergenerational transmission of trauma as children sense discord but struggle to process this (Ancharoff et al., 1998).

Previous studies have described how children provide practical and emotional support to ex-service parents with PTSD (Sherman et al., 2016). However, within the theme of 'protective influence of children', it was the presence of children rather than them 'doing' things per se, which appeared to distract from distress and motivated participants to engage in treatment and generally 'keep going' even when this felt challenging. These findings concur

with previous research recognising the role that having a child can play in motivating positive change in fathers experiencing mental health difficulties (Evenson et al., 2008). Furthermore, in contrast to previous research reporting an association between PTSD and decreased parenting satisfaction (Samper et al., 2004), half of the participants described the happiness and pleasure they experienced as fathers, despite the challenges outlined.

Limitations

In line with guidelines for conducting research using IPA attempts were made to recruit a homogenous sample. The group were closely defined in terms of several characteristics such as gender, being fathers, ex-military status, and PTSD diagnosis; however, it is recognised that there were vast differences in the ages of the participants and the age of their children. Though all had regular contact with their children, it is acknowledged that the experiences of caring for younger children who live in the family home at least some of the time may have been very different to participants who had older children living more independent lives. Within this, there is a recognition that some participants may have relied on more retrospective reporting.

Individuals experiencing active psychosis and / or suicidal ideation were excluded from participating, as determined by the charity's inclusion and exclusion criteria. Research reports associations between traumatic life events and psychosis and suicidal ideation (Glenn et al., 2020; Kozarić-Kovačić & Borovečki, 2005), and as such, these could be considered a response to trauma. A limitation, therefore, is that the views of veterans experiencing more acute levels of trauma related distress may have been excluded.

Though it is acknowledged that some individuals find receiving a mental health diagnosis helpful, illness models of distress have been criticised for being reductionist, with the validity of discrete diagnoses also questioned (Allsopp et al., 2019). PTSD symptoms are only one way of conceptualising trauma related distress; thus, it is recognised that by focusing

on PTSD diagnosis only, the study may have excluded the views of veteran fathers experiencing other responses to trauma.

The response rate to the initial recruitment email was low; however, it is not clear how many recipients were parents so the number of eligible potential participants cannot be estimated. The potential for selection bias is nevertheless acknowledged. Anecdotally, all participants discussed feeling motivated to engage in the research to help others and to enhance understanding and support for military families in which a parent has a diagnosis of PTSD.

The interview schedule focused on experiences of parenting more generally, with one question asking about trauma experiences and parenting, and no questions explicitly referencing the military or veteran status. A limitation of this is that there was an inherent assumption that participants would speak about their experiences of military trauma and as veterans in relation to parenting, even though this was not asked about explicitly. This may have impacted how much these aspects were considered by the participants, though the schedule was used flexibly to follow-up on discussions and personal meaning making. Furthermore, as veteran status and military trauma were key characteristics of the homogeneity of this group, a limitation of not referring to these in the questions is that the experiences discussed may be related to fatherhood more generally and not in the context of the experiences of this particular population.

IPA does not seek to generalise from results; however, given that all participants in this study identified as White British and in / were in heterosexual relationships, the sample was likely not representative and may not reflect the views of minoritised groups.

The double hermeneutic inherent in IPA research means that the findings presented here are the result of the author making sense of the participant making sense of their experiences, and as such alternative interpretations may be reported by a different researcher. Though steps were undertaken to make conscious the author's motivation and biases, it is

acknowledged that development of the research and interpretations would have been somewhat influenced by the researcher's experiences and beliefs.

Clinical Implications

This study highlights the centrality of the parenting role for veterans diagnosed with PTSD. Initiating discussions about parenting and family life during assessment and treatment utilising a strength-based approach is likely to support gathering of relevant information, whilst also offering ex-service parents a space to develop an alternative, less problem-saturated narrative.

Current National Institute for Health and Care Excellence (NICE) guidelines recommend individual interventions for the treatment of PTSD (NICE, 2018). The reported significance of understanding by participants indicates that including children and families in treatment provision may be beneficial. This may take the form of joint sessions between ex-service members and their families or adjunctive sessions for families, with the expanding literature in this area documenting the benefits of these approaches (Jones & Lucero, 2017). Furthermore, adopting more systemically informed interventions may also helpfully support a move away from the perception that the problem is located in the ex-service member. If family involvement is not requested or feasible, clinicians offering practical support with talking about traumatic experiences and resulting mental health difficulties, or signposting to relevant child age-appropriate material, may also be helpful in alleviating concerns about explaining PTSD.

Though all participants described experiencing combat related trauma, the finding that some participants also spoke about childhood trauma and adversity highlights the need for clinicians to remain aware of prolonged or multiple traumatic experiences in this population. Furthermore, traumas involving children appeared particularly significant for some participants, with parenting influenced by intrusive memories and avoiding trauma-related

triggers involving children. As such, it may be beneficial for clinicians to remain curious about the impact of traumas involving children for ex-service parents.

Research Implications

Given that mothers and fathers often assume differential parenting roles and practices (Yaffe, 2020), it is recommended that further qualitative research be conducted exploring the parenting experiences of ex-service mothers diagnosed with PTSD. Additionally, understanding more about the experiences of ex-service parents from minoritised ethnic backgrounds and those from the LGBTQ+ community would also enhance the literature in this area.

This study included participants with children with a wide range of ages. It is acknowledged that the demands of parenting are likely to be very different at varying developmental milestones. As such, further research could explore the experiences of more specific groups of parents, for example, those who are parents to babies and young children, adolescents, and adult children.

Finally, obtaining alternative viewpoints may be beneficial considering the influence of attentional bias towards threat and the negative impact of trauma on perceptions of the self and others in ex-service parents with PTSD (Brown et al., 2016). Exploring the experiences of children of ex-service parents would therefore further enhance the understanding of how PTSD plays a role in parent-child relationships.

Conclusions

This study explored how ex-military fathers diagnosed with PTSD experience and make sense of parenting and the parent-child relationship. Ten interviews were undertaken which were analysed using IPA. The analysis resulted in four themes and 10 subthemes relating to the perceived impact of PTSD symptoms on parenting and an evolving perception of the self as a parent in relation to this, a need to protect children from distress and harm, the importance

of developing insights and understanding, and the protective influence of children on well-being. The use of more systemically informed interventions may support ex-military fathers and their families in developing understanding and connection. Further research exploring the experiences of ex-military mothers as well as children could further enhance the understanding of the experience of a parent's diagnosis of PTSD in ex-military families.

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Section C: Appendix of Supporting Material

Appendix A

Mixed Methods Appraisal Tool

Table 3

Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018)

Studies	Methodological quality criteria						
	Qualitative studies						
	Are there clear research questions?	Do the collected data allow to address the research questions?	Is the qualitative approach appropriate to answer the research question?	Are the qualitative data collection methods adequate to address the research question?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?
McGaw et al. (2018)	Yes – research questions clearly outlined.	Yes – qualitative data collected and reported.	Yes – study focus was on exploring veteran's lived experience of parenthood and family life.	Yes – participants engaged in 1:1 semi-structured interviews which were audiotaped.	Yes – thematic content analysis used.	Yes – quotes provided throughout to demonstrate themes.	Yes – clear links are demonstrated, and results are discussed in the context of previous research and theory.
	Quantitative non-randomised studies						
	Are there clear research questions?	Do the collected data allow to address the	Are the participants representative of the target population?	Are measurements appropriate regarding both the outcome and	Are there complete outcome data?	Are the confounders accounted for in the design and analysis?	During the study period, is the intervention administered (or exposure

		research questions?		intervention (or exposure)?			occurred) as intended?
Zerach & Solomon (2016)	Yes – research aims and hypotheses clearly outlined	Yes – data collected and reported using a number of relevant measures.	No – not enough details about target population. Attrition noted at all time points for both ex-prisoner of war veterans and control group veterans.	Yes – measures appropriate for answering research questions, measures reported to be reliable and valid (this information is reported).	No – as mentioned, attrition was noted at all time points. Response rates for prisoner of war adult offspring = 87% and for control offspring = 80.6%.	Yes – control participants matched on military and personal variables.	Yes – exposure was being an ex-prisoner of war or not so this did not change. However, the authors note the potential impact offspring's mental health and personality which was not measured (other than PTSD).
Quantitative descriptive studies							
	Are there clear research questions?	Do the collected data allow to address the research questions?	Is the sampling strategy relevant to address the research question?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?
Bachem et al. (2021)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – the sample was selected based on a particular time point in a longitudinal	Can't tell – not enough detail provided about target population. 213 out of 250 couples	Yes – measures appropriate for answering research questions, measures	No – Tests showed missing data was not missing completely at random;	Yes – describes appropriate analyses used to test each hypothesis.

			study, but no rationale is given for selecting this time point.	participated, no data on differences between responders and non-responders.	reported to be reliable and valid (this information is reported).	however, missing data handled using maximum likelihood when running models. Strength and direction of correlations were noted to be the same before and after handling for missing data.	
Creech et al. (2016)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – participant sample randomly selected.	No – no clear description of target population; however, representativeness unlikely given low response rate and 81.3% of sample being white.	Yes – measures appropriate for answering research questions, measures reported to be reliable and valid (this information is reported).	No – Response rate noted to be 27%. No information about differences between responders and non-responders. Missing data accounted for 4.58% of the data set. Listwise deletion was	Yes – describes appropriate analyses used to test each hypothesis.

						used for missing data.	
Creech et al. (2021)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – purposive sampling used.	No – authors document that sample was not representative, and this is reflected in demographic detail (e.g., 60% white participants).	Yes – measures appropriate; however, validity and reliability not explicitly described.	Can't tell – information on response rates not documented.	Yes – describes appropriate analyses used to test each hypothesis.
Feingold & Zerach (2021)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – volunteer sampling with outlined inclusion criteria.	No – authors document that sample was not representative. Of the 253 participants who gave consent, 18.9% did not complete questionnaires, 3.5% did not meet inclusion criteria, and data for 2.7% were removed due to fixed response set.	Yes – measures appropriate for answering research questions, measures reported to be reliable and valid (this information is reported).	No – 74.7% response rate. No detail on differences between respondents and non-respondents.	Yes – describes analyses used to test each hypothesis.
Franz et al. (2021)	Yes – research questions and	Yes – data collected and	Yes – initial sample obtained	Can't tell – not enough detail,	Yes – measures appropriate;	Yes – Low non-response rate	Yes – describes appropriate

	hypotheses clearly outlined.	reported using a number of relevant measures.	using random sampling with outlined criteria, and then stratified sampling used to oversample underrepresented groups.	though authors note they oversampled female participants and participants from high crime areas and sample size was large.	however, validity and reliability not explicitly described.	(7.7%) noted. Data analysed using complete case analysis.	analyses used to test each hypothesis. Analysis accounted for multiple relevant covariates.
Gogger et al. (2021)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – purposive sampling via primary care clinics or designated nurse co-ordinator.	Can't tell – no clear description of target population, though inclusion and exclusion criteria are outlined. Small sample size may limit representativeness.	Yes – measures appropriate; however, validity and reliability not explicitly described.	Yes – 17.8% of women did not return for post-partum assessment; however, other than all being married and multiparous, there were no differences in terms of clinical variables or demographics.	Yes – describes analyses used to test each hypothesis.
Levin et al. (2017)	Yes – research questions and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – the sample was selected based on two particular time points in a longitudinal	No – no details about target population; however, attrition noted across time points. Reasons	Yes – measures appropriate for answering research questions, measures	Yes – 17 – 30% of values were missing. Tests showed missing data was not missing	Yes – describes appropriate analyses used to test each hypothesis.

			study, but no rationale is given for selecting these time points.	included refusal, not being able to locate participants, mental health deterioration, and death.	reported to be reliable and valid (this information is reported).	completely at random; however, missing data handled using maximum likelihood when running models.	
O'Toole et al. (2018)	Yes – research aims clearly described.	Yes – data collected and reported using a number of relevant measures.	Yes – randomly sampling used.	No – no detail regarding target population; however, authors note low response rates from sons in particular.	Yes – measures appropriate for answering research questions. Though the inter-coding of the Family Affective Attitude Rating Scale was noted to be reliable, Cronbach's alpha was below levels reported in other research using this scale.	No – though only small differences noted between responders and non-responders in relation to veteran characteristics, there was a lower response rate from sons.	Yes – describes appropriate analyses used in line with research aims.

O'Toole (2022)	Yes – research aims clearly described.	Yes – data collected and reported using a number of relevant measures.	Yes – randomly sampling used.	No – no clear description of target population; however, only 56% of eligible offspring responded and low response rates from sons in particular.	Yes – measures appropriate for answering research questions, though Cronbach's alpha for the Family Affective Attitude Rating Scale was below levels reported in other research using this scale.	No – Differences noted between responders and non-responders (based on available veteran variables), also lower response rate from sons compared with daughters.	Yes – describes appropriate analyses used in line with research aims.
Smith et al. (2017)	Yes – research aims and hypotheses clearly outlined.	Yes – data collected and reported using a number of relevant measures.	Yes – random sampling initially used, then stratified in terms of previous service and gender.	Yes – Time 1 and time 2 responders and non-responders were compared on a number of characteristics and this analysis yielded modest differences.	Yes – measures appropriate for answering research questions, Cronbach's alpha reported for all.	Yes – Response rate 64.2%; however, exploration of differences between responders and non-responders were noted to be modest.	Yes – describes appropriate analyses used in line with research aims.
Vogt et al. (2016)	Yes – research aims and hypotheses	Yes – data collected and reported using a number of	Yes – random sampling initially used, then stratified in	Yes – Time 1 and time 2 responders and non-responders were	Yes – measures appropriate for answering research	Yes – Response rate 64.2% - exploration of differences	Yes – describes appropriate analyses used

	clearly outlined.	relevant measures.	terms of previous service and gender.	compared on a number of characteristics and this analysis yielded minor differences.	questions, Cronbach's alpha reported for all.	between responders and non-responders were noted to be minor.	in line with research aims.
Mixed methods studies							
	Are there clear research questions?	Do the collected data allow to address the research questions?	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Sherman et al. (2016)	Yes – research aims clearly outlined.	Yes – quantitative and qualitative data reported and collected. Authors do note that emphasis is on qualitative component.	No – emphasises obtaining qualitative data from veterans about their experiences, but no rationale as such for why mixed methods.	No – focus is on qualitative data, quantitative data only reported as descriptive statistics.	No – again, focus is on qualitative data, quantitative data not explored in terms of research questions.	No – this is not reported.	Yes – Qualitative component: 5/5 Quantitative component: 3/5

Appendix B

International Trauma Questionnaire (ITQ; Cloitre et al., 2018)

This has been removed from the electronic copy.

Appendix C

Semi-Structured Interview Schedule

Semi-Structured Interview Schedule

Opening: Check in with how they are. Do they have any questions from the last meeting or anything they wanted to discuss? Reiterate they don't have to take part and can stop / take a break at any time. Explain that I am interested in exploring their experiences as a veteran, a person who has experienced trauma, and as a parent, and will ask several questions related to these areas. Ask them to please give as much information as they feel comfortable and able to. Emphasise that there are no right or wrong answers, and that I am interested in their personal experiences. Remind about recording on Dictaphone.

Questions:

- Can you tell me about your family life and what role you play in the family?

- How would you describe yourself as a parent?

- Can you tell me about your relationship with your child / children?

- How do you think your child / children see you?

- Has anything changed over time in how you think about or relate to your family?
  If you think so, can you tell me in what way you think it has changed?

- Do you think there is any relationship between your experiences of trauma and how you relate to your child / children?
  If yes / no, can you say more about this?

  Are there any challenges you face as a parent because of your mental health difficulties?

Examples of further prompts:

- What was that like for you?
- Can you tell me more about that? / Can you tell me more about what you mean?
- Can you tell me more about how 'X' affected 'X'?
- How did you make sense of that?
- How did / does that make you feel?
- Can you give an example?

Ending: We have now reached the end of the interview; is there anything else you would like to add, or feel like we may have missed?
Do you have any questions for me?
Would they like to receive a summary of the study once it has been written?
At the end – verbal debrief about the nature of the study using debrief form; check with participants how to send this form to them (e.g., email).
Ensure the participants has the relevant contact details and knows who to contact should they feel they need further support.
Thank the participants for taking part.

Appendix D

Salomons Ethics Approval Letter

This has been removed from the electronic copy.

Appendix E

Email to Prospective Participants

Dear [name],

I am emailing you on behalf of the research team at (charity name) to tell you about an important new study that you may be interested in taking part in. The study is a collaboration between (charity name) and Canterbury Christ Church University.

You can see a message below from Michaela, the person leading the project, explaining what the study will involve. We kindly ask that you read the message below. If you would like to take part in the study, or if you have any further questions, you can contact Michaela directly via email at m.sturgeon1127@canterbury.ac.uk

Hello, my name is Michaela Sturgeon, and I am a Trainee Clinical Psychologist studying at Canterbury Christ Church University.

I am emailing to see if you would like to take part in a research project that explores UK veterans' views of family life and being a parent, with a particular focus on the impact of difficult and traumatic life events.

Taking part in the study would involve completing a questionnaire (which would take approximately 15 minutes) and having a conversation where I would ask some questions about your experiences (this part would take approximately 1 hour, though this time is flexible and dependent on how much you wish to say).

We hope that the results of the research will help to better inform support that is made available to both veterans and their families.

If you would like to know more about the project, please follow this link to view the full project information sheet:
https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_2noaGo2RAoMJaMC

If you are interested in taking part, or would like to discuss the project further, please email me on m.sturgeon1127@canterbury.ac.uk

Thank you very much for your time.

Kind regards,
Michaela Sturgeon

Kind regards,
The research team at [charity name]

Appendix F

Participant Information Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Date: 27/11/2020
Version number: 2
Ethics approval number: ETH2021-0058

Information about the Research

Title of study: An exploration of the parenting experiences of UK armed forces veterans who have experienced trauma

Hello. My name is Michaela Sturgeon, and I am a Trainee Clinical Psychologist studying at the Salmons Institute for Applied Psychology, Canterbury Christ Church University. I would like to invite you to take part in a research study which is being run by me (Michaela) and supervised by Dr Jerry Burgess, Salomons Institute, and Professor Dominic Murphy, [name of charity].

Before you decide whether to take part, it is important that you understand why the research
is being done and what it would involve for you.

Part 1 of this information sheet tells you the purpose of this study and what will happen if you
decide to take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1 of the information sheet

What is the purpose of this study?

The research is being undertaken as part of my clinical psychology doctoral training. Although the research exploring the impact of traumatic stress on military families is growing, there is very little research exploring the lived experiences of parents who are veterans and who have experienced multiple or prolonged traumas, and to date research in this area has not been undertaken with UK veterans.

This study aims to explore and understand how veteran parents / guardians who have experienced traumatic stress experience parenting and the parent-child relationship. It is hoped that the results of the research will help to inform support and interventions available to both veterans and their families.

Why have I been invited?
The study is interested in exploring the views of UK armed forces veterans who are parents.

Do I have to take part?
No, it is completely your decision. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw your data, without giving a reason, up to two working days after you have participated in the study. Your current care and / or any future treatment will not be affected by your decision to take part or not.

What does taking part involve?
You will be invited to complete an questionnaire during which you will be asked to briefly identify an experience that troubles you, and then you will be asked to rate how much you agree or disagree with 18 statements relating to your coping strategies and how you feel this experience has impacted your life. This questionnaire forms part of assessing eligibility for the second part of the study (semi-structured interviews), as we are interested in further exploring the views of veterans who have had similar experiences. Your eligibility for the second part of the study will be discussed with you after you have completed the questionnaire, and there will be the opportunity for you to ask questions and learn more about the study if you are not going on to take part in the interviews. Due to the current circumstances with regards to Covid-19, all contact, including the completion of the questionnaire, will take place over the telephone or via video format (such as Skype or Zoom), depending on your preference.

For the second part of the study I will be conducting semi-structured interviews over the telephone or via video format that should last approximately 1 hour, with a short break if needed. I will ask you for some information about yourself, such as your age, your service in the armed forces, and the age and gender of your children. These interviews will be audio recorded, and information will be included in the final project report, however, identifying information will be removed.

During the interview I will ask you some questions about your experiences of being a veteran, a parent / guardian, and living with traumatic stress, and what this is like for you. You can share as much or as little as you feel comfortable, and you are free to ask to questions / ask for clarification at any point during the interview.

What are the possible disadvantages and risks of taking part?
You may find that reflecting on and speaking about your experiences brings up difficult or painful feelings for you. You are free to stop, or take a break at any time, and there will also be time at the end of the interviews to discuss how you are feeling if you wish.

What are the possible benefits of taking part?
Some people welcome the opportunity for space to speak freely about a topic that they may not feel able to speak with others about or may not have had the space to think or talk about previously.

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. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes Part 1. If the information in Part 1 has interested you and you are considering taking part in the study, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
You are free to stop participating at any point during our meetings. Once I have collected your responses to the questionnaire and interview (if participating in these), you will have two weeks from the date you participated to withdraw your data. You can do this by contacting me on the details at the end of this form. You do not have to give a reason and your care will not be affected. If you choose to withdraw, all information that you have provided included questionnaire and interview data will be deleted.

What happens to the information I provide and will it be kept confidential?
Questionnaires that you complete with me will be stored on a password protected storage device. The interviews will be audio recorded on a digital recorder and I will use the recordings to transcribe the interviews on an electronic password protected word document. The audio files will be encrypted and stored on a password protected storage device. Only I will listen to the recordings and type them up. Any information that may identify you or others will be changed in the transcripts to ensure confidentiality. The typed transcripts may be read by my supervisors or the examiners who assess my final thesis; however, no one else will have access to the transcripts.

It is a University requirement that, after completion of the project, data (i.e. the disguised / anonymised interview transcriptions and anonymised completed questionnaires) must be provided on a password protected CD where it will be stored in the Salomons Institute's office in a locked cabinet for 10 years, after which time it will be destroyed. I also have an obligation to securely keep the data in my possession for 10 years after the study is completed, after which time it will also be destroyed.

Although a clinician you are working with at [the charity] may have mentioned the study to you and passed on this information, I will not be informing anyone at [the charity], or anywhere else, that you are taking part in the study and I will not be taking about your participation with them.

One exception to not speaking with others about your participation is if you tell me something that indicates, or I have concerns about, potential risk to yourself or others including your family members. In this case, I have a duty of care to safeguard both you and others, and in line with this would need raise such concerns via local policies and procedures. The other exception is if the interview is terminated abruptly, either

through choice or due to technical difficulties, and I cannot make contact with you, I may need to contact others so that they can see if you are okay or if you require any further support.

What will happen to the results of the research study?
I am undertaking this research as part of my doctoral training, and the completed research will take the form of an academic thesis. The information obtained from you during the interviews will be analysed for themes which will be discussed in the final write up of the research, with relevant anonymised quotes included. In order to share the results of this research and to contribute to knowledge in this area, I hope to use the data to write articles to be published in academic journals. In all instances any identifying information will have been removed so it will not be possible to identify you or link you to the study or results in any way. A summary of the findings of the study can be shared with you if you would like this.

What if I have a concern or wish to make a complaint?
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 address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for Michaela Sturgeon and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology – fergal.jones@canterbury.ac.uk

Who is sponsoring and funding the research?
The research is sponsored and funded by Canterbury Christ Church University.

Who has reviewed the study?
This study has been reviewed and approved by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

What happens next?
If you are happy to participate in the project you will be asked to sign a separate consent form, which both you and I will keep a copy of. Please also keep hold of this information sheet for your information.

You can either contact me directly on the details below to discuss your participation in the study, or you can let your clinician know that you would like to take part and they will contact me. I can also contact you if you have provided me with your details, or they have been provided to me via your clinician with your consent.

If you are not interested in taking part, you do not need to do anything.

Researcher contact information
Michaela Sturgeon
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology
m.sturgeon1127@canterbury.ac.uk

Appendix G

Consent Form

Exploring the Parenting Experiences of UK Armed Forces Veterans Study

Ethics approval number: ETH2021-0058

Please read the statements below and mark your responses.

I confirm that I have read the participant information sheet and have been given a copy to keep.

Yes ○ No ○

I understand the nature and aims of the study and have been given the opportunity to ask questions and have had these answered satisfactorily.

Yes ○ No ○

I am aware of the study procedures and what my participation will involve, and what will happen to my data once this has been collected and the study completed has been explained to me.

Yes ○ No ○

I understand that my involvement in the research, and any data that I contribute, will remain strictly confidential. I recognise the exception to this is if I disclose something to the researcher that causes concern for my own or others' well-being or safety. In this case the researcher has a duty of care to raise these concerns with the relevant authorities.

Yes ○ No ○

Should I go on to participate in the second part of the study (interview with the researcher), I consent to my interview being audio recorded and typed up by the researcher and used for data analysis purposes.

Yes ○ No ○

I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings.

Yes ○ No ○

I understand that my participation in the research is entirely voluntary, and that I am free to withdraw my participation and / or my data, without giving a reason, within two working days of me completing the questionnaire / within two working days of me engaging in the interview. This will have no bearing on my current or any future treatment.

Yes | No

I hereby freely consent to participating in the above-mentioned study.

I consent | I do not consent

I agree that my anonymised interview transcript can be used in a future study similar to this one. [OPTIONAL - this has no bearing on your consent to participate in this study only]

Yes | No

Please type your first name and first initial of your surname:

We ask all participants to create a unique participant code that they can remember. This code will be used on study documentation, instead of your name or any other identifying details, to help preserve confidentiality.

Your unique code should be made up of the last two letters of your post code and the last three numbers of your phone number; for example, HJ895.

Please enter the date you completed this form:

Please add your signature using your mouse or touch screen. Once you have added this please click on the arrow button (bottom right) to save your responses.

SIGN HERE

Appendix H

Demographic Information Sheet

Unique participant ID: **Date:**

Opening: Opening statement asking how the participant is, reminding them about issues relating to confidentiality and that they are free to take a break at any time or withdraw their data completely, without giving a reason, should they wish to, up to two weeks after their interview. Ask the participant if they have any questions.

Demographic information: Before we begin, I would like to ask you some questions about yourself.

Demographic questions:

- Gender
- Age
- Ethnicity
- Which branch of the armed forces did you serve with?
- How long did you serve for?
- Which year did you leave the armed forces?
- Are you currently employed? If yes, what is your current role?
- Marital status
- Questions about children:

  How many children do you have?

  How old are they and what is their gender?

  Are they your biological children? If not, can you tell me how long you have taken on a parenting / caregiving role?

  Do they currently live with you? If no, how much contact do you have with them?

Appendix I

Participant Debrief Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Date: 27/11/2020
Version number: 1
Ethics approval number: ETH2021-0058

Participant Debrief Sheet

Title of study: An exploration of the parenting experiences of UK armed forces veterans diagnosed with PTSD

Name of Researcher: Michaela Sturgeon

Thank you for taking the time to complete the International Trauma Questionnaire and engage in the semi-structured interview as part of this research study exploring the parenting experiences of veterans who have experienced trauma.

Background and research aims
Although research exploring the impact that trauma and post-traumatic stress disorder (PTSD) can have on an individual's experience of parenting and family life is growing, little is known about the subjective experiences of UK veterans who are parents.

This research aimed to explore two main questions:

- How do ex-service parents who have received a diagnosis of PTSD experience parenting?
- How do ex-service parents who have received a diagnosis of PTSD make sense of their role within the parent-child relationship?
- How do ex-service parents who have received a diagnosis of PTSD make sense of any interaction between their experiences of trauma, living with a diagnosis of PTSD, and their relationship with their child(ren)?

How is the research being carried out?
This project was comprised of two parts. Participants were first asked to complete the International Trauma Questionnaire (Cloitre et al., 2018). Previous research has shown that the International Trauma Questionnaire can distinguish between PTSD and Complex PTSD when completed with veterans, and as such the questionnaire was used to provide further information about your experiences of trauma. It is of note that scores were not used for diagnostic purposes as part of this study.

You were then invited to take part in a semi-structured interview exploring your experiences of being a parent, and your views of how your experiences of trauma may have influenced your relationships with your child(ren).

What if I would like to withdraw my data?
You can withdraw your data without giving a reason anytime up to two weeks from the date of completing the questionnaire. To withdraw your data please contact the researcher, Michaela Sturgeon, on m.sturgeon1127@canterbury.ac.uk or 01227 927070. If using the telephone number, please leave a message and a contact number so that I can get back to you.

Where can I access further information?
If you would like to speak to me (Michaela Sturgeon) and find out more about the study or have questions about it answered, you can email me on m.sturgeon1127@canterbury.ac.uk, or you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for Michaela Sturgeon and leave a contact number so that I can get back to you.

What if I have concerns about the study or would like to make a complaint?
If you have any concerns about the study or how it is being conducted please also contact me in the first instance and I will do my best to address these. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology – fergal.jones@canterbury.ac.uk.

What if I would like further support?
Although it is hoped that you found completing the questionnaire as part of this study interesting, it is recognised that you have shared personal and potentially distressing information.

If you feel that you need some more support, you can contact the [charity's] 24-hour helpline on [phone number]. You can also contact the Samaritans free 24/7 on 116 123 or on https://www.samaritans.org.

Speaking to your GP or accessing the NHS 111 service online (https://111.nhs.uk/) or via phone (dialling 111) may also be a useful step if you feel you need further support. If you feel you need emergency support please telephone 999.

Appendix J

Bracketing Interview – Pre-Analysis Questions and Notes

This has been removed from the electronic copy.

Appendix K

Abridged Research Diary

This has been removed from the electronic copy.

Appendix L

Coded Transcript for Ben

This has been removed from the electronic copy.

Appendix M

Personal Experiential Themes for Tim

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Appendix N

Process of Theme Development

Table 6

Personal Experiential Themes for Each Participant

Ben	**Not always being the dad I 'should' be or want to be** Never feeling like a good enough dad Not living up to expectations as a dad Conflict between his behaviour and who he wants to be as a dad Blames self for imposing this life on his children Feeling guilty about parenting behaviour Feeling guilty about not living up to expectations Guilt about parenting behaviours negatively impacts mental health Questioning long-term negative impact on children Can still be a fun, active, playful dad **Trauma came first: Not knowing any different** Children don't know any different War / trauma has changed him as a person Nothing to compare experiences to	**Protective function of keeping up appearances** Concerns about children's negative perceptions of him Acutely aware of behaviour around children Showing difficulties is not conducive with being a good dad Pretending that things are ok Shielding children from the realities of lived experience Importance of being a positive role model as a father **New insights and understanding** Trauma experiences change perspective Developing new insights from own experiences PTSD enhances curiosity and empathising with children Improved understanding of child's perspective	**Experiences of symptoms disrupting / disconnecting parenting** Parenting is more challenging due to impact of mental health difficulties Negative impact of deterioration in mood on parenting behaviours Feeling emotionally disconnected More avoidant following trauma Hypervigilance Parallels between the military and parenting Battle between managing own and children's needs Needing to distance self from children / from parenting role **Protective and motivating influence of children** Importance of maintaining a positive relationship Time with children is precious Positive impact of becoming a father

	Influence of children's age		Positive impact of fatherhood on mental health Children as a motivating factor for seeking support
Oliver	**Assuming a mask to protect self and children** Putting on a mask to protect self and others from true feelings Concerns about children seeing him as weak Aware of children's awareness Vicious cycle of deception Hiding things to protect children Tries to keep trauma separate from family life Importance of being seen as resilient by children Doesn't want to children to experience what he has Concerns about intergenerational transmission of difficulties **Developing insights** Trauma changed him Therapy helped with talking about emotions Showing more vulnerability to family since treatment Importance of being present Parenting changes over time	**Guilt shapes view of fatherhood** Guilt about not doing enough Guilt negatively impacts on perception of parenting role Balancing care and concern for children Pressure on self as parent Being a role model Shared enjoyment with children A good enough dad **Influence of psychological and behavioural symptoms** Impact of symptoms Impact of low mood Both missing out due to avoidance **The impact of the relationship with his own father** Taught to be a practical provider Conscious not to repeat parenting behaviours that induce fear	**Children's needs come first** A need to become selfless Children's happiness is paramount Prioritises time with children **Protective influence of children** Children motivate positive changes Selflessness benefits both Children are a welcome distraction The protective role of children Children bring joy and fun Fulfilment from being a dad Enjoyment in being able to share war experiences with children **Needing to know, but they don't need to know everything** Not understanding trauma makes it difficult to talk about Importance of communication Striking the balance between honesty and protecting them from the truth Challenge of not knowing what to share

Adam	**Guilt in relation to not fulfilling parental duties** Blames self Feeling like he's let his daughter down Feeling guilty Made to feel like a bad dad because of difficulties Separation impacts ability to maintain bond Child's perception of him versus his own perception Can still be a 'normal' parent Remained consistent for daughter Important that dads are consistent **A need for explanation and understanding** Questioning impact of PTSD diagnosis on child Questioning self and others Questioning daughter's understanding Questioning and overanalysing A need for someone else to understand and interject Challenging to explain experiences, even to adult children Unsure how to manage talking about experiences with daughter A need to explain and reassure	**Reliving results in disconnection** Daughter reminded him of past traumas involving children Reliving trauma involving children Reliving traumatic memory results in disconnection Physically but not mentally present Reliving traumatic memory impeded ability to be present with his daughter **Hypervigilance defends against threats** Hypervigilance - a need to know where daughter was at all times Scared of losing daughter - a need to protect her Hypervigilance - a need to protect daughter took priority **Hiding self and experiences can be adaptive** Burying the trauma helped to maintain parent role well Keeping away from child was beneficial when not feeling in a good place Putting on a front Fears that others will reinforce judgement of self Risk of judgement is reduced around strangers / professionals	**Protective role of daughter** Spending time with daughter was one of the best therapies Daughter helped him cope Daughter was a welcome distraction Daughter is his rock Daughter saved him from suicide attempt A special parent-child relationship Needing the safety and distraction that daughter bought Kept it together for her Safety of the father-daughter bubble **Concerns about impact of PTSD** Impact of PTSD on child depends on their age Impact of PTSD is variable Worries about impact on daughter - just wants her to be happy Concerns about impact on daughter Support from others helped to maintain parent-child relationship

Jason	**Putting on a mask to protect son from reality** Putting on a mask to show that everything is fine Hiding parts of self from son Portraying the dad he wants son to remember Conscious of son picking up on his anxiety Going through the motions It's difficult and draining to pretend that everything is ok Dangers of pretending everything is fine **Negative impact of deterioration in mood** Mood is variable and as such behaviour is variable Deterioration in mental health impacts ability to be around son Sometimes snaps at son out of the blue **Developing insights through intervention and support** Better insight and support positively impacts relationship Helps to be able to access support and information	**Conscious effort to be consistent and reliable** Conscious of how he appears to son Hopes that son will remember the good times Importance of showing consistency and reliability Concerns that son will focus on / remember only the negatives Importance of spending quality time together Sometimes the mask slips Importance of providing positive experiences Glad that he's seen as an approachable dad His perception of himself may be different to his son's **'I've let him down' - experiencing guilt** Feeling like he's let son down Son doesn't deserve to see / experience the negatives	**Understanding each other** Son has some understanding of PTSD Age plays a role in how much is explained about PTSD Tries to help son understand Challenges of explaining experiences to son Easier not to explain Curious about what son thinks of him **Protective role of son** Son means everything Son knows enough that he offers valuable support **Breaking the family cycle** Breaking the family cycle Influence of own father in childhood Doing things differently to his own dad

Richard	**Choosing to keep PTSD a secret** A need to filter his private life around daughter Chose not to tell wife and daughter about experiences Chose not to tell daughter about his problems Making a distinction between lying and not telling the truth PTSD is a secret that needs to be kept from daughter It's his business and nobody else's Conscious of presenting himself in a certain way Can keep impact of PTSD from daughter as long as it feels under control **A need for understanding** Relief at not having to discuss difficulties with daughter Civilians don't understand what war is like Wasn't aware of the extent of his problems	**Not saying anything about difficulties protects the relationship** Daughter's needs come first Frightened that lumbering daughter with problems with negatively impact their relationship Doesn't want to worry or burden daughter Concern that daughter would change how she sees and interacts with him Daughter sees him as emotionally strong Doing a good enough job **Trauma changes perspective** Change in attitudes following trauma spills over to family relationships Change in perspective impacts love for daughter **Physical and emotional disconnection** Distance and disconnection from daughter Offers practical support Traditional, disciplinarian dad	**Pride prevents him from sharing** Feeling embarrassed is a barrier to him sharing difficulties Pride prevents him from sharing Would damage his pride and lose self-respect if he told her His responses are unmanly Puts up a barrier to preserve perception that he is emotionally strong Didn't want to address the problem Being a father is a responsibility **Challenges of acknowledging reality** Lying to self that daughter doesn't know Despite hiding things, daughter probably knows about his difficulties Daughter has occasionally seen him angry and sulking **The influence of the relationship with his own father** Influence of lack of father figure in childhood
Shaun	**Not able to be the dad he wants / wanted to be** Feels guilty Felt as though he'd ruined her life Felt that daughter deserved better than him	**Detrimental impact of the overwhelming need to protect** Felt he had to guard her Uber protective Overprotective to the extent it stopped daughter living her life	**I'm supposed to be a tough bloke** Important that he shows daughter that he can handle his problems Fears that daughter thinks that she won't be able to cope because he hasn't Showing emotion is a sign of weakness

Blames himself for daughter's mental health difficulties
Daughter doesn't deserve to suffer
Felt like he wasn't there for her
Viewing himself as an 'ogre' of a father - hideous, frightening
Felt he wasn't a good enough dad
Feeling terrible about what's happened
Thinks daughter would be better off without him

Putting on an act
Putting on an act
Hiding behind a joker façade
Putting on a mask that sometimes slips
Hiding emotions
Trying to hold back parts of self
Concerns about intergenerational transmission of trauma
Found it hard to talk about difficulties

PTSD exacerbates 'normal' parenting challenges
PTSD exacerbates normal parenting challenges
PTSD takes over all aspects of life

Needed daughter to understand why he was being so protective
Overprotectiveness impacts well-being and subsequent behaviour
Overprotectiveness scared daughter
Taking the protector role benefits both of them
Daughter keeps things from him
Always scanning for threats
The need to protect led to verbal and physical aggression
Good intentions became obsessive
Anger plays a role in being fiercely protective
Obsessed with her safety
Needs to ensure daughter won't come to any harm

Too difficult to be present at times
Avoidance meant they both missed out
Avoidance
Some things are too difficult to talk about together
PTSD created distance and disconnection

Fighting on for them
Protective role of daughter and granddaughter

Should have been able to keep it together
Doesn't want daughter to see him as weak

The impact of past traumas involving children
Impact of specific trauma involving female child
Relating experiences with daughter back to trauma involving a child in Bosnia
Thought that daughter was going to die like the girl in Bosnia
Avoiding triggers related to past traumas involving children

A need for understanding and explanation
Recognised that daughter needed support
Wanted support in explaining difficulties to daughter
Didn't know how to explain difficulties to daughter
Helps that she understands more
Age makes a difference in how much daughter understands
A need for daughter to understand
It might be helpful to be more open

Chris	**Disconnection**	**I should have done more**	**Protective role of children**
	Disconnected	Guilt associated with not doing enough	Children keep him going
	Lost love	Hates himself for his actions	Family motivated him to continue taking medication
	Not the same person anymore	Feels awful that family think he's changed	Grandchildren are a welcome distraction
	PTSD changed him - no longer a family man	Could have done better as a father	Becoming a dad was a joyous event
	Withdrawal created a distance between him and his children	Proud of his children	
	Devastating impact - 'that's not my dad'	Acknowledging he's done something right as a father makes him feel better	
	Found it hard to be sympathetic	Disciplinarian	
	Disassociated from family emotionally but provided for them practically	**Importance of understanding and acceptance**	
	Withdrew from others as a form of self-protection	Importance of understanding and acceptance	
	Estranged from family	At a loss as to what to do to make it better	
	Wife and children treading on eggshells	Others understanding is helpful	
	Treated family badly	Positive impact of therapeutic intervention	
	Able to be more present with he feels better in himself	Values the care and support provided by his children	
		Wife was the rock that kept the family together	
Jonathan	**Treasured father-daughter bond**	**Daughter understands and accepts him**	**A reliable and supportive dad despite own challenges**
	Being with daughter is a source of pleasure	Can talk to his daughter about things he feels unable to share with wife	Hopes he is like a 'good horse' - a strong and reliable dad
	Enjoying shared experiences	Daughter was very supportive, more so than wife	Views himself as a reasonable father
	Strong bond	Daughter is a source of strength	Important that he will always be a caring and supportive dad
	Valued being able to share a big part of his life with daughter		

	Pride in daughter and their relationship Got on really well Time with daughter then became a priority Doing things with daughter supported forming a close bond Taking more of a caring role than wife **Making up for lost time** Separation from daughter due to work Seemed like a stranger to daughter Feeling like daughter didn't know him hurt him Making up for lost time with daughter via granddaughter A second chance to do things differently with granddaughter	Importance of daughter's understanding and validation Daughter is his 'go to' person It was difficult to tell daughter about difficulties **Not doing what my father did - breaking the cycle of violence** Vivid memories of own father's violence A conscious effort to not do what own father did **Seeking support helped to make sense of experiences** Therapy helped it to make sense Impact of treatment on understanding Treatment prompted him to be open with daughter Importance of support from others	Able to maintain relationship with daughter until break down happened Things changed for the better as he was more present **I didn't know what was happening** Didn't know his mental health was deteriorating PTSD bubbling away in the background Reclusiveness meant he stopped talking to daughter Hypervigilance
Keith	**Reconciling the good enough versus 'terrible' parent** The 'baggage' of trauma negatively impacts everyone Considers himself a burden on his family Viewing himself as an 'ogre' of a father - hideous, frightening Always got it wrong as a parent Views himself as a 'terrible' parent Surprised at the impact of himself on his children and their lives	**Can't shake guilt and regret** Regrets actions Punishing self for actions Accepted by children but not by self Remorseful but can't change the past Experiences of guilt and shame about previous actions Worries about son following in his footsteps **Knee-jerk responses**	**The need for understanding** Wife had to take on caring responsibilities It helps when children understand A need for children to understand A sense that children did things on purpose - they didn't understand Support from peers who understand is important Understanding the impact of trauma

	Done something right Pride in children's achievements Provider role Children accepting him for who he is **Army mentality stays with you** Upholding ingrained military standards Military discipline influences parental discipline Punitive parenting style The military changes the way you think	Explosive reactions Aggressive Overwhelmed by stress Hypervigilance Things are ok if responsibilities feel manageable Difficult times create distance	Not always aware of impact of self on wife and children Grandchildren saved him
Tim	**Emasculated and disempowered** Feeling disempowered changes the family dynamic Loss of role Emasculating impact of trauma Wife took on parenting role for both No longer a proper dad Significant relationship between experiences of trauma and parenting **Living with guilt and regret** Guilt and regret over actions Not feeling like a good parent is horrible Estrangement from children / grandchildren is emotionally painful Critical of self as parent Must be doing something right An 'alright' dad	**Consciously hid mental health difficulties** Conscious decision to hide mental health difficulties Hiding difficulties was a consciously honed skill Hiding things is taxing Hiding things paid off Military mentality impacting keeping things to self One child didn't know any different - trauma came first **Importance of understanding** Daughter and wife understand him Feeling understood feels good Children are perceptive to difficulties	**Disconnection** Children scared of father changed by trauma Behaviours pushed child away Caution and distance in parent-child relationship Children stay away to protect dad from stress Behaviour overwhelmed children Children are important to him **Severity of PTSD impacted behaviour** Psychological aggression towards to children Verbal aggression towards children Ready to explode A 'horrible' person to live with Link between PTSD severity and parenting capability

	Perception of parenting potentially not aligned with reality	Experiences of PTSD change over time Learning to deal with things better PTSD affects decision making

Note. Bold type represents personal experiential themes, non-bold type represents experiential statements which make up the theme.

Figure 1

Initial Grouping of Personal Experiential Themes

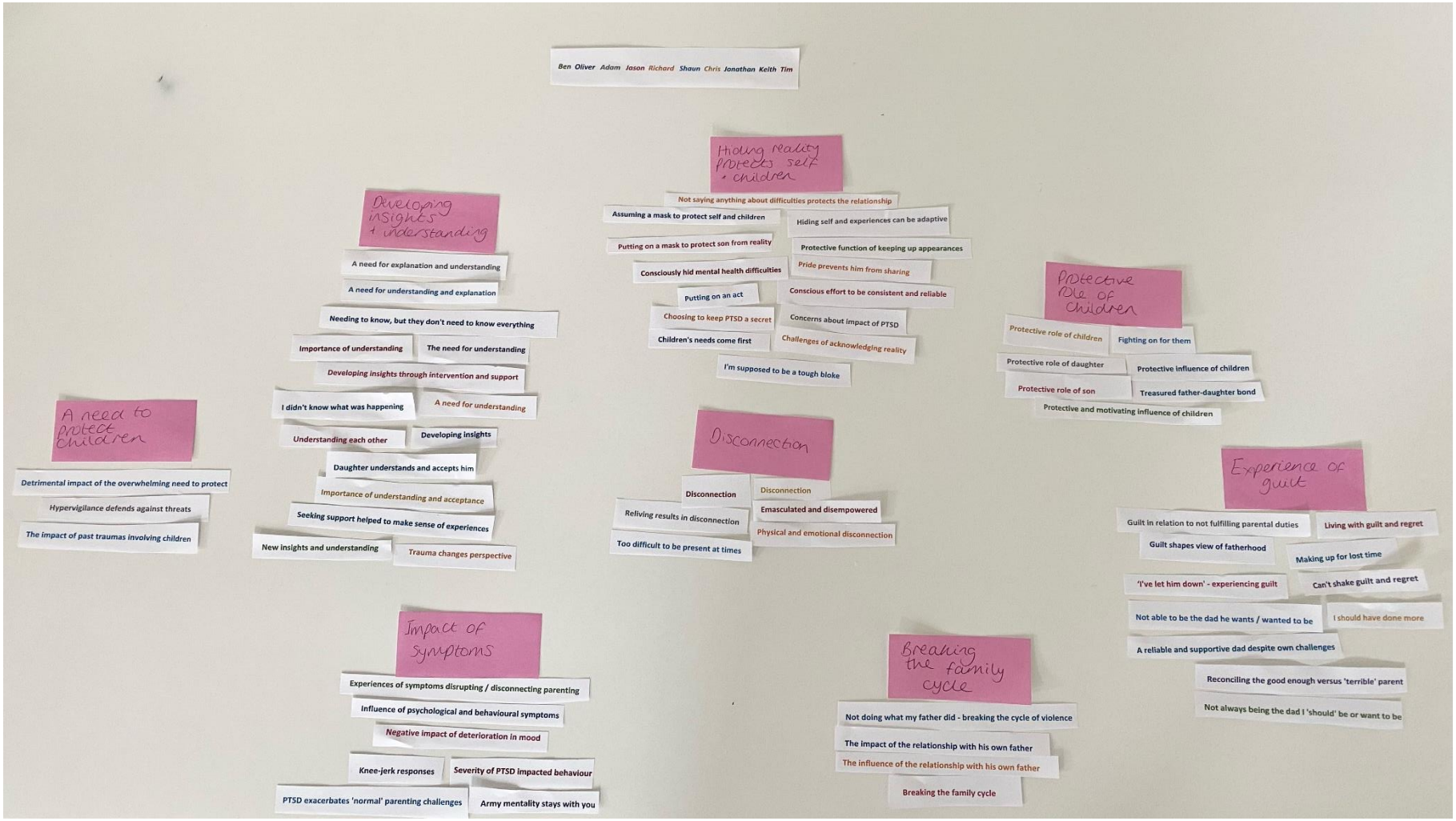

Table 7

Final Group Experiential Themes

Not Always Being the Dad I Want to Be

Disconnection

Disconnection

Reliving results in disconnection

Physical and emotional disconnection

Severity of PTSD impacted behaviour

Emasculated and disempowered

Too difficult to be present at times

PTSD exacerbates 'normal' parenting challenges

Negative impact of deterioration in mood

Experiences of symptoms disrupting / disconnecting parenting

Knee-jerk responses

Army mentality stays with you

Influence of psychological and behavioural symptoms

Avoiding triggers related to past traumas involving children

Deterioration in mental health impacts ability to be around son

Reclusiveness meant he stopped talking to daughter

Can keep impact of PTSD from daughter as long as it feels under control

Daughter has occasionally seen him angry and sulking

Guilt in relation to not fulfilling parental duties

Guilt shapes view of fatherhood

I should have done more

Can't shake guilt and regret

Living with guilt and regret

'I've let him down' - experiencing guilt

Making up for lost time

Not able to be the dad he wants / wanted to be

Not always being the dad I 'should' be or want to be

A reliable and supportive dad despite own challenges

Reconciling the good enough versus 'terrible' parent

Can still be a fun, active, playful dad

Doing a good enough job

A good enough dad

Pressure on self as parent

Must be doing something right

An 'alright' dad

Perception of parenting potentially not aligned with reality

Can still be a 'normal' parent

Remained consistent for daughter

Important that dads are consistent

Proud of his children

Acknowledging he's done something right as a father makes him feel better

Glad that he's seen as an approachable dad

Striving to Protect

Assuming a mask to protect self and children
Putting on a mask to protect son from reality
Conscious effort to be consistent and reliable
Consciously hid mental health difficulties
Putting on an act
I'm supposed to be a tough bloke
Choosing to keep PTSD a secret
Not saying anything about difficulties protects the relationship
Pride prevents him from sharing
Challenges of acknowledging the realities
Concerns about impact of PTSD
Hiding self and experiences can be adaptive
Protective function of keeping up appearances

Detrimental impact of the overwhelming need to protect
The impact of past traumas involving children
Hypervigilance defends against threats
Hypervigilance
Hypervigilance
Hypervigilance
Parallels between the military and parenting

The impact of the relationship with his own father
Not doing what my father did - breaking the cycle of violence
Breaking the family cycle
The influence of the relationship with his own father

Developing Insight and Understanding

A need for understanding and explanation
A need for explanation and understanding
Importance of understanding
Needing to know, but they don't need to know everything
Developing insights
Developing insights through intervention and support
Understanding each other
Importance of understanding and acceptance
The need for understanding

A need for understanding
Trauma changes perspective
Seeking support helped to make sense of experiences
I didn't know what was happening
Daughter understands and accepts him
Daughter understands and accepts him
New insights and understanding

Protective Influence of Children

Protective role of children
Protective role of daughter
Protective role of son
Protective and motivating influence of children
Fighting on for them

Protective influence of children
Children's needs come first
Treasured father-daughter bond
Grandchildren saved him

Note. Bold type represents personal experiential themes, non-bold type represents experiential statements.

Appendix O

Themes with Additional Participant Quotes

Table 8

Themes with Additional Participant Quotes

Group Experiential Themes	Subthemes	Additional quotes
Not Always Being the Dad I Want to Be	Disconnected and Disrupted Parenting	"You know I sort of had a go at him a couple of times and that's why he always turns to his mum now." (Tim) "Then any normal problem like your daughter- I don't mean it's normal, but having a fall out with your daughter is 20 times- well 10 times worse because of your mental state." (Shaun) "Um did it affect the relationship? And the answer is yes it did, I became more distant while it was happening, perhaps at a time when I shouldn't have been." (Chris) "I guess like going back to that thing where um they're with me for a weekend and I don't feel particularly engaged with them or I don't feel particularly emotionally attached to them." (Ben) "I think it does depend entirely on what mood I'm in, where my head's at, if I'm feeling people-y or not." (Jason)

	"I didn't like umm I didn't like to pick her up from school because I thought I'd cry, you know, I thought I'd break down, burst into tears, because well I don't know if it was relief of seeing her, you know." (Shaun)
	"I've been a drunken, bully, with outbursts of violence. Even now it takes me a long time to calm down after a big upset." (Keith)
I Haven't Fulfilled my Parental Duties	"But I don't know, it's just constant, I just feel constant guilt and I don't know if it's because you know sometimes I feel fragile and perhaps I sit here and think oh I need to man up a bit…I don't know, it's really difficult, it's a really difficult emotion to have. I don't know, I just feel like sometimes that I should do more." (Oliver)
	"They can live with it, I can't." (Keith)
	"Yeah it goes against my whole ethos of trying to be a better dad. I don't think shouting at your kids, you know sometimes it's necessary, but when it, but when you find yourself you've done it like 5 or 6 times in an hour, it's like 'what am I doing?', you know." (Ben)
	"Do you know what to think about it now…I sort of hate myself for it." (Chris)
Maybe I am a Good Enough Dad?	"Well I don't know, I don't know how she sees me as her dad. I'd like to think in years to come when I've gone that she'll look back on me and think of me as like a good horse, yeah he was a good horse. That's how I'd like her to think of me; I was reliable, didn't let her down, like a good horse. That's how I like to think of it." (Jonathan)
	"They just see me as you know I think an alright dad, so it's alright. I get a lot of cuddles, I get a lot of smiles, you know, we play a lot." (Oliver)

		"I've obviously done something right with three of them, not sure about the fourth one but we're working on it. He's the one who went through the forces so we do clash at times." (Keith)
		"I feel like I'd still do anything for her you know always be there for her you know the normal sort of parental things um yeah." (Adam)
Striving to Protect	Shielding Children from the Realities of Distress	"When I got told that your children can be affected by proxy, you have to work really hard I think to a) put on a mask but b) to try and make that mask as real as possible so that it's not seen through 'cause you're living with people all the time, so they know how you feel don't they, they know if you're off, they know if you're acting funny or whatever." (Oliver)
		"I don't want it to affect them and their perception of me in the future. I'm very aware of that." (Ben)
		"And again it's about I'm not trying to portray my thoughts into a physical way, or show them in a physical way, that he picks up on. Because now I can see him giving it what if, what if, what if, what if? And I'm really conscious of- oh god I hope he hasn't got that from me." (Jason)
		"I've written some poems and one of them is err I think it's called the mask- And I mention my daughter in one of them about this mask, you've seen the real me you know. I'm a clown but when I get on my own…I'm not." (Shaun)
		"You know you want them to think you're the best dad and there's no problems." (Ben)

	"So it is pride, so I'm letting pride dictate part of my behaviour which is is it right or wrong I don't know but it's a fact and it's something I think one has to deal with." (Chris)
I Can't Let Anything Happen to Them	"When we went anywhere the kids would like to sit at the windows and look out and I wanted to be hidden in the corner so I could see everything." (Keith)
	"I was so exhausted – mentally and physically exhausted you know. But because I couldn't let anything happen- I wouldn't fall asleep – What if there was a fire downstairs? What if a car crashes into the front room? Any excuse that I could think of- What if an aeroplane lands on the house? What if a flying elephant falls from- You know the stupidest, weirdest things, but I thought of every single one of them and it's so much stress, it was horrible." (Shaun)
	"The moment I was with daughter with me everything within me changed and this went back to the hypervigilance – I went into full on protector mode so nothing had the ability to creep in because that was my one sole responsibility." (Adam)
	"That is still with me, the vigilance has to remain." (Keith)
Breaking the Family Cycle	"And so that was the upbringing we had, you know, I remember him hitting my brother and splitting his eye down the side and I mean really violent, you know a nasty piece of work." (Jonathan)
	"How would I describe myself as a father? Um it's very difficult because my dad divorced my mum when I was 10." (Richard)
	"So I think that was to break that cycle really mainly. And not be the same, albeit there was nothing wrong with my dad, it was just how he was bought up so it was shown to him

		by his dad I guess, who I never met. So I just wanted to have that slightly different relationship with son." (Jason) "I've always been a bit of a believer that if they do something wrong, it's better to sit and explain it to them so they understand why, rather than just losing it and going arghh get to your bedrooms and all of that. Which my dad did sometimes, and it used to really scare me, you know, he never hit us or anything like that, but you know he'd just snap and it's horrible." (Oliver) "I also thought that a father's responsibility is number one to teach a daughter how men should behave." (Richard)
Developing Insight and Understanding	Understanding Supports Connection	"Yeah. Simple answer. It always will be. Albeit I can see where the problems are, what the problems are, and try and work around them." (Keith) "Like he [son] bought me a little heart shaped stone, I think it's not a jade, it's green, but it's one you keep in your pocket, and it's…you know… When you might feel depressed or anxious or something it's nice it's something you hold onto you know so I carry that everywhere, it's always in my pocket, even when I'm at work, or when I'm popping down to Tesco's to buy food, or whatever it might be, it's always in my pocket. So he understands enough to grasp the real basics of it but not in any great detail." (Jason) "And that was the thing, and there was nothing but kindness there and somebody that wanted to help, as I said without any criticism and without telling me what to do, and I think for me that's exactly the right way." (Jonathan)

		"I feel as though my daughter has a lot of respect for me. She understands now what I did." (Chris)
	How do I Explain it? (If I Want to Explain)	"There wasn't really anything there then, the problem being the ages, you know, what each…what my daughter was at the time there was nothing that could explain to her in sort of child friendly erm child friendly terms you know." (Shaun) "Even my medication you know…'what's that?' 'why do you take a pill every day?' Those sorts of challenges I find quite difficult because I don't want to lie to them, because what's the point, to a degree but at the same time I don't want them to know everything because they don't need to." (Oliver) "And not knowing what to do about it, it's hard. And I don't- I don't know what to do about it. I'm totally at a loss. I'm trying to, I suppose, realistically I'm trying to build that relationship again. Yeah I am. I'm trying my hardest." (Chris)
Protective Influence of Children	Keeping Going for Them	"It was the fact that you know that she was the thing that was keeping me pinned to this planet in the big scheme of things." (Adam) "I don't see him the same as everyone else; he's son, he's my family, he's the family for me, excluding my parents which I'm not excluding them in that sense, but son's everything, son's the reason, you know." (Jason) "I think it really saved me having children in a way." (Oliver) "The kids kept me going. Their families keep me going now." (Chris) "So I think you know if I'm being realistic about it she probably was my initial grounding technique and the moment she was taken away from me, that's when I was on shaky

	ground like the moment I'd drop her at school I could almost feel- right so I'd drop her at school, I could almost feel as I walk away from the school gates nervous…and I don't know whether maybe that was almost like a sense of I've just left my- I don't know my core responsibility my grounding technique." (Adam)
The Joy of Fatherhood	"Yeah, yeah, you know, for me it's been a- with her it's an absolute joy." (Jonathan)
	"I loved my family you know when the kids were born and everything. We tried for a few years and we were told we wouldn't have children, and then the first one turned up out of the blue and that was such a joyous time and then [daughter's name] come along two years later...fantastic, it was great." (Chris)

Appendix P

End of Study Summary Letter to Salomons Ethics Panel

Dear Salomons Ethics Panel members,

Re: A qualitative exploration of the parenting experiences of ex-military fathers diagnosed with post-traumatic stress disorder (PTSD)

I am writing to inform you that the above major research project is now complete. Included below is a summary of the research for your information.

Background and Aims

Research indicates that parental experience of post-traumatic stress can negatively impact parenting and child well-being. The aims of this research were to gain an in-depth understanding of how ex-military parents who had received a diagnosis of post-traumatic stress disorder (PTSD) experience and make sense of parenthood, their role as a parent, and the parent-child relationship.

Method

10 fathers who had previously served in the military were interviewed. Interviews were transcribed and analysed using interpretative phenomenological analysis (IPA).

Results

The analysis resulted in four group experiential themes and 10 subthemes, which are outlined in the table below and briefly described.

Group Experiential Themes	Subthemes	Number of Participants Contributing to Subtheme
Not Always Being the Dad I Want to Be	Disconnected and Disrupted Parenting	10
	I Haven't Fulfilled my Parental Duties	9
	Maybe I am a Good Enough Dad?	8
Striving to Protect	Shielding Children from the Realities of Distress	7
	I Can't Let Anything Happen to Them	5
	Breaking the Family Cycle	4
Developing Insight and Understanding	Understanding Supports Connection	10
	How do I Explain it? (If I Want to Explain)	5
Protective Influence of Children	Keeping Going for Them	8
	The Joy of Fatherhood	5

Participants described how symptoms of PTSD negatively impacted their parenting, which in turn was experienced in relation to guilt with regards to feeling as though they had not been able to be the fathers they wanted or expected themselves to be. There appeared to be an evolving view of the self as a parent as towards the end of the interviews, many participants were able to reflect on their strengths as fathers. An awareness of the negative impact of PTSD symptoms appeared to influence consciously acting in ways to protect children from harm and preserve a positive view of themselves as fathers. For example, some participants described wearing a mask to hide distress. Remaining hypervigilant to threat influenced some participants to overprotect their children. Four participants described wanting to do things differently protect their children from the traumas and losses they had experienced during their own childhoods. All participants described the importance of understanding and acceptance in supporting closer relationships with their children and families; however, there were questions as to how to facilitate understanding and concerns about getting it wrong. Finally, participants spoke about their enjoyment of fatherhood and the positive role that children play in maintaining their well-being, for example, distracting from distress or motivating them to continue with treatment.

Implications

Recommendations from this research include a need for clinicians to remain aware of parental status when working with treatment seeking veterans. In line with this, initiating strengths-based conversations may support ex-service parents to reconcile their strengths a parent within the context of challenging PTSD symptoms. The findings highlight the need for ex-service parents to be supported with talking about PTSD and their experiences with their families. This may be facilitated in various ways, for example, by including families in treatment or providing age-appropriate information for children. It would be beneficial for future research to explore the views of mothers, as well as parents from different ethnic and cultural backgrounds. Obtaining the viewpoints of children and partners may also offer a more holistic understanding.

Dissemination

A written summary will be shared with participants, and I also plan to submit a paper for publication in the Journal of Family Studies.

Yours sincerely,

Michaela Sturgeon

Appendix Q

End of Study Summary Letter to Participants

Dear [participant],

Re: A qualitative exploration of the parenting experiences of ex-military fathers diagnosed with post-traumatic stress disorder (PTSD)

Thank you for taking part in this study and for sharing your stories and experiences. The research has now come to an end, and as agreed, I am writing to you with a summary of the findings.

The aims of this research were to gain an in-depth understanding of how ex-military parents who had received a diagnosis of post-traumatic stress disorder (PTSD) experience and make sense of parenthood and their role as a parent.

10 fathers who had previously served in the military were interviewed. These interviews were then transcribed and analysed using a method called interpretative phenomenological analysis (IPA). The aim of IPA research is to explore how people experience and make sense of their lives and significant events. IPA also recognises the active role of the researcher in the analysis in that the researcher is making sense of the participant making sense of their experiences.

The analysis resulted in the development of four overall themes, with ten subthemes. These are outlined in the table below and described further, along with anonymised quotes.

Group Experiential Themes	Subthemes	Number of Participants Contributing to Subtheme
Not Always Being the Dad I Want to Be	Disconnected and Disrupted Parenting	10
	I Haven't Fulfilled my Parental Duties	9
	Maybe I am a Good Enough Dad?	8
Striving to Protect	Shielding Children from the Realities of Distress	7
	I Can't Let Anything Happen to Them	5
	Breaking the Family Cycle	4
Developing Insight and Understanding	Understanding Supports Connection	10
	How do I Explain it? (If I Want to Explain)	5
Protective Influence of Children	Keeping Going for Them	8
	The Joy of Fatherhood	5

Not Always Being the Dad I Want to Be

This theme captures participants' experiences of how PTSD impact their parenting and views of themselves as parents. There was a sense that parenting was experienced as more challenging when symptoms of PTSD were worse. In reflecting on experiences of parenthood, almost all participants described feeling guilty and as though they had not lived up to expectations. However, the word 'always' is important in this theme title as towards the end of the interviews, many participants were able to reflect on times when they had done a good job as a father, demonstrating an evolving view of the self as a parent and ability to engage in the parent role despite the challenges of PTSD.

> *"When I'm on a downer I'm more shouty, I'm a bit more shouty with them. Then when I'm in a good mood I'm more cuddly."*

> *"I want to take a bit of the praise and I feel as though I have done something towards it, not as much as the wife, but it takes two of us to model the kids. So yeah I've got it right. I have. That makes me feel better, I was starting to feel quite down actually, but no, I'm feeling ok."*

Striving to Protect

This theme describes the conscious effort made by participants to change and moderate their behaviour in response to an awareness and understanding of the potential detrimental impact of trauma on their children and relationships. Within this, participants described engaging in behaviours such as assuming a 'mask' to hide distress to try and ensure that this did not affect children negatively, but also to try and preserve their children's positive view of them as a father. Many participants described experiencing hypervigilance to threat and how this meant that they were often 'overprotective' to protect them from perceived harm. Finally, four participants reflected on their own childhoods and wanting to 'do things differently' with their children in order break family cycles of trauma and emotional disconnection.

> *"It's a mask really. It's more of putting a mask on to say, 'everything's great, there's no problem here', so he doesn't really get to see it."*

> *"I daren't sleep at night in case anyone came in the room. How ridiculous was that? So I went for days not sleeping which made me worse, you know grumpy, sleep deprivation, it was killing me, and just ruined everything for everyone really."*

Developing Insight and Understanding

This theme captures the importance of understanding on different levels – participants' understanding of their experiences, children and family understanding and accepting the participant, and a need for participants to reassure children that they were not at fault or to blame. For some participants new insights and understanding developed following engagement in treatment, and for others, it was the experience of trauma itself and subsequent mental health difficulties which had prompted new perspectives. Within this theme, participants described questioning whether or not to explain to their children about

PTSD and fears about 'getting it wrong', but simultaneously recognised that explanation may support understanding.

> *"The big thing is she listens, she doesn't try and criticise or say well why are you doing that…"*

> *"I think that can be quite a scary sort of thought about where you go [with explaining] because you know is that helpful or not helpful? Will that have an impact or not have an impact? I don't know really, it's not the easiest thing in the world really to go with."*

Protective Influence of Children

This final theme describes the ways in which participants experienced their children as providing a significant and valued source of enjoyment and support in their lives. For many of the participants, their children and the parent-child relationship provided support, distraction, comfort, and a way of coping with difficulties even when other relationships and activities could not. Additionally, many participants described feeling motivated by their children, for example, to continue with treatment or to engage in day-to-day activities. Within this, participants described needing to be selfless, which could be challenging, but was noted to result in benefits for both participants and their children.

> *"I could spend hours just watching her draw, and I found that was probably like one of my best therapies you know was doing that and being with her."*

> *"Yeah… If it wasn't for them I might not be here."*

The findings have implications for clinical and research practice. These include clinicians being aware of the potential impact of PTSD on the experience of parenting when conducting assessments and treatment with ex-military parents, support for ex-military parents to talk about their experiences with their children, for example, incorporating this into existing treatment by inviting children and families, or alternatively offering practical support to parents and age-appropriate information for children. Furthermore, as this study was conducted with fathers, it would be beneficial for a similar study to be undertaken with ex-military mothers.

To further share the research, I plan to submit a paper for publication in an academic journal which can be accessed by professionals and researchers working in the field of veteran mental health.

I hope that this summary has been interesting reading. If you have any comments or questions, please do not hesitate to contact me via email: m.sturgeon1127@canterbury.ac.uk

Thank you again for your valuable contributions to this research; it was a real privilege to hear your experiences.

With best wishes,
Michaela

Michaela Sturgeon, Trainee Clinical Psychologist

Appendix R

Author Submission Guidelines for Journal of Family Studies

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