

# The Together Programme: Supporting Caregiving Partners of veterans

2019



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## Combat Stress

Combat Stress is a national veterans charity in the UK that was established in 1919. It specialises in providing clinical mental health services for UK veterans with a history of trauma. Combat Stress receives approximately 2,500 new referrals per year. Clinical services are spread across the UK with 14 community teams and three residential treatment centres. Clinical services are delivered by a multi-disciplinary team of clinicians and are informed by

NICE approved guidance for the treatment of PTSD. More information about Combat Stress can be found at [combatstress.org.uk](http://combatstress.org.uk).

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## Glossary

### **Posttraumatic stress disorder (PTSD)**

A psychological disorder caused by experiencing or witnessing a traumatic event. Symptoms include intrusive memories, avoidance, hyper-arousal and negative alterations of mood and cognition.

### **Psycho-education**

A process of providing educational information relating to mental health and psychology.

### **Cognitive Behavioural Therapy (CBT)**

A type of psychotherapy used to help a person change how they think, feel and behave.

### **Dialectical Behavioural Therapy (DBT)**

Dialectical behavior therapy (DBT) is a type of talking treatment. It is designed to help people who experience emotions very intensely.

### **Compassion Focused Therapy (CFT)**

CFT is a type of psychotherapy designed to help those who suffer from high levels of self-criticism and shame.

### **Mindfulness**

A psychological process of bringing one's attention to the present moment, which has been adapted for use in psychological therapies.

### **Acceptance and Commitment Therapy (ACT)**

ACT is a psychological approach which helps individuals live and behave in ways consistent with personal values while developing psychological flexibility.

### **Confidence interval (CI)**

A range of values so defined that there is a specified probability (usually 95%) that the value of a parameter lies within it.

### **Beta coefficient ( $\beta$ )**

A standardized statistic which compares the strength of the effect of each individual independent variable in a statistical analysis.

### **The Royal British Legion (TRBL)**

A UK charity providing lifelong support for the Royal Navy, British Army, Royal Air Force, Reservists, veterans, and their families.

### **Support and Family Education Programme (SAFE, Sherman, 2008).**

A psychoeducational family intervention created by Oklahoma City Veteran Affairs in 1999.

**Homefront Strong (Kees, Nerenberg, Bachrach & Sommer, 2015).** An evidence-based intervention for military spouses that reduces symptoms of depression and enhances resilience.



# The Together Programme: Supporting Caregiving Partners.

## Executive summary

In a recent analysis conducted by Combat Stress of UK, partners living alongside veterans with mental health difficulties, rates for depression and PTSD were higher compared to the external population (depression 39% Vs 20%, PTSD 17% Vs 3%. (Murphy, Palmer & Busuttil, 2016). As such this suggests the high burden of need within this group.

The support currently available here in the UK mainly comprises of peer based support. Whilst research indicates the positive impact peer led groups can have, the clinical severity of partners symptoms implies a need for more structured, bespoke and evidence based intervention. To this end, a bid for funding to support the development of an evidence based intervention '*The Together Programme*' for UK veterans partners was made and kindly awarded by The Royal British Legion in 2016.

Based on review findings, two US psychoeducational programmes, SAFE and Homefront Strong (see glossary)

which have been found to be effective and well accepted within the US military population were selected as the most appropriate base to develop a UK specific intervention to support military partners.

### Study aims

1. Develop UK specific intervention to support the partners of veterans living alongside complex mental health difficulties.
2. Assess the acceptability of offering this support.
3. Assess efficiency of improving health and wellbeing.

The Combat Stress Research Team was committed to upholding evidence based practice and continuing to substantiate existing research into the mental health of UK military partners. Since we were implementing this programme that had not been tested before in the UK, we wanted to ensure firstly the programme was feasible in terms of recruitment, participant engagement and being cost effective. We wanted to ensure the programme was effective in improving mental health difficulties and other aspects of psychological wellbeing. We also wanted to evaluate if it would be accepted by this population.

## **Piloting the Intervention**

Between June 2017 and March 2018 we ran nine five week psycho education based support programmes in city locations across the UK.

Each weekly session lasted 2.5 hours and was organised into two parts. The first part consisted of psychoeducation and self management strategies for veteran partners. Part two consisted of skills training for participants themselves.

## **Our findings**

### **Feasibility outcomes**

Treatment completion rates were high with 57 participants commencing the programme, of which 51 completed (89%). Of the 51 participants who completed, 44 (86%) were successfully followed up at 3 months.

We found significant reductions in participants anxiety and depression and PTSD symptoms were maintained three months after completing the programme. Improvements in participants relationship satisfaction were observed. We found no significant changes in participants ratings of alcohol misuse, social support or self-efficacy.

### **Acceptability outcomes**

Acceptability was measured through an evaluation completed at the end of the programme and included the NHS Friends and Family Test.

**94% of participants were extremely likely to recommend The Together Programme to their friends and family.**

Four key themes from the programme evaluation emerged;

### **1. Taking care of my needs**

Participants rated the programme highly for helping them to develop coping strategies to better take care of their own needs, in addition to learning effective ways to support the veteran.

### **2. Conjoint sessions**

Majority of participants suggested they would like additional conjoint sessions with their veteran partner either on a 1:1 basis or in a group format.

### **3. Longer programme**

The majority of participants reported they would like a longer programme and further top up sessions.

### **4. Barriers in accessing support**

Potential barriers for engaging in the programme which were identified by participants included; Childcare, travel and financial responsibilities.

## **Discussion & recommendations**

Overall findings of this pilot study provide promising support that it was feasible and well accepted by partners and resulted in improvements in mental health and relationship satisfaction.

Consideration needs to be given firstly to partners suggestions for improvements; Longer programme, top up sessions, more information and support for parents and conjoint sessions with veterans.

Further consideration is needed to be given about where The Together Programme would fit in with current

services. For example this support may be most beneficial for partners of veterans who are at the early stages of their care pathway. Combat Stress peer support service, which often involves liaising with veteran families, may help to remove some of the help seeking barriers in this population.

It is important for the delivery of this intervention to be carefully deliberated. Given the incorporation of many psychological models and clinical skills required in managing group dynamics and containing emotional distress, it is recommended for groups to be delivered by psychologists under supervision and co-facilitated by clinicians who have experience running groups with the veteran population.

It is recommended guidelines be developed to help future facilitators in understanding their roles and responsibilities in relation to what

support can or cannot be offered to veterans of participants attending the programme.

Many participants who were screened and considered suitable for the programme were unable to attend for practical reasons, suggesting the need to make this service more accessible. Adapting the programme into a web-based programme looks like an appealing and effective option for developing a flexible service and offering more choice moving forward.

### Conclusion

Based on these study findings and in view of recommendations made The Together Programme presents itself as a viable and effective support programme for UK partners living alongside veterans with mental health difficulties.

## Summary of findings from 3 studies Combat Stress has conducted with UK military partners

Date published	Study	What we found?
2016	Mental health profile of UK military partners	<p><b>Of 100 partners surveyed;</b></p> <ul style="list-style-type: none"> <li>• 39% Depression</li> <li>• 37% Anxiety</li> <li>• 17% PTSD</li> <li>• 45% Alcohol</li> </ul>
2017	A qualitative study of female partners experiences with UK veterans	<ul style="list-style-type: none"> <li>• Common challenges faced by partners; Inequality in relationships, loss of congruence of own identity, volatile environments &amp; emotional distress &amp; isolation.</li> <li>• Barriers to help; Practical &amp; ambivalence about involvement of others in treatment.</li> </ul>
2018	A feasibility & acceptability pilot study for a psychoeducational support programme for UK military partners	<ul style="list-style-type: none"> <li>• The Together Programme is a feasible and acceptable support intervention for UK partners.</li> <li>• Significant improvements were seen in primary mental health outcomes and PTSD. Improvements were also observed in participants ratings of relationship satisfaction.</li> </ul>



## Introduction

### 1.1. Mental health of veterans

In the past decade considerable research has been conducted globally into the significant impact of deployment upon veteran's mental health (Fear et al., 2010; Sundin et al., 2014; Hoge, Auchterlone & Milliken, 2006; Pinder et al., 2012). In the UK there has been a fourfold increase in the number of veterans seeking help for mental health difficulties (Murphy, Weijers, Palmer & Busuttil, 2015). Several studies indicate the higher prevalence rates of mental health difficulties like anxiety, depression, PTSD and substance misuse in treatment seeking veterans compared with the general population (Murphy et al., 2017).

### Impact on relationships

Research into treatment seeking veterans shows high rates of comorbidity indicating the complicated nature of the difficulties veterans live with (Murphy, Palmer, Hill, Ashwick & Busuttil, 2017). Evidence suggests the complex interaction of these symptoms can have a profound impact on veterans' intimate relationships (Taft, Watkins, Stafford & Manson, 2011). In a study conducted by US Veteran Affairs, findings show 42% of veterans struggled to get along with their partners after deployment while 35% reported being separated or divorced (Sayer et al., 2010). Other studies also report higher rates of divorce

(Cook, Riggs, Thompson, Coyne & Sheilch, 2004) and domestic violence (Sherman, Saulter, Jackson, Lyons & Han, 2006) in veterans with PTSD compared with veterans without PTSD.

Symptoms of PTSD in veterans has been related with family stress, difficulties in partners psychological adjustment and decreased couples functioning (Sherman et al, 2005). Specific trauma related symptom clusters like dissociation, anxiety, sexual and sleep problems have been found to be strongly associated with reduced levels of relationship satisfaction as reported by military spouses (Goff, Cross, Reisbig & Hamilton, 2007). In addition, Riggs, Byrne, Weathers and Litz (1998) found greater levels of anxiety about intimacy in veterans with PTSD compared to veterans without PTSD. These findings indicate the significant implications on veterans' relationships with their partners.

### Impact on family

Military children living alongside a parent with mental health difficulties are also directly affected. For example, research which has sought to understand how children are affected indicate PTSD symptom of emotional numbing to be more positively associated with child misbehaviour and disagreement with children and most negatively correlated with sharing, contact and overall quality of parent-child relationship (Benedek & Wynn, 2001, p210).

Other symptom clusters of PTSD like anger have also been found to significantly impair the relationship and interpersonal functioning between veterans and intimate partners and children. In a study by Grieger et al., (2010) not only did the severity of veterans' violence reported positively correlate with severity of PTSD, so did behavioural patterns of aggressive responding. Taken together, these findings illustrate the stressors partners and children must contend with after leaving the military.

## **1.2. Mental health of military partners**

Evidence suggests that a large proportion of treatment seeking veterans are in a relationship (Murphy et al., 2015), however, less focus has been given to looking at the impact on the mental health and needs of partners. A recent analysis of UK military partners living alongside veterans with mental health difficulties found 17% presented with PTSD difficulties themselves, four times that of the general population (3%, Murphy, Palmer & Busuttil, 2016). Partners in this study also reported much higher percentages of alcohol misuse (45%) when compared to that of the general population (16%). These findings are consistent with larger studies which have found military spouses to experience higher rates of psychological distress compared with the general population (44.9%, Renshaw, Rogues & Jones, 2008) and other caregiving populations. For instance, in a study of caregivers for

relatives with dementia 29.5% report experiencing psychological distress (Cohen et al., 1990). These findings infer the challenges military partners experience in their caregiving roles may be unique and complex compared with other caregiving populations.

Research into the factors which might increase rates of distress among military partners show the level of distress is mediated by the stage a veteran is at in terms of accessing treatment or support. For example, in a US study, psychological distress is likely to be increased when a partner perceives the veteran partner to have PTSD symptoms which the veteran partner did not themselves acknowledge (Renshaw et al, 2008). This infers partners of veterans who are not accessing support or treatment may be at greater risk for developing psychological difficulties.

Other factors have also been found to positively correlate with higher levels distress among military partners and spouses, including, employment, living with the veteran and being ex-military themselves (Murphy, Palmer & Busuttil, 2016). Beyond demographic predictors of distress experienced by military partners, there is also evidence to suggest longer deployments and deployment extensions to have a significant impact (de Burgh et al., 2011).

### **Explanations for why partners experience distress**

Different theories have been proposed to explain the heightened risk for veteran's partners developing mental health difficulties. One explanation suggests partners begin to mirror the veteran's symptoms of PTSD, also referred to as 'secondary traumatisation' (Ahmadi, Azamper-Afshar, Karami & Mokhtar, 2011). This refers to a partner being exposed to or listening to a family member suffering and subsequently having similar reactions to that of PTSD.

Another explanation suggests partners caring for veterans feel responsible for controlling stressors which could worsen veteran's PTSD symptoms (Fredman et al., 2011). In an attempt to protect the relationship, it is suggested this leads to the partner feeling isolated and increased emotional pressure and inequality in the relationship (Lawn & McMahon, 2014). In this qualitative study capturing the experiences of partners living alongside veterans living with PTSD, partners also described being afforded little opportunity to develop their own sense of identity within their relationship and investing most of their efforts and time accommodating for the veteran's needs (Murphy, Palmer, Hill, Ashwick & Busuttil, 2017).

### **Barriers for partners accessing help**

There is a large disparity between the percentages of UK military partners reporting psychological difficulties compared with those accessing support (only 47%, with a difficulty report seeking support, Murphy et al, 2015). Furthermore, this disparity is larger in UK military partners compared with military- spouse populations in other countries. For example, in the US, 68% of partners reporting difficulties have accessed primary mental health care services (Eaton et al., 2008) suggesting the need to understand the specific barriers for UK military partners accessing support.

Internal barriers such as stigmatising beliefs have been reported to be the biggest barriers to both veterans and their partners accessing support. General internal barriers which are commonly reported include, feeling embarrassed about seeking support or being perceived as weak by others. Stigma related beliefs found to be specifically relevant to UK military partners include; thinking others would not understand, too embarrassed to ask for help and being concerned about what others might think (Murphy, Palmer, Hill, Ashwick & Busuttil, 2017). This evidence suggests the toughness and self-reliance which is often promoted in the military culture is also adopted by veterans' partners. As denoted by Rossi (2012, p9), "The concept of mental toughness is also expected from spouses and family members".

Practical barriers to accessing help and which have been endorsed by UK

military partners included; time, financial, work commitments, and feeling unable to leave family or caring duties (Murphy, Palmer, Hill, Ashwick & Busuttil, 2017). This evidence suggests consideration needs to be given to both reducing stigma and these practical barriers in interventions designed to support military partners.

### **1.3. Partners influential role of treatment of veterans**

Numerous studies have demonstrated the direct influence of partners and their family's wellbeing on veteran's treatment outcomes (Sautter et al, 2006). That is, the distress experienced by partners and the family have been associated with poorer treatment outcomes (Evans et al., 2010). One study acknowledges the role partners and family issues have particularly on precipitating factors for risk and attempts of suicide (Mental Health Advisory II, 2010). This highlights the psychopathology of both veteran and the military partner to be critical in a military family's mental health.

With a greater appreciation for the needs of military partners, innovative interventions have been put together over the past couple of decades. However, the majority of the interventions developed so far have been restricted to the US and Australia. These vary in the range of support they offer from being group based, couple therapy (veteran & partner) and family orientated programmes. These are offered in the community as well as residential settings and online. To

date, studies have found these interventions to be highly effective (Hayes et al., 2015; Lester et al., 2016; Whealin et al., 2017).

### **1.4. Current service provision in the UK**

Existing resources for military mental health in the UK however, primarily target the veteran's individual needs, often neglecting the mental health needs of the partner. Unlike US and Australian based support interventions which provide support to address the clinical needs of military partners and their families, to the best of our knowledge, the support currently available here in the UK mainly comprises of peer-based support. Whilst research indicates tentatively the positive impact peer led groups can have, the clinical severity of partners symptoms implies a need for more structured, bespoke and evidence-based interventions (Murphy, Palmer & Busuttil, 2016).

### **1.5. Current service provision further afield**

The US and Australia have taken a leading role in developing more integrated models to support veterans and their families. Many of these models developed are psycho education-based and have been found to reduce partners psychological difficulties and improve family relationships with those experiencing serious mental health difficulties (Frain, Bethal & Bishop, 2010). The benefits of educating partners are now emerging. For example, in one study which involved educating partners about PTSD, veterans

reported receiving increased support and higher levels of engagement in therapy. Moreover, partners in this study also reported it gave them an understanding which meant they were able to interpret the veteran partners behaviours as symptoms and therefore lowered their distress levels (Sherman et al, 2010). Other studies have also highlighted the importance of educating spouses, to improving PTSD treatment outcomes (Lester et al., 2016., Whealin et al., 2017) and being key to helping veterans (Gourley., 2016).

Several studies have illustrated how military partners who have not received any education are likely to misinterpret symptoms of PTSD (Rossi et al., 2012 & Renshaw & Caska, 2015). Furthermore, in partners accommodation of the veteran's symptoms, the levels of distress the veteran and their partner subsequently experience, increases (Fredman, Vorstenbosch, Wagner & Macdonald, 2014). In fact, Miller et al., (2013) warns treating a veteran alone for PTSD without supporting the partner increases the risk of the relationship becoming more unbalanced and strained.

The purpose of this pilot study was to explore the feasibility and acceptability of offering an evidence-based support programme to UK veteran partners who themselves have mental health difficulties or are at risk of developing mental health difficulties.

### 1.6. Aims of current study

1. Develop and deliver a structured evidence-based support programme to partners of veterans with mental health difficulties across the UK.
2. Collect feedback from partners who attended the programme and that of the facilitators to learn how to further refine support.
3. Evaluate the barriers which might otherwise prevent partners from accessing support of this kind.
4. Measure the effectiveness of the support intervention on partners psychological wellbeing, relationship satisfaction and social support.

## 2.Method

### 2.1. Study Overview

An observational design was used in this study to explore the effects of an evidence-based support programme on UK military partners living alongside veterans with mental health difficulties. A quantitative analysis was used to determine the feasibility of the programme. Mental health outcomes were collected at the start and end of the programme and then again three months later.

### 2.2. Development of programme

In the initial stages of developing the intervention, a review was undertaken to explore components of programmes which seek to support veterans and better understand their mental health. Full descriptions of these programmes can be found in Appendix 1. Each intervention was assessed and rated using a table matrix to compare against a set criterion (See Appendix 2).

Based on these findings, two psychoeducational programmes were found to be most relevant, S.A.F.E (Support and Family Education Programme, Sherman, 2008) and, Homefront Strong (Kees, Nerenberg, Bachrach & Sommer, 2015). These programmes were selected as the most appropriate on which to base the intervention for the present study.

SAFE is a programme which has been running since 1999 in the US and was developed by Oklahoma Veterans Affairs Medical Centre to support veteran's families with mental health difficulties with a primary focus on PTSD.

SAFE has a strong focus on psychoeducational material and building symptom management skills. For example, within its eighteen-session programme, it includes sessions on causes of mental illness, common family reactions to mental illness, coping with stigma and problem solving with families. Moreover, the aims of SAFE align closely with those identified as needed to provide an effective programme of support and education for veterans' partners, it can be offered in a community-based setting to increase engagement and it also incorporates unique challenges of being a caregiver to a veteran. The sessions are conducted face to face and in a group format to enable partners to build valuable support networks.

Homefront Strong is an eight-week programme specifically targeted at military spouses and is based on resilience, stress, optimism, building community and staying strong. Kees, Nerenberg, Bachrach & Sommer (2015) found military partners who attended this eight-week programme, their symptoms of depression decreased. They also found an improvement in resilience characteristics, life satisfaction and social support. Limited information is available on follow up.

While the content of both interventions was used to guide the development of our intervention, they were not used verbatim and were adapted to meet the needs of UK partners. For example, we surveyed military partners during the development of the intervention to elucidate their needs in terms of content and format. This was conducted in accordance to the Medical Research Council (MRC) guidance into the development of complex interventions (MRC, 2010).

### **2.3. Service user involvement**

To tailor the intervention to UK veterans' partners, partners of veterans receiving treatment from Combat Stress were asked to complete a survey about what program would best meet their needs and be most practical. This was completed in the early phases of developing the intervention and considered the following factors; length of programme and sessions, distance partners would be prepared to travel to groups, preference for telephone support, size of group, obstacles for attendance, things that might encourage attendance, and expectations and goals of attending a programme of this kind. These survey results can be found in Appendix 3. Engagement with partners in the early phases also helped to start to publicise the support programme. In addition, clinicians were consulted in the development of the intervention.

### **2.4. Participants**

Participants were recruited from referrals into Combat Stress over an 18-month period (January 2016-July 2017). In design of this pilot study, a sample size of at least 31 had been identified using a power calculation to detect a 0.5% effect size using a General Health Questionnaire (GHQ) between the start and end of intervention at 80% power and 5% significance level. This is based upon the prevalence rates as observed in a previous published study profiling the mental health needs of this group of participants.

An audit was conducted to establish where the highest numbers of Combat Stress referrals in the past 12 months (January 2016- January 2017) were populated across the UK. This helped determine where the intervention would be piloted across the UK

alongside a consideration for venue availability and accessibility. Based on this information and demand for support the intervention was offered in nine city locations; Birmingham, Derby, Glasgow, Liverpool, Leeds, Belfast, Cardiff, Portsmouth and Newcastle.

### **Eligibility Criteria**

Participants were eligible for the pilot study if; the veteran met the diagnostic criteria for PTSD or other mental health related difficulties and was or had previously engaged with Combat Stress (minimal requirement is for veteran to have called veteran helpline). The participants also had to be in an intimate relationship with the veteran at the time of recruitment. This was determined during telephone screening when the study coordinator established there was a current emotional attachment between the two individuals.

Initially the study coordinator wrote to veterans (see Appendix 4) informing them about the pilot programme and informed them about the date the programme was due to commence in their local area (within approximately 50 miles of venue).

### **Veterans consent**

Veterans were asked if they were currently in a relationship and, if they consented, were asked to share the information enclosed to their partners. Information enclosed contained details of the support programme and how both the partners or veteran could get in touch with the programme coordinator to find out more. Three waves of mail outs were sent to veterans over the course of an eight-week period.

## Referrals

Referrals were also accepted from Combat Stress clinicians. Depending upon where the recruitment drive was for a group, contact was made directly with clinicians working in the community to make them aware of eligibility criteria, referral process and were asked to disseminate information when carrying out assessments, groups and reviews.

In later stages of recruitment, referrals were also accepted from external agencies like Ripple Pond and Veterans Outreach Service (VOS), Portsmouth who work closely with Combat Stress in providing support to veterans with mental health difficulties and their families. The same eligibility criteria were applied to veterans and their partners being referred from these sources. In all cases consent was obtained from veterans first before screening any potential participants interested in the programme.

## Exclusion criteria

The programme strived to provide a safe and comfortable space where participants felt they could be open in sharing their experiences with others. It was important for participants to feel understood by others in the group without fearing they would offend the veteran. For this reason, veterans of participants were not permitted to attend the group programme.

Other family members were also not permitted to attend because the content of the programme has been written specifically for partners in an intimate relationship with the veteran.

## 2.5. Settings

The study was coordinated from Tyrwhitt House, headquarters of Combat Stress in Surrey, UK. As discussed below, participants were recruited from across the UK and group programme sessions were led by study coordinator and cofacilitated with an Assistant Psychologist across nine different city locations across the UK.

For seven out of nine of the groups, The Royal British Legion (TRBL) Pop In centres were used to host the intervention. TRBL was chosen as the most suitable venue because of its accessibility and being easy to get to in terms of public transport links. Moreover, for most participants the Pop Ins were familiar with many previously assisting the veteran to Combat Stress appointments or other TRBL services.

Secondly, we were able to host the group at TRBL Pop In centres during daytime hours which matched the practical needs of partners. Of 18 participants who were surveyed in the early phases of developing the intervention about their needs, 95% expressed a preference for daytime group sessions.

Thirdly, TRBL Pop In was chosen to host these groups because it offered suitable facilities and resources needed to deliver the group successfully.

In locations where TRBL Pop In Centres were not available, suitable alternatives were found, e.g. The Coming Home Centre in Glasgow and The Carers Centre in Portsmouth.



**The Intervention was piloted in 9 cities  
across the UK  
June 2017—March 2018.**



## 2.6. Procedure

### Screening for suitability

Participants were considered for the project if the veteran met the eligibility criteria. Thereafter, a telephone screening was undertaken by the study coordinator with those interested to determine their goals and if the programme would be suitable and meet their needs. All interested participants were informed about the nature and content of the course. It was highlighted during screening the support offered is limited as the programme is not a therapy group and the duration of support available is restricted to the duration of the 5-week programme and a 3-month postal follow up. Anyone seeking therapy was advised to speak with their GP about services available locally to them.

Participants were also informed about the importance of attending a minimum of eight out of ten sessions and engaging in a mid-programme telephone review to obtain maximum benefit. For those meeting the inclusion criteria, they were invited to attend the programme with a formal letter of invitation (see Appendix 5) and where identified, a letter of support

for the employer was offered (see Appendix 6). For those who could not attend for practical reasons, they were sent out an information pack written for family members supporting someone with PTSD or mental illness.

### Delivery of groups

Groups were delivered by the study coordinator and co facilitated by the Assistant Psychologist from the nearest treatment centre. Both study coordinator and Assistant Psychologists had prior experience delivering psychoeducation groups and 1:1 sessions with supervision on different treatment programmes with veterans at the treatment centre. They were experienced in applying the psychological models which the manualised programme was based upon.

By having the Assistant Psychologist co facilitate sessions, it was possible for any queries about the veteran's treatment to be passed on directly to the appropriate team members at the treatment centre.

### Management of risk

Upon arrival to the first session, GP details were collected from participants and the group was informed about the limits of confidentiality. These were reiterated in the group rules which were outlined by facilitators at the start of each session. Also, participants were asked to avoid using names of their partners in the group sessions to protect their confidentiality.

For any individuals indicating high levels of risk during the group session, immediate support was planned (for example calling 999 or calling child protection services) in line with existing Combat Stress policy. For other issues it was agreed the study coordinator speak with the participant privately at

the end of the session and arrange a telephone follow up call to gather more information. Where appropriate, the study coordinator would write to the participant's GP to inform of risk and any recommendations. Safeguarding issues were discussed during clinical supervision sessions.

All staff involved in the delivery of the study were required to attend the safe guarding training for vulnerable adults and children that's is routinely offered to clinical staff. Staff were familiar with standard Combat Stress policy on risk management.

In circumstances where potential risk issues for the veteran was highlighted by the partner of the veteran, the Assistant Psychologist liaised with, and informed clinicians involved in their care at the relevant treatment centre or community team.

### **Supervision**

Fortnightly clinical supervision sessions with an experienced Clinical Psychologist was given to the Study Coordinator throughout the development and delivery of the programmes. Assistant Psychologists continued to receive fortnightly clinical supervision from a Clinical Psychologist at the treatment centre where upon their post is based.

### **2.7. Outcome measures**

Participants were asked to complete a psychometric questionnaire with seven measures at three-time points (see Appendix 7); Before attending the programme, upon completion of the programme and at a three-month postal follow up. In addition, demographic information was collected from participants before commencing the course. Participants were also invited to provide their feedback in a programme evaluation (see Appendix

9) which was included in the end of programme measures.

### **Effectiveness**

Outcome measures for mental health included;

*General Health Questionnaire (GHQ-12)*. The GHQ (Goldberg & Williams, 1988) is a 12-item self-administered instrument used to assess psychological distress. Items are rated on a 4-point Likert scale with participants rating the extent they were affected in the past month.

*Secondary Traumatic Stress Scale (STSS, Bride, Robinson, Yegidis & Figley 2004)* is a 17 item self-report measure of secondary trauma symptoms over the past month using a 5-point Likert Scale.

Alcohol problems were recorded using the *Alcohol Use Disorders Identification Test (Audit-C, Bush, Kivlahan, McDonnell, Fihn & Bradley, 1998)* which includes 3 items that are scored on a 5-point scale.

Relationship satisfaction was measured using the *Dyadic Adjustment Scale (DAS, Hunsley, Best, Lefebvre & Vito, 2001)* and the *Relationship Assessment Scale (RAS, Hendrick, 1988)* which both use a 7-item scale, with each item being scored on a 5-point scale.

The functioning measures included *perceived social support (MSPSS)* and general self-efficacy (GSE). MSPSS (Zimet, Dahlem, Zimet & Farley, 1988). Is a brief 12 item self-report scale which measures support from 3 sources; Family, friends and a significant other. The score for each item answer is scaled between 1 and 4.

GSE (Schwarzer & Jerusalem, 1995) is a 10 item self-report measure designed to evaluate an individual's ability to cope. Each score is scaled between 1 and 4. See Appendix 8 a more detailed description of the measures.

### **Feasibility**

To measure the feasibility of the partners' intervention, data was collected on the number of participants who completed the programme (attending a minimum of 8 out of 10 sessions) and the total number of sessions attended. Additionally, feasibility was measured regarding the recruitment process. These measures included the number of participants who responded to the invitations, number of referrals received from other sources (including community psychiatric nurses, occupational therapists and psychologists), the total number of participants screened, the number deemed suitable for the programme and reasons for non-suitability.

Finally, feasibility was also measured in terms of running costs.

### **Acceptability**

Acceptability was measured through the NHS Friends and Family test (FFT; NHS England, 2014) which asks participants how likely they are to recommend the service to friends and family if they needed similar support. Scores are rated on a 5-point scale from "highly unlikely" to "highly likely". In addition, a range of program evaluation items were asked, including; "what are the top 3 things you liked about the groups", "what are the top 3 things you disliked about the groups" and "what 3 things would you liked to see changed about the groups?" (see Appendix 7).

## **2.8. Intervention and Materials**

The programme consisted of ten sessions. These were organised into two categories; firstly, psychoeducation and self-management strategies for participants (partners) supporting the veteran with PTSD or mental health difficulties, and secondly self-management strategies and skills training for participants themselves. Please refer to Table 1.0 for programme outline. Although each session was structured and dyadic in its design, there was plenty of opportunity for participants to share in their experiences through discussion.

These sessions were planned to take place over five consecutive weeks and were arranged at the same time each week to promote consistency and attendance.

A mid programme telephone call was scheduled for each participant in the group and conducted by the study coordinator who had already carried out the initial screening. The purpose of this was to check in with the participant about how they were finding the programme and group dynamics, review materials and to identify any additional support the participant may need after the programme finished. This typically took place during week 3 of the programme although, to accommodate for both participant and study coordinators availability, these were arranged between week 3 and 5.

For participants who had been identified to struggle with any learning needs, adaptations were made, and extra support was offered.

For participants who missed any of the sessions, an additional 30-minute face to face 1:1 session was offered before the start of the next group session. Where this was not possible, a

telephone meeting was scheduled. In all catch up or review sessions the study coordinator orientated the participant to the session notes, handouts and worksheets in the partners manual (see Appendix 10).

### Content of the programme

The programme incorporated a range of different psychological techniques including CBT, DBT, CFT & ACT. See below for more detail and Appendix 11 for facilitators manual.

### Cognitive Behavioural Therapy (CBT)

Sessions incorporated CBT strategies to help illustrate the maintenance cycle of symptoms of PTSD, like; low mood, depression and anxiety. This basic model was also used to help participants explore the impact mental health symptoms has had on both the veteran and themselves. Participants were given strategies to support the veteran and themselves with managing anger triggers and

**Table 1** The Together Programme appraisals. Strategies to help

participants examine the evidence and reframe unhelpful thinking styles were presented in these sessions.

### Dialectical Behavioural Therapy (DBT)

The dialectical tools taught in sessions provided participants with strategies to manage their own reactions to veteran's symptoms and emotional dysregulation. Facilitators helped participants to recognise their own emotions, be mindful without judgement and maintain healthy boundaries in their relationship. Basic mindfulness skills were also introduced in sessions to improve participants relaxation and tolerance of stress.

### Compassion Focused Therapy (CFT)

CFT techniques were incorporated and focused on helping participants to take care of their own wellbeing. Attention was particularly focused on supporting participants to access their own soothing system. Practical exercises like progressive muscle relaxation, soothing rhythm breathing, building a compassionate image and safe place visualisations were introduced during each weekly session.

	Week 1	Week 2	Week 3	Week 4	Week 5
<b>Part A</b> Psyched & Strategies to support veteran (1 hour)	Session 1 Understanding PTSD & mental illness. How can I help?	Session 3 Understanding PTSD & anger	Session 5 Communicating & reconnecting with my partner	Session 7. Supporting my partner with low mood & depression	Session 9 Problem solving in relationships
Break (30 mins)	Break	Break	Break	Break	Break
<b>Part B</b> Self-care for partners (1 hour)	Session 2 Living alongside PTSD & mental illness	Session 4 Finding me again	Session 6 How to explain PTSD to children & other people	Session 8 Managing difficult emotions	Session 10 Moving Forward

### **Acceptance and Commitment Therapy (ACT)**

ACT value-based exercises were used to help participants support the veteran reduce avoidance behaviours and improve their engagement with meaningful activities. Values of the military were also discussed in relation to adjusting to civilian values and the impact of these. ACT metaphors were used to help participants explore the role of their emotions and the impact of these on their own goals. Participants were given tools to help diffuse themselves from difficult emotions and rediscover a sense of themselves.

### **2.9. Data Analysis**

After outcomes were collected this data was inputted into a statistical database, SPSS (Statistical Package for the Social Sciences) from which it was cleaned and analysed.

Descriptive statistics were initially used to explore demographics of participants. Following this, differences between participants who were successfully followed up and those who were lost at 3 months were assessed in terms of demographics: primary and secondary outcomes. Mann Whitney U test were used to compare the health scores between responders and non-responders.  $\chi^2$  tests were also to explore sociodemographic differences between those who responded and those who did not. An alpha level of 5% was used to indicate a statistically significant difference.

The final stage of analysis involved running unpaired Two Sample T Tests to compare primary and secondary outcomes following attendance to The Together Programme. Again, an alpha level of 5% was used to indicate a statistically significant difference.

Effect sizes between pre-programme and at follow up for primary and secondary measures were calculated and interpreted using accepted guidelines (Effect size 0.2= small, 0.5=medium and 0.8 and above=large).

## 3. Results

### 3.1. Participants and recruitment

Based on the analysis of Combat Stress referrals in the UK over a period of 19-months (Jan 2016-July 2017), specific city locations were targeted to pilot the 5 week Together Programme. See Appendix 12 for full analysis. As displayed in Table 2. below, in total 207 referrals were made for, 'The Together Programme' between April 2017 and March 2018. While attempts were made to contact all interested participants, it was not possible to contact 45 of these. In these cases, efforts were made to contact them by telephone, email or SMS three times. Where no contact was successfully made, a message was left requesting them to get in touch with the study coordinator.

Most referrals (175, 85%) were made by participants themselves. Typically, participants self-referred by returning a letter with their contact details by post. However, in some instances, participants made contact by email or telephone. A smaller number, 30 participants were referred by clinicians working in either one of the residential treatment centres in Surrey, Ayrshire or Shropshire or by members of Combat Stress community teams. Only 1% of referrals received, were from external agencies in this study. Overall, of the 207 referrals made, 57 participants commenced the programme.

As depicted in Table 3, of the 207 participants interested, 162 participants were screened mainly by telephone. Some participants expressed a preference to

communicate using email. Of those screened, 48% were deemed suitable for the programme and 52% not suitable for the programme. Reasons for non-suitability included; Childcare, unable to attend sessions during daytime, travel (distance & transport) to venue, financial, including being the primary financial provider in the relationship, work commitments, not wanting to disclose veteran's mental health difficulties to employers, unavailability of interpreter, mental health difficulties of partner being too severe to attend group and caregiving responsibilities (veteran and others). In total, of 77 participants who were invited to attend the programme, 20 required letters of support for their employers, thus indicating the importance of helping to remove barriers such as work or stigma in talking to employers about mental health difficulties for them accessing support.

As illustrated in Table 3, Liverpool and Portsmouth attracted the greatest interest as reflected in the number of participants screened. Derby appeared to attract less interest. Different levels of interest are also reflected by the size of groups in different locations of where the programme was piloted. For instance, Table 3 indicates the largest groups which comprised of 9 participants were in Liverpool and Portsmouth and the smallest groups which contained 4 participants each were in Cardiff and Derby. Overall the average size of the group was 6.3. The maximum number of participants in each group was capped at 10.

**Table 2 Table demonstrating rates of referrals**

	Number	(%)
Participants self-referred	175	(85%)
Referrals- Internal	30	(14%)
Referrals-External	2	(1%)
Total no of referrals	207	

**Table 3 Table demonstrating participants screened**

	Number	%
Total no of participants screened	162	
Birmingham	14	
Derby	5	
Glasgow	12	
Leeds	16	
Liverpool	20	
Belfast	17	
Cardiff	15	
Portsmouth	20	
Newcastle	12	
<b>Participants deemed suitable</b>	77	48%
<b>Participants deemed non-suitable</b>	85	52%

*Note: 45 interested participants were not able to be contacted for screening.*

Table 4 displays details of participant demographics. Compared with the population of treatment seeking veterans at Combat Stress, of which 96% are male (Ashwick, Syed & Murphy, 2018), these figures show all participants in this pilot study were female, thus, indicating male partners of female treatment seeking veterans may be less likely to seek out support. Unfortunately, because no male partners expressed interest in the programme or were screened, it was not possible to elucidate what barriers to care there may be for this population.

## **3.2. Feasibility outcomes**

### **3.2.1. Participant engagement**

Figures of participant engagement in Table 5 indicate, of 77 who were invited to attend the programme, 57 (74%) commenced the programme of which 51 participants completed (89%). Of the 51 participants who completed, 44 (86%) were followed up at 3 months and completed outcome measures.

The average number of sessions attended by those who completed the programme was 9.2 out of a possible 10. Attendance ranged from 8.5 to 9.6, thus indicating overall high levels of participant engagement. In total, 7 participants who commenced the programme dropped out. Reasons given for participants not being able to complete the programme include; health difficulties, childcare, relationship separation and other caregiving responsibilities.



**Table 4 Demographic data**

<b>Demographic characteristics</b>	<b>N= 57 (%)</b>
Sex	
Female	57 (100%)
Male	0 (0%)
Average age	46 years (Max 67)
Living with partner	
Yes	47 (82%)
No	10 (18%)
Dependents	
Yes	29 (51%)
No	28 (49%)
Length of relationship	
<9 years	24 (42%)
>9 years	53 (58%)
Served in military	
Yes	6 (11%)
No	51 (89%)
Employment status	
Working	35 (61%)
Not working	22 (39%)
Education	
Low (A Levels/HNDs/NVQ/GCSEs)	38 (68%)
High (Degree/Postgrad)	18 (32%)
Quality of life	
Low	25 (45%)
High	31 (55%)

**Table 5 Table demonstrating participant attendance**

	Number	%
<i>Overall Average no of sessions attended (out of possible 10)</i>	<b>9.2</b>	<b>92%</b>
Birmingham	9	90%
Derby	8.5	85%
Glasgow	9.2	92%
Leeds	9.5	95%
Liverpool	9.5	95%
Belfast	9.2	92%
Portsmouth	9.8	98%
Cardiff	9.0	90%
Newcastle	9.6	96%

### 3.2.2. Mental health outcomes

Analyses were conducted with the sample of all 57 participants who engaged in the programme.

Changes in primary and secondary mental health outcomes following the 5-week support intervention have been reported (Table, 5). Significant reductions in anxiety and depression were maintained three months after completing the programme were observed. Changes in mean GHQ scores between pre-programme and at 3 months follow up suggest these have fallen from above the cut off score of 12/13 to subthreshold levels of anxiety and depression (17.1 to 11.8,  $p < 0.05$ ). A medium effect size (0.73) was observed.

Furthermore, significant reductions in participants self-reported secondary traumatic stress symptoms between pre-programme and 3 months follow up were observed. Changes in mean Secondary Traumatic Scale scores reduced from being above the cut off score of, 38 to below this threshold (44.5 to 33.2,  $p < 0.05$ ). A medium effect size (0.59) was observed.

Although improvements in participants alcohol use were observed and approached statistical significance these were not as profound. As noted by mean audit scores pre-intervention, (3.1) and at 3 months follow up (2.0,  $p < 0.08$ ). Please refer to Table 6 for more details of results.

The final data presented is of our secondary measures of social support, self-efficacy and relationship quality and satisfaction. Significant Improvements were observed in participants ratings of relationship satisfaction after completing the programme (16.3 to 18.9,  $p < 0.05$ ).

A small effect size was observed (0.23).

Participants ratings of relationship/marital adjustment however, did not change over time. The measures showed no significant changes in participants ratings of social support or self-efficacy after completing the programme.

### Responders and non-responders

Table 7 reports on the differences between individuals who reported at 3 months follow up and those who did not. No significant differences in social demographics or mental health outcomes found between those who responded and those who did not. Although non-responders were more likely to report higher levels of secondary trauma stress symptoms this did not reach statistical significance.

**Table 6** Mental health and wellbeing outcomes of participants who were successfully and not successfully followed up at 3 months.

	<b>Successfully followed up at 3 months (N=44)</b>	<b>Not successfully followed up at 3 months (N=7)</b>	<b>P value</b>
<b>Primary Outcomes at baseline</b>	<b>Mean (SD)</b>	<b>Mean (SD)</b>	
GHQ	17.1 (6.0)	17.3 (8.7)	0.89
STSS	43.3 (15.5)	52.1 (7.6)	0.09
<b>Secondary outcomes at baseline</b>			
GSE	18.3 (5.8)	19.9 (4.3)	0.47
MSPSS	4.5 (1.2)	4.4 (1.1)	0.63
DAS	17.4 (4.8)	15.1 (6.9)	0.32
RAS	17.2 (11.4)	10.4 (7.5)	0.09
AUDIT C	2.7 (2.3)	5.7 (8.3)	0.52
<b>Demographics</b>			
Age	46.0 (9.7)	44.4 (10.9)	0.73
Living with partner			0.57
Yes	37 (84.1%)	6 (85.7)	
No	7 (15.9)	1 (14.3)	
Dependents			0.57
Yes	24 (54.6)	3 (42.9)	
No	20 (45.5)	4 (57.1)	
Served in military			0.67
Yes	4 (9.1)	1 (14.3)	
No	40 (90.9)	6 (85.7)	

**Table 6** Mental health and wellbeing outcomes of participants who were successfully and not successfully followed up at 3 months

	Successfully followed up at 3 months (N=44)	Not successfully followed up at 3 months (N=7)	P value
<b>Demographics</b>			
Education			0.25
Low	28 (63.6)	6 (85.7)	
High	16 (36.4)	1 (14.3)	
Employment			0.57
Working	30 (68.2)	4 (57.1)	
Not working	14 (31.8)	3 (42.9)	
Relationship length			0.10
<9 years	17 (38.6)	5 (71.4)	
>9 years	27 (61.4)	2 (28.6)	
Quality of life			0.49
<Low	19 (43.2)	4 (57.1)	
>High	25 (56.8)	3 (42.9)	

**Table 7:** Mental health outcomes before and after The Together Programme

	<b>Pre Programme Mean score (SD)</b>	<b>Follow-up Mean score (SD)</b>	<b>P- Value</b>	<b>Effect size</b>
<b>Primary Outcomes</b>				
GHQ	17.1 (6.4)	11.8 (8.0)	0.00*	0.73
STSS	44.5 (15.0)	34.2 (19.3)	0.00*	0.73
<b>Secondary Outcomes</b>				
GSE	18.5 (5.6)	17.7 (8.8)	0.59	NA
MSPSS	4.5 (1.1)	3.9 (2.3)	0.11	NA
DAS	17.1 (5.1)	14.3 (8.4)	0.04*	0.4
RAS	16.3 (11.1)	18.9 (11.5)	0.25	NA
AUDIT	3.1 (3.7)	2.0 (2.3)	0.08	NA

*Note: Table above includes data for participants (N=51) who completed The Together Programme.*

### 3.2.3. Project costings

The average cost per group was £745 and ranged between £109-£1161. An estimated cost of £118 per participant engaging in the 5-week intervention has been calculated.

**Table 8** Table demonstrating estimated costs of running groups

<b>Total cost of running group programmes</b>	<b>Cost (£)</b>
Average cost per group	<b>745</b>
Cost per group range	109-1161
Average cost per participant	118

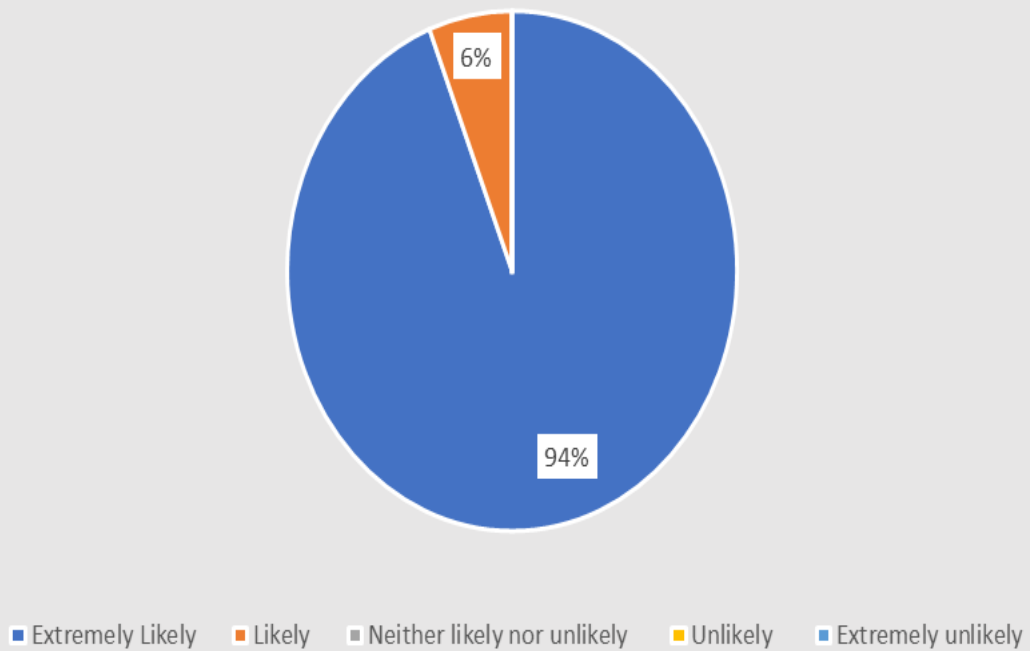
*Note: Estimated costings are based on running of 9 group programmes and exclude staff salaries.*

### 3.3. Acceptability outcomes

#### 3.3.1. Friends and Family Test

**Figure 2** Friends and Family Test Evaluation data

How likely are you to recommend this service to friends and family?





**Table 9** Table summarising the key themes from programme evaluation

Evaluation question	Key themes
1.Top 3 things you liked about the groups	<ol style="list-style-type: none"> <li>1. Coping strategies for self</li> <li>2. Normalisation: Meeting, sharing and listening to other partners</li> <li>3. Understanding of PTSD</li> </ol>
2.Top 3 things you disliked about the groups	<ol style="list-style-type: none"> <li>1. Nothing</li> <li>2. Programme is not long enough</li> <li>3. Longer sessions are needed</li> </ol>
3.Things you would like to see changed about the groups to better meet your needs	<ol style="list-style-type: none"> <li>1. Longer programme &amp; longer sessions</li> <li>2. Conjoint sessions with veteran</li> <li>3. Top up sessions</li> </ol>
4.Obstacles there were that could have prevented you from attending these sessions?	<ol style="list-style-type: none"> <li>1. Work/Employers</li> <li>2. Travelling</li> <li>3. Childcare</li> </ol>
5.Ideas about how these obstacles could be overcome	<ol style="list-style-type: none"> <li>1. Letter of support for employer helpful</li> <li>2. Support with travel expenses</li> <li>3. More accessible times of sessions e.g. evening, weekend.</li> </ol>
6.Any other suggestions or further comments	<ol style="list-style-type: none"> <li>1. Good delivery of groups. Feeling safe &amp; able to share without judgement.</li> <li>2. Programme needs to be readily available to partners.</li> <li>3. Extra time in 1<sup>st</sup> session needed, residential programme for partners, longer programme</li> </ol>

### **3.3.2. Programme evaluation**

Four key themes from the programme evaluation emerged. Please refer to Table 9.

#### **Taking care of my own needs**

A common theme which emerged was the importance of having a safe environment to share, without feeling judged. Many participants said they felt misunderstood and isolated from friends and family members. They frequently reported hiding their own feelings and needs from their veteran partner to preserve the relationship. Participants said the group offered a space for them to talk openly about their own experiences and develop coping strategies for themselves as well as gain a better understanding of PTSD.

#### **Length of programme and session timings**

Majority of participants reported they would like a longer programme. Participants said extra sessions would allow more opportunity to consolidate the knowledge gathered during the programme and afford more time for sharing experiences. While many groups continued to offer each other peer support after the programme, participants expressed the need for ongoing support to revisit material covered and help maintain gains.

Participants also reported session timings to be an area for improvement. Participants expressed the need for more flexible timings, such as evening or weekend sessions.

#### **Barriers to accessing support**

One of the main obstacles which participants noted to potentially hamper their engagement in the programme included work or employers. Despite offering participants a letter of support for employers, some participants said they did not feel comfortable disclosing to their employers about the veteran's mental health difficulties. Other participants talked about their sense of responsibility of being the primary financial provider in the relationship and taking time out of work would be too great a risk to take.

Other potential obstacles for participants included travelling to the venue and time away from the veteran, often feeling anxious or guilty about leaving the veteran by themselves. Childcare was also noted to be a challenging roadblock for many participants who felt responsible for making these arrangements in their relationship.

#### **Conjoint sessions with veteran**

Majority of participants suggested conjoint sessions with veterans to be incorporated into the programme. Participants said they would prefer sessions with veterans on a 1:1 basis as opposed to partners and veterans in a group scenario and these would be added into the programme and not replace the current format. Participants reported having this additional form of support would help develop a shared narrative, correct misunderstandings and promote joint problem solving to help ameliorate the veteran's symptoms.

## 4. Discussion

### 4.1. Summary of results

This study aimed to investigate the feasibility and acceptability of an evidence-based programme for UK veteran partners who themselves have mental health difficulties or are at risk of developing mental health difficulties.

Results suggest The Together Programme is a feasible model of support for veterans' partners with 57 commencing the programme and 51 completing in total. A high rate of session engagement (9.2) was observed. The ability to retain participants for this 5-week (10 Session) period is noteworthy. In contrast, longer programmes like SAFE 18 session programme has yielded lower retention rates of 6.3 (Sherman, 2016).

Findings of this study suggested the content and delivery of the 5-week intervention to be an acceptable medium of support with all (100%) of participants who completed The Together Programme, recommending it to friends and family members. Participants highly rated the programme for providing a safe place to share their experiences and to feel understood by others who "just get it" and for giving them knowledge and understanding to support the veteran manage their mental health symptoms. Importantly, participants reported gaining valuable coping strategies for themselves. These findings are consistent with other education-based support programmes where family members have highlighted the value in the knowledge and confidence they have gained in helping their relationships, loved ones and other family members (Sherman et al, 2006).

In terms of the clinical effectiveness, results at 3 months follow up are

promising. Results showed participants levels of depression, anxiety and secondary trauma symptoms to have significantly reduced, suggesting more helpful coping strategies were adopted after engaging in this self-management programme.

In addition, significant improvements were observed in participants levels of relationship satisfaction indicating The Together Programme is an important source of emotional support for interpersonal functioning within their relationship with their veteran partner.

Collectively, these outcomes endorse the importance of providing structured and bespoke support interventions. These results indicate educating partners and supporting their mental health needs could be key to helping veterans. As denoted earlier in the introduction, Miller (2013) shows treating veterans without spouse's involvement can have detrimental effect on treatment outcomes. For example; Whilst veterans may collect a toolkit of helpful coping strategies during a course of treatment, without support and education, partners may continue to use counterproductive behaviours which may dilute, if not dissolve new skills acquired. As such, an integrated approach is likely to have greater long-term benefits, as evidenced by Gourley (2006).

### Non-significant changes

Significant changes in participants perceived social support were not observed after completing the programme. Although participants consistently reported sharing experiences with peers was helpful and reduced their sense of isolation, levels of perceived social support did not increase. These findings infer the

social support offered over the course of 5 weeks did not generalise or extend outside of the context of the group. Alternatively, the programme may not be long enough for these gains to be made in this area, as echoed in participants feedback. Many participants expressed feeling daunted by the prospect of no longer having the support available. This is supported by evidence US Department and Human Services (2009) which reinforce family-based psychoeducation programmes not to be a short-term intervention. Studies have found such interventions which offer twelve or more sessions to have larger effects compared with shorter interventions (Cuijpers, 1999).

In addition, changes in participants levels of self-efficacy were not observed after the intervention: One explanation for these results could be participants greater acceptance of not needing to control or fix the veterans illness. This is reinforced in Karp and Tanarugasach (2000) 4 stages in the caregiver's experience model which describes caregivers moving through a series of stages from fear and confusion, hope and compassion, loss and resentment and recognition that the caregiver cannot control the individual's illness and thus has greater acceptance of them.

Some participants found it more difficult to engage in self-care exercises which involved a process which felt unfamiliar and uncomfortable for many. As elicited during screening, participants varied in their knowledge and experience in self-management of mental health symptoms at the start of the programme. These findings may indicate the need for preparation work prior to starting the programme. Other psych education-based programmes for military families such as US based,

Veteran Affairs REACH programme included four joining sessions for building rapport, assessment, expanding coping skills repertoire and preparation for the next phase (Sherman, Doerman, Bowling and Thrash, 2011), As such, incorporating preparation or joining sessions may help remove these roadblocks.

Taken together the clinical and acceptability outcomes provide strong evidence The Together Programme can be incorporated into current service provision as a cost-effective intervention for supporting partners living alongside veterans with mental health difficulties.

## 4.2. Strengths and Limitations

### Study strengths

This pilot had notable strengths. Firstly, participants recruited were of treatment seeking veterans and therefore of a homogenous sample. That is, a high proportion of participants veteran partners had a diagnosis of PTSD or combat related mental health difficulties, thus increasing our confidence in the ecological validity of our findings.

Secondly, using manualised approach increased our confidence in fidelity of the intervention being received. However, some groups or individuals would have benefited from a more flexible approach where more than one telephone support session are offered.

Thirdly, we were able to successfully follow up 86% of those who completed the programme.

## Study limitations

The generalisability of this study's findings is limited by the modest sample size used in the study and the use of self-report measures alone. Should this intervention continue to be run, it would be helpful to explore the process of change and transition participants go through during the programme in greater depth.

Secondly, participants in this study were followed up for a relatively short time after completing the programme. Having longer follow up points may help to determine if these gains made are sustained.

Another limitation is, most referrals made were internal and could have excluded partners of veterans who had not accessed help. In addition, the exclusion criteria could have excluded veteran's partners of veterans whom did not give their consent or pass on relevant information sent to them. As a result, we may be excluding partners the opportunity to engage in the programme who might need support. Unfortunately, it is not known if these responses may have influenced participants interest and engagement in the programme. Greater understanding of veteran's attitudes towards their partners engagement in support is needed. Meanwhile providing veterans with more understanding about what the programme entails in the early stages of recruitment may help allay concerns about their loved ones accessing support.

All participants in the sample were female. Because no male participants expressed an interest or were screened for the programme, information could not be gathered about potential barriers. Thus, future research would benefit from exploring

barriers and enablers for male partners looking after female veterans with mental health difficulties.

Finally, we only recruited from Combat Stress. Data suggests 82% of Combat Stress veterans have PTSD and comorbidities of three or more mental health difficulties and physical health needs are extremely common (Murphy, Ashwick, Palmer & Busutill, 2017). As such, this sample may represent the 'most ill' veterans. This may limit our findings to only partners of the most unwell.

Theoretically, if this programme is very effective in this sample, it should also be in veterans with less complex mental health presentations.

## 5. Recommendations

### 5.1. Partners recommendations

There were several participants suggestions which emerged regarding how to improve The Together Programme in the future. Participants identified the following four areas; (1). Longer programme (2). Top up sessions (3). More information and support available for parents and (3). Conjoint sessions with veteran.

### 5.2. Delivery of programme

If The Together Programme is to be considered in its current form, attention needs to be given to the staff group who deliver these groups. Given the content of the programme involves the incorporation of many psychological models and requires clinical skills in managing complex group dynamics and containing emotional distress, it is recommended a trained therapist with access to regular supervision leads these groups. Staff recommended to co facilitate these groups alongside a therapist included clinicians who are

well equipped in running groups with a veteran population.

Having service users involved in the development of The Together Programme was extremely valuable when it came to ensure practical needs were met. However, by utilising professionals only to present strategies may have been limiting. Conversely, having participants in their roles as 'experts by experience' involved more in the delivery phase of the intervention is likely to be empowering to other participants. There is evidence to support the involvement of service users to have many benefits to others and for themselves (Driessen's, McLaughlin & Van Dorn, 2016). Therefore, going forward, it is recommended partners are given more opportunity to have meaningful involvement in the delivery phase of the intervention.

Facilitators and participants reflections upon content of the programme indicate a review of sessions 9 and 10 is needed. In its original format participants in the final week of the programme complete a structured psychoeducation session on problem solving before engaging in a goodbye session. Many participants spoke about not being afforded sufficient opportunity to say goodbye to their peers properly whom they had developed a relationship with over the five weeks because of limited time available. To address this issue, it is recommended the final goodbye session be delivered in a one-week standalone session.

Session 9 addresses problem solving skills for participants supporting veterans. Facilitators in their experiences of running this session found introducing the seven-step process of problem solving to

participants to be superfluous. This was also echoed in many participants feedback. It is speculated one of the reasons for this is because partners in their caregiving role develop many problem-solving skills and may not perceive problem solving to be a need.

Similar support programmes such as SAFE (Sherman, 2008) which incorporates problem solving model focuses on common challenges faced by families as opposed to veterans specifically and adopt a more systemic approach. In view of this, combined with the feedback gathered It is suggested this session be revised and problem-solving exercises which encourage a more systemic approach be included. Consideration also needs to be given to other problem-solving related issues which were not fully addressed in this session like helping participants maintain boundaries in their relationship.

Participants who were parents of children expressed additional education and support beyond that was covered in session 6 'How to explain PTSD to children and other people'. This would help equip parents with a more comprehensive toolkit to support their children living alongside a veteran parent. Some participants suggested add on sessions for parents only.

### **5.3. Role of facilitators**

The role of the facilitator during the delivery of the programme was at times unclear. For example, on numerous occasions participants made requests regarding the veteran's treatment plan e.g. Assessments, reviews. Where formal consent had already been given by the veteran, the facilitator liaised with relevant members of staff and exchanged information. Actions needed or not

needed to be taken by the facilitator in these scenarios was often unclear. In addition, there was ambiguity around recording these events when the veteran's partner is not a service user of Combat Stress services per se. Thus, it is recommended guidelines be developed to help guide future programme facilitators about their roles and responsibilities. Based on these guidelines, what support the facilitators can offer can be clearly communicated to participants during screening.

#### **5.4. Contact issues**

Because sessions were conducted in the community there was no way for participants to communicate with facilitators on the day of groups to inform of late arrival or nonattendance. In some instances, this led to participants feeling frustrated or anxious with no point of contact. In the future, programme facilitators would benefit from a mobile phone to be provided by the employer.

#### **5.5. Attendance & accessibility**

Many participants who were screened or engaged in the programme expressed the need for a more flexible service. Common themes identified as potential barriers included; sessions taking place during the week day, childcare, travel and financial responsibilities. These findings indicate it is essential to make The Together Programme more accessible to the population of military partners.

The use of web-based platforms to support services users here in the UK NHS and in the US and Canada are becoming more widely adopted. These online therapies are typically offered in adjunct to traditional face to face interventions as a means of increasing accessibility and patient choice.

A recent review of web-based therapy for veterans reported that they are well accepted by veterans and that treatment outcomes were comparable with in-person delivered therapy (Turgoose, Ashwick & Murphy, 2017). Therefore, adapting 'The Together Programme' into a web-based programme looks like an appealing and effective option for developing a flexible service moving forward.

### **6. Conclusions**

This study is the first of its kind in the UK to pilot a structured support intervention for partners living alongside veterans with mental health difficulties.

Significant improvements in participants rates of depression, anxiety and relationship satisfaction implies this psychoeducation-based approach to be effective. Our findings highlight the feasibility and acceptability of this type of intervention among this population, reinforcing previous literature which emphasises the importance of tailoring the intervention to the specific needs of military partners.

In view of the feedback gathered for why partners deemed suitable for the programme yet could not attend, indicates we must continue to adapt this service to ensure it is accessible. Moving forward, web-based interventions look like an effective and viable option. Involving partners in their roles as experts by experience during both development and delivery of the intervention is also essential for learning how to best overcome these practical barriers.

We have suggested non-significant changes in participants self-efficacy and perceived social support at follow up may be because either participants

were not able to generalise from the group context into their daily lives within this relatively short period of five weeks. This suggests the need for further work to establish if a longer programme or top up sessions could be beneficial, particularly in these areas.

Finally, consideration needs to be given to how this service might be

incorporated into the veteran's care pathway. Further work into understanding the impact of supporting partners on veteran's treatment outcomes at different stages of the journey. Exploration of the acceptability of conjoint sessions with the veteran in adjunct to The Together Programme for partners is needed, to be considered as a potentially viable service.



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## **Appendix One Intervention Options Review**

### **An options review of the effectiveness of different psycho-educational programmes for military partners.**

#### **Introduction**

Evidence has found that educating family members can significantly reduce veterans' symptoms of PTSD, anxiety and depression and reduce veteran drop-out rates to treatment programmes (Galovski & Lyons., 2004). Batten et al (2009) found that 86% of veterans viewed their PTSD as a form of family stress, not just an individual problem. Partners also undergo a great deal of stress surrounding deployment, relocation, reunion and boundaries (Chandra et al., 2011). This can often lead to psychological difficulties such as anxiety and depression (Westerink & Giarratan., 1999). Psycho-education programmes have been shown to effectively reduce partners' psychological difficulties and improve family relationships (Frain, Bethel, & Bishop., 2010).

This report will review the effectiveness of the SAFE, FOCUS, REACH, READI, FFEP, lifestyle management course, Military One Source, HomeFront Strong and Ripple pond programmes to determine which the best programme to use at Combat Stress is.

#### **SAFE programme**

The Support and Family Education (SAFE) Program began in the Veterans Affairs (VA) centre in Oklahoma, USA. The program comprises of 18 sessions with a psychologist and psychiatrist aimed at comforting and teaching veterans' partners (and in some cases parents where the veteran lived with them) about coping strategies. The SAFE program has a particular emphasis on PTSD education and how to manage it (Makin-Byrd et al., 2011). Specific areas focused on are depression, bipolar, PTSD, schizophrenia; causes, communication, boundaries, problem solving, minimising crises, anger, family reactions, caring for yourself, stress, stigma, children and how to help your loved ones. Each session lasts for 90 minutes. The sessions occur once a month.

It was found that the more SAFE sessions family members attended, the greater their understanding of mental illness, awareness of available resources and ability to perform self-care activities for their loved one (Sherman, 2003). Sherman (2003) also found that satisfaction levels from 314 partners were high, with a mean score of 18 out of 20. This was discovered using a questionnaire with a 0 – 5 rating scale. 75% of the participants returned for multiple sessions, meaning 25% dropped out. The average number of sessions attended was 6.

### **FOCUS program**

The Families OverComing Under Stress (FOCUS) program was designed to help veterans' families understand the effect their emotions and reactions can have on the veterans and teaches them to communicate clearly, problem-solve and set goals. It is focused around building resilience and positive adaptation for both partners and children. This programme includes parent-only sessions (sessions 1 and 2), child-only (sessions 3 and 4), parent-only (session 5), and family sessions (sessions 6–8). Sessions specifically focus on emotions, misunderstandings, viewpoints, family strengths, support, problem solving and goal setting. The sessions with only parents lasted 90 minutes, whereas sessions including the children were between 30 and 60 minutes.

Lester et al (2012) assessed the satisfaction of 363 veterans and partners with the program using questions on a scale of 0 – 7. Overall satisfaction was 6.58, with high ratings above 6 for improvements in emotional regulation, understanding PTSD, overall helpfulness and willingness to recommend to a friend. Furthermore, Lester et al (2016) recently found that the success of this programme was sustained at a 6 month follow-up, although there was a slight drop at the 1 month follow-up. Partners were found to experience a reduction in anxiety and depression symptoms from 23% to 11% at the 6 month follow-up. Improvements were also seen in children. It was also found that 30% of the veterans and families 'dropped-out' of the program.

### **REACH program**

The Oklahoma City Veterans Affairs (VA) centre modified the multifamily group model (McFarlane, 2002) to educate veterans and families about PTSD. This was named the REACH Program (Reaching out to Educate and Assist Caring, Healthy Families). The REACH program has 3 phases of treatment, spread over 16 sessions

with one to two psychologists. Phase 1 involves 4 weekly sessions with the veteran and their family. It focuses on rapport, assessment and goals. Phase 2 consists of 6 weekly education and support sessions with 4-6 veterans and their families. Phase 3 involves the veteran and their family attending 6 monthly groups to help them maintain their skills learnt.

Sherman et al (2009) found that 60% of veterans and families were *very satisfied* and 39% were *mostly satisfied* with REACH services. 60% described the quality of their mental health care as *excellent* and 37% said it was *good*. Furthermore, 47% said the program helped them to deal effectively with problems *a great deal* and 51% said *somewhat*. 99% said they would refer a friend to the REACH program. In addition, completion rates of the program by veterans and family members was high; 89% completed the first phase. Drop-out rates between phase 1 and 2 were 30%.

### **READI (formerly 'Spouse-BATTLEMIND') program**

Spouse-BATTLEMIND originally focused on a 1.5 hour telephone call to military spouses post-deployment. It was based on 10 areas; Bonds, Adding/subtracting family roles, Taking control, Talking, Loyalty, Emotional balance, Mental health, Independence, Navigating the army system and Denial of self. The Resilience Education and Deployment Information (READI) program expanded on this to involve telephone support groups with 6 spouses and a trained counsellor. It involved 12 sessions, twice a month for 6 months. Each group lasted 1 hour. The READI program is focused on developing resilience through psycho-education, coping skills such as problem solving and communication and cognitive restructuring exercises to reshape negative thoughts.

In a report, Nichols (2011) found that spouse mental health significantly improved. The effect size was 0.33 for depression and 0.40 for anxiety. However, there were no significant improvements in marriage quality, family coping or family communication after completing the program as the effect size was only 0.17 for social support.

### **Family-to-Family Education program (FFEP)**

The veterans' health administration partnered with the National Alliance on Mental Illness (NAMI) to administer their Family-to-Family Education Program (FFEP) for veterans and their families. FFEP sessions last between 2-3 hours and are



implemented once a week for 12 weeks. It is led by family members of veterans who volunteer and are trained. The program provides psycho-education about mental illness, medication, and treatments. It also addresses problem solving, communication techniques, care, and information on services.

Dixon et al (2004) found that the FFEP helped reduce caregiver burden in families and improved feelings of empowerment, understanding of mental illness and services, and increased caregiver self-care. Pickett-Schenk et al (2006) also found that family members reported fewer depressive symptoms and had more positive views of their relationships. However, Dixon et al (2011) found that only 58% of participants attended 10-12 sessions, meaning 42% dropped out. Significant improvements were seen in problem solving (effect size of 0.30), anxiety levels (0.26), acceptance (0.38) and knowledge (0.40), however other areas assessed saw no significant differences before and after treatment. The benefits of the program were sustained at a six-month follow up.

### **Lifestyle management course (LM)**

The Queensland Vietnam Veterans Counselling Service created the lifestyle management course. It is a 5 day residential course for both veterans and their partners, run by a multi-disciplinary team. It focuses on the psycho-education of areas including anger management, self-esteem, communication, PTSD, diet, medical issues, alcohol, depression, problem solving, goal setting, relaxation and medication and care.

Deville (2002) found that after a six month follow-up spouses displayed a significant decrease in stress, anxiety and depression. Stress had reliably improved in 11.94% of the partners, anxiety in 10.61% and depression in 9.09%. There was also an improvement in anger and a small change in marital happiness. However, the least improvement was seen on subjective quality of life.

### **Military One Source program**

Military One Source is a psycho-education program for military families sponsored by the US Department of Defence. It is a short term program offering counselling through online video tutorials and a 24-hour call line. It also offers up to 12 sessions in person, however this is optional. It has a focus on early prevention.

There are no published results on the efficacy of this program

### **HomeFront Strong (HFS) program**

HomeFront Strong is an 8 week program specifically targeted at military spouses. There is one session a week for 8 weeks; each session lasts two hours. It is run by a clinical psychologist. The key areas focused on are resilience, stress, optimism, re-thinking, building community, emotions and staying strong. The program incorporates a range of different psychological techniques including positive psychology, cognitive-behavioural therapy and dialectical behaviour therapy to educate partners. Finally, HomeFront Strong also relies on friendship support through the group-based design. Kees et al (2015) found that military partners' symptoms of depression decreased after completing the 8 week programme. They also found an improvement in resilience characteristics, life satisfaction and social support. Limited information was available in relation to follow up.

### **Ripple pond peer support**

The ripple pond provides a peer-based self-help group for families of servicemen. It was set up by two mothers of injured veterans in the UK. The group lasts for 2-3 hours and are unstructured, allowing military families to discuss issues that are most prominent to them. The groups are based at different locations across the UK and families can attend sessions as and when they need. There are no published results on the efficacy of this program.

### **Conclusions**

There are several interesting factors that have become apparent upon reviewing the existing programs. Addressing these factors appear key to providing a successful psycho-education program for military partners. These findings are shown below:

- Long term programs (above 3 months) tend to have drop-out rates of 30% and above.
- Group settings are highly regarded among military families.
- Individual telephone help has been suggested to decrease drop-out.
- Many of the programs have success in reducing mental health symptoms but are not as effective at reducing social problems.
- Few programs focus only on military partners.

- Sessions varied in length; ranging from 30 minutes to two hours.

Each program we assessed was then rated using a table matrix to compare against a set of criteria (see table one below). The Safe program and Homefront Strong program appear to be good options to base the intervention on.

**Appendix Two: Table of military partner programs and related interventions**

Program	Criteria							
	Structured psycho-education	Military specific	Partner specific	Therapist based	Practical	Efficacy at 3mth F/U	Community based	Face-to-face
SAFE	✓	✓	✓	✓	✓	✓	✓	✓
FOCUS	✓	✓	x	✓	x	✓	✓	✓
REACH	✓	✓	x	✓	x	x	✓	✓
READI	✓	✓	✓	✓	x	✓	✓	x
FFEP	✓	x	x	x	✓	✓	✓	✓
Lifestyle management	✓	✓	x	x	✓	✓	x	✓
Military One Source	x	✓	x	✓	✓	x	✓	x
Homefront Strong	✓	✓	✓	✓	✓	x	✓	✓
Ripple pond	x	✓	x	x	x	x	✓	✓

## Appendix Three: Outcomes from partners needs Assessment Questionnaire

### Needs Assessment Questionnaire

	<i>Miles</i>	0-5	6-10	11-15	20+
1. How far would you be willing to travel to a group		0%	6%	41%	53%

9a. What might be some of the advantages For running a group at an RBL center?	Familiar, accessible, local & convenient
9b. What might be some of the obstacles for Running a group in this location?	Parking, traffic & city centre

	<i>Weeks</i>	4	5	6	7
3. What length of programme could you commit to?		29.5%	0%	29.5%	41%

	Yes	No
4. Would you like telephone follow ups between group sessions?	71%	29%

	4-6	6-8	8-10	10+	Any
5. What size of group would you prefer?	35%	35%	0%	24%	6%

	Mon	Tue	Wed	Thurs	Fri	Any
6. What day of the week works best for you?	17%	13%	26%	0%	11%	22%

	Mornin g	Lunchtim e	Afternoon	Evenin g	Any
7. What time of day works best for you?	26%	12%	42%	5%	5%

	2 hrs	3 hrs	4+hrs	Any time
8. What length of session would you prefer?	47%	47%	0%	6%

9. What other commitments do you have which might stop you from attending the group?

Work

Children

Gym

10. What would encourage you to attend the group if it was available?

1. Saw improvement in partner

2. Shared experience with other partner's

3. Employment letter for support.

11. What would be the top three things you would like to get from a group programme of this kind?

1. Understanding PTSD as illness

2. Self-help strategies

3. Knowing not alone/peer support

## Appendix Four: Invitation letter to veterans



Tyrwhitt House ▪ Oaklawn Road  
Leatherhead ▪ Surrey ▪ KT22 0BX

Tel: 01372 587000  
Fax: 01372 587101  
Helpline: 0800 138 1619

[contactus@combatstress.org.uk](mailto:contactus@combatstress.org.uk)  
[www.combatstress.org.uk](http://www.combatstress.org.uk)

**Dear Veteran**

[RE: Supporting veterans' partners](#)

We are writing to you because we are developing a programme to support military partners. If you are currently in a relationship and think your partner may be interested in receiving support, please do ask them to contact me (contact details included).

Your help is critical to us developing valuable services for the future and we thank you in advance for your time. Each person that takes part at every stage really does help.

Yours sincerely,

*LS Harper*

Project coordinator

*How to get in touch*

Email me at: [lucy.spencer-harper@combatstress.org.uk](mailto:lucy.spencer-harper@combatstress.org.uk)

or

Phone me on: **01372 587191** (please leave a message and include a phone number)

or

*Please complete the slip below and return using the s.a.e enclosed*



**Partners Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Landline Telephone:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**When is the best time of day to contact you by telephone?**

Morning \_\_\_ Lunchtime \_\_\_ Afternoon \_\_\_



## Appendix Five: Formal letter of invitation

Tyrwhitt House • Oaklawn Road  
Leatherhead • Surrey • KT22 0BX

Tel: 01372 587000  
Fax: 01372 587101  
Helpline: 0800 138 1619

[contactus@combatstress.org.uk](mailto:contactus@combatstress.org.uk)  
[www.combatstress.org.uk](http://www.combatstress.org.uk)

Dear Partner

*RE: Supporting veterans' partners*

*Following our recent telephone conversation, I am pleased to invite you to attend the 5-week group programme supporting military partners in Derby. The programme is due to commence on Thursday 8th June and will take place at The Royal British Legion (RBL) Hub, 18 St Peters Street, Derby, DE1 1SH (getting here & parking for more information).*

*Dates and times for all 5 weekly sessions;*

Week 1: Thursday 8<sup>th</sup> June, 11am- 1:30pm

Week 2: Thursday 15<sup>th</sup> June, 11am- 1:30pm

Week 3: Thursday 22<sup>nd</sup> June, 11am- 1:30pm

Week 4: Thursday 29<sup>th</sup> June, 11am- 1:30pm

Week 5: Thursday 6<sup>th</sup> July, 11am- 1:30pm

On arrival please sign the visitor's book and wait in the foyer inside the RBL and one of the group facilitators will come and meet you. Staff at the RBL will redirect you if you get lost. It is important you arrive on time, so we can start the group session on time. For the first session we recommend you arrive 15 minutes earlier.

Please note, in each session we will take a 30-minute break where tea, coffee and biscuits will be provided. There are a variety of cafes and shops within a couple of minutes' walks from the hub if you wish to make use of these.

### **Attendance**

As we have already discussed each weekly session has a different outline and material which has been carefully put together to give you the best opportunity to gain support. Therefore, it is essential you are able to attend all 5 sessions. As you can imagine there is a high demand for support for military partners and we want to provide this to as many as possible. Attendance is also important so that you can fully benefit from the programme. THEREFORE, PLEASE INFORM RESEARCH ASSISTANT/PROJECT COORDINATOR IF THERE HAVE BEEN ANY CHANGES IN YOUR CIRCUMSTANCES WHICH WILL AFFECT YOUR ATTENDANCE.

### **Outcome measures/questionnaires**

We would like to monitor your mental health and wellbeing before and at the end of the 5-week group programme. We have enclosed a set of questionnaires and a stamped addressed envelope and would be grateful if you could complete and return these. We recognize completing these can be a time-consuming process, but your completion is

critical to monitoring the effectiveness of this pilot programme. We thank you in advance for this.

We are looking forward to welcoming you to the group. If there is anything further you wish to discuss, please do get in touch via email: [lucy.spencer-harper@combatstress.org.uk](mailto:lucy.spencer-harper@combatstress.org.uk) or phone: 01372 587191.

Yours Sincerely,

*LS-Harper*

Lucy Spencer-Harper  
Project coordinator

## **Getting here**

**The Royal British Legion (RBL) Hub, 18 St Peters Street, Derby, DE1 1SH**

### **By bus**

We're centrally located near Derby City Bus Station so there are lots of buses to choose from.

### **By train**

We're approximately 30 minutes' walk from Derby Railway Station. Follow the signs for the City Centre and St Peter's Quarter and we are situated opposite Tesco Express on the high street. Or you can catch a bus directly outside of the train station to the Bus Station in the City Centre.

### **By car**

The closest car parks are the NCP Car Parks located on Colyear Street (DE1 1LA) and Becket Well Lane (DE1 1JW), just a short walk away. Here are a list of car parks which are close to the RBL Hub.

## **Parking**

NCP St Peters Quarter. DE1 1LA  
 4 mins walk from RBL  
 3hrs- £3.50  
 4+hrs-£4.50  
 Cash or card

Full Street. DE1 3AF  
 6 mins walk from RBL  
 3hrs- £3.50  
 4+hrs-£4.00  
 Cash or card

Crompton car park DE1 1NY  
 3 mins walk from RBL  
 3 hrs: £3.00  
 4+hrs: £4.00  
 Pay & display, cash only

**Park & Ride**  
 Meteor centre, DE21 4SY  
 £3 per car.

Pride park, DE24 8BW,  
 £3 per car.

Little City DE1 1PQ  
 5 mins walk from RBL  
 4 hrs: £3.80

## Appendix Six: Employer letter of support

Tyrwhitt House ▪ Oaklawn Road  
Leatherhead ▪ Surrey ▪ KT22 0BX

Tel: 01372 587000

Fax: 01372 587101

Helpline: 0800 138 1619

[contactus@combatstress.org.uk](mailto:contactus@combatstress.org.uk)

[www.combatstress.org.uk](http://www.combatstress.org.uk)

To whom it may concern

**RE:**

**DoB:**

**Address:**

I am writing in support for (Partners name) to be offered appropriate time from work to attend our five-week community programme for support of her partners symptoms of Post-traumatic Stress and her own wellbeing.

The programme is due to commence on Thursday 28<sup>th</sup> September 2017 in Liverpool. Below are the specific dates for each weekly session.

Week 1: Thursday 28<sup>th</sup> September

Week 2: Thursday 5<sup>th</sup> October

Week 3: Thursday 12<sup>th</sup> October

Week 4: Thursday 19<sup>th</sup> October

Week 5: Thursday 26<sup>th</sup> October

Evidence suggests that the wellbeing of partners who are also caregivers of veterans with PTSD can be impacted.

We are piloting a group intervention for partners in order to help them understand and manage mental health difficulties of their partner & develop strategies to support their own wellbeing. Currently, there are few structured support programmes here in the UK designed specifically for veteran partners. This group programme has been developed based on longstanding interventions in the US which have been found to be highly effective in improving understanding of mental illness, improving self-care & reducing distress of partners with PTSD.

Given the influential role a partner could play in the success of a veteran's treatment outcomes, providing this in a timely manner which coordinates with the veteran's treatment is important. As such (Partners name) could stand to greatly benefit from taking part in this group. Unfortunately, we are only able to offer the group during working hours at the moment.

Please do not hesitate to contact me for further information.

Yours sincerely

*LS-Harper*

Lucy Spencer-Harper

Project coordinator

T: 01372 587191/Lucy.spencer-harper@combatstress.org.uk

## Appendix Seven Psychometric measures

### A few quick questions about you...

1. Name \_\_\_\_\_ 2. Date of Birth \_\_\_\_\_ (DD/MM/YY)
3. Gender: Male <sup>1</sup> Female <sup>2</sup> 4. Age \_\_\_\_\_ (years)
5. Do you currently live with your partner? Yes <sup>1</sup> No <sup>2</sup>
6. Do you have any dependents or children living with you? Yes <sup>1</sup> No <sup>2</sup>
7. Length of relationship? 0-3 years <sup>1</sup> 4-6 years <sup>2</sup> 7-9 years <sup>3</sup> 10-15 years <sup>4</sup> 16+ years <sup>5</sup>
8. Have you served in the UK military? Yes <sup>1</sup> No <sup>2</sup>
9. Are you currently working? Full-time <sup>1</sup> Part-time <sup>2</sup> Not working, seeking employment <sup>3</sup>  
 Not working due to ill health <sup>4</sup> Retired <sup>5</sup> Other <sup>6</sup>
10. What is your highest level of education? Left school with no formal qualifications <sup>1</sup>  
 O Levels/GCSEs/NVQs Level 1-2 <sup>2</sup> A Levels/HNDs/NVQ Level 3/Highers <sup>3</sup>  
 Degree/NVQ Level 4-5 <sup>4</sup> Postgraduate qualifications <sup>5</sup>
11. Thinking about the good & bad things, how would you rate your quality of life as a whole?  
 Very good <sup>1</sup> Good <sup>2</sup> Alright <sup>3</sup> Bad <sup>4</sup> Very bad <sup>5</sup>

### Questions about accomplishing tasks

	Not at all true	Hardly true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try hard.	0	1	2	3
2. Is someone opposes me, I can find the means and ways to get what I want.	0	1	2	3
3. It is easy for me to stick to my aims and accomplish goals.	0	1	2	3
4. I am confident that I could deal efficiently with unexpected events.	0	1	2	3
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.	0	1	2	3
6. I can solve most problems if I invest the necessary effort.	0	1	2	3
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	0	1	2	3
8. When I am confronted with a problem, I can usually find several solutions.	0	1	2	3
9. If I am in trouble, I can usually think of a solution.	0	1	2	3
10. I can usually handle whatever comes my way.	0	1	2	3

## Questions about your social support

We are very interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement. Please rate each question from 1 to 7 with a circle.

1 Very strongly disagree	2 Strongly disagree	3 Mildly disagree	4 Neutral	5 Mildly agree	6 Strongly agree	7 Very strongly agree
-----------------------------------	---------------------------	-------------------------	--------------	-------------------	------------------------	--------------------------------

1. There is a special person who is around when I am in need

1      2      3      4      5      6      7

2. There is a special person with whom I can share my joys and sorrows.

1      2      3      4      5      6      7

3. My family really tries to help me.

1      2      3      4      5      6      7

4. I get the emotional help and support I need from my family

1      2      3      4      5      6      7

5. I have a special person who is a real source of comfort to me

1      2      3      4      5      6      7

6. My friends really try to help me.

1      2      3      4      5      6      7

7. I can count on my friends when things go wrong.

1      2      3      4      5      6      7

8. I can talk about my problems with my family

1      2      3      4      5      6      7

9. I have friends with whom I share my joys and sorrows.

1      2      3      4      5      6      7

10. There is a special person in my life who cares about my feelings

1      2      3      4      5      6      7

11. My family is willing to help make decisions

1      2      3      4      5      6      7

12. I can talk about my problems with my friends.

1      2      3      4      5      6      7

**Questions about alcohol use.**

Circle the option that best represents your answer to each question over the past month:

	0	1	2	3	4
How often do you have a drink containing alcohol	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
How often do you have six or more drinks in once occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or remorse after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	0 No		2 Yes, but not in the last year		4 Yes, during the last year
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?		No	Yes, but not in the last year		Yes, during the last year
Have you ever felt you should cut down on your drinking?		1 Yes		0 No	
How often do you use non-prescription drugs other than alcohol?	0 Never	1 Once a month or less often	2 2-4 times a month	3 2-3 times a week	4 4 or more times a week



## About your mental health

Within the past month have you (please circle one option per statement):

	Not at all	No more than usual	Rather more than usual	Much more than usual
Lost much sleep over worry?	0	1	2	3
Felt constantly under strain?	0	1	2	3
Felt you couldn't overcome your difficulties?	0	1	2	3
Been feeling unhappy and depressed?	0	1	2	3
Been losing confidence in yourself?	0	1	2	3
Been thinking of yourself as a worthless person?	0	1	2	3
	Much less than usual	Less so than usual	Same as usual	More so than usual
Been able to enjoy your normal day-to-day activities?	0	1	2	3
Been feeling reasonably happy, all things considered?	0	1	2	3
Been able to concentrate on whatever you're doing?	0	1	2	3
Been able to face up to your problems?	0	1	2	3
Felt that you are playing a useful part in things?	0	1	2	3
Felt capable of making decisions about things?	0	1	2	3

**About your relationship.**

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each of the following items.

5- Always agree	4-Almost always agree	3- Sometimes agree	2- Sometimes disagree	1- Almost always disagree	0-Always disagree
-----------------------	-----------------------------	--------------------------	-----------------------------	------------------------------------	----------------------

1. Philosophy about life.

5                      4                      3                      2                      1                      0

2. Aims, goals and things believed important.

5                      4                      3                      2                      1                      0

3. Amount of time spent together

5                      4                      3                      2                      1                      0

How often would you say the following events occur between you and your partner;

0 Never	1 Less than once a month	2 Once or twice a month	3 Once or twice a week	4 Once a day	5 More often
------------	--------------------------------	----------------------------------	---------------------------------	--------------------	-----------------

4. Have a stimulating exchange of ideas

0                      1                      2                      3                      4                      5

5. Calmly discuss something together.

0                      1                      2                      3                      4                      5

6. Work together on a project

0                      1                      2                      3                      4                      5

7. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0                      1                      2                      3                      4                      5  
6

-----  
Extremely      Fairly                      A little                      Happy                      Very Happy  
Extremely      Perfect                                                                                                                                
Unhappy      Unhappy                      Unhappy                                                                                                           
 Happy

**About your relationship.**

**Low**

**Neutral**

**High**

1. How well does your partner meet your needs?	1	2	3	4	5
1. In general, how satisfied are you with your relationship	1	2	3	4	5
2. How good is your relationship compared with most?	1	2	3	4	5
3. How often do you wish you hadn't gotten into this relationship?	1	2	3	4	5
4. To what extent has your relationship met your original expectations?	1	2	3	4	5
5. How much do you love your partner?	1	2	3	4	5
6. How many problems are there in your relationship?	1	2	3	4	5

**About your experiences living alongside mental health difficulties.**

	Never	Rarely	Sometimes	Often	Very often
1. I feel emotionally numb	1	2	3	4	5
2. My heart starts pounding when I think about caring for my partner	1	2	3	4	5
3. It seems as if I am reliving the trauma(s) experienced by my partner	1	2	3	4	5
4. I have trouble sleeping	1	2	3	4	5
5. I feel discouraged about the future	1	2	3	4	5
6. Reminders of my partner upset me	1	2	3	4	5
7. I have little interest in being around others	1	2	3	4	5
8. I feel jumpy	1	2	3	4	5
9. I am less active than usual	1	2	3	4	5
10. I think about my caring responsibilities for my partner when I don't intend to	1	2	3	4	5
11. I have trouble concentrating	1	2	3	4	5
12. I avoid people, places or things that remind me	1	2	3	4	5
13. I have disturbing dreams about caring for my partner	1	2	3	4	5
14. I want to avoid caring for my partner	1	2	3	4	5
15. I am easily annoyed	1	2	3	4	5
16. I expect something bad to happen	1	2	3	4	5
17. I notice gaps in my memory about caring for my partner	1	2	3	4	5

**THANK YOU VERY MUCH FOR YOUR TIME!**

## Appendix Eight, description and interpretation of psychometric measures

Outcome measure	Title	Purpose	How to score	Cut-off score
<b>MSPSS</b>	Perceived Social Support  <i>Zimet, Dahlem, Zimet, &amp; Farley (1988).</i>	The Multidimensional Scale of Perceived Social Support is a measure of how much support a parent feels they get from family, friends and significant others.  The parent completes 12 questions and includes subscales relating to perceived support 1. from a significant other, 2. from friends and 3. from family.	To calculate subscale scores: Significant Other: Add items 1, 2, 5, & 10, then divide by 4. Family: Add items 3, 4, 8, & 11, then divide by 4. Friends: Add items 6, 7, 9, & 12, then divide by 4. To calculate total Scale: Add all 12 items, then divide by 12.	Any mean total scale score ranging from 1 to 2.9 could be considered low support; a score of 3 to 5 could be considered moderate support; a score from 5.1 to 7 could be considered high support
<b>AUDITC</b>	Alcohol Use Disorders Identification Test Bush, Kivlahan & McDonell (1998)	Measuring risk of alcohol misuse	Add up scores for a total.	In men 4 or more, women. 3 or more is indicative of hazardous drinking.
<b>GSE</b>	General Self Efficacy  <i>Schwarzer &amp; Jerusalem (1995).</i>	10 Item scale. Assessing the strength of an individual's belief in their ability to respond to new or difficult situations	Add up scores. Scores range from 10-40 points.	N/A  (The higher the scores the greater the person's sense of self-efficacy)
<b>GHQ 12</b>	General Health Questionnaire Suitable for all ages from adolescent upwards. Goldberg & William (1988)	The <b>GHQ (12 items)</b> is used to detect psychiatric disorder in the general population and within community or non-psychiatric clinical settings such as primary care or general medical out-patients.	The higher the score, the more severe the condition. Reverse score items 7, 8, 9, 10, 11 & 12 only. The higher the score, the more severe the condition. GHQ 12 yields an overall total score.	Turner & Lee advocate a cut-off of 12/13 as almost always indicating a positive psychiatric condition in the PTSD context
<b>DAS-7</b>	7 Item short Form of Dyadic Adjustment Scale  <i>Hunsley, Best, Lefebvre &amp; Vito (2001).</i>	A 7-item scale designed to measure general relationship satisfaction. Respondents answer each item using a 5-point scale ranging from 1 to 5.	Add up scores. Items 4 & 7 are reversed.	The higher the score the more satisfied he/she is in relationship.
<b>RAS</b>	Relationship Assessment Scale  <i>Hendrick (1988).</i>	Measures relationship satisfaction. It consists of seven items, each rated on a five-point Likert scale. It is suitable for use with any individuals who are in an intimate relationship.	Items 4 and 7 are reverse scored. A=1, B=2, C=3, D=4, E=5. You add up the items and divide by 7 to get a mean score	The higher the score, the more satisfied the respondent is with his/her relationship.

<b>STSS</b>	Secondary Traumatic Stress Scale Bride, Robinson, Yegidis & Figley (2004).	17 item self-report measure of secondary trauma symptoms over the past month. 3 domains: Intrusion, arousal & avoidance. Each item is rated on a 5-point Likert scale.	The higher the score the more severe the condition. 3 subscales; Avoidance: 1,5,7,9,12,14,17 Arousal: 4,8,11,15,16 Intrusions: 2,3,6,10,13	Bride et al (2004) advocate a cut off score of above 38 to meet criteria. <28 little or no STS 28>37 mild STS 38-43 moderate STS 44>48 high 44+ severe
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## Appendix Nine. Programme evaluation

### Evaluation

*Please read each statement carefully and indicate how you feel about each statement.*

1. How many sessions did you attend during the 5-week programme?

1 session \_\_\_ 2 sessions \_\_\_ 3 sessions \_\_\_ 4 sessions \_\_\_ 5 sessions \_\_\_

2. Did you receive a mid-programme support telephone call?

Yes \_\_\_ No \_\_\_

3. How likely are you to recommend this service to friends & family if they needed similar

support?

Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely
---------------------	--------	--------------------------------	----------	-----------------------

4. What are the top 3 things you liked about the groups?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

5. What are the top 3 things you disliked about the groups?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

6. What 3 things would you like to see changed about the groups to better meet your needs?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

7. How best do you think we could support partners to attend these sessions?

---

8. Could you tell us what obstacles there were that could have prevented you from attending these sessions?

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9. Could you think about how these obstacles could be overcome?

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Any suggestions or other comments

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**Thank you**







Tyrwhitt House • Oaklawn Road  
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GP Address

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[www.combatstress.org.uk](http://www.combatstress.org.uk)

Dear Dr \_\_\_\_\_,

**RE:** Name of partner **DOB:** \_\_\_\_\_ **NI No:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I am writing to advise you that (Partners name) attended our five-week community support group programme for partners living alongside veterans with PTSD and mental health difficulties. The programme took place between the \_\_\_\_\_ and the \_\_\_\_\_ in \_\_\_\_\_.

The aim of the programme is to enable participants to understand more about the symptoms their partner is experiencing, how they can support in symptom management and learn effective ways of coping. The programme is delivered through a combination of psychoeducation, cognitive behavioural and self-management-based groups.

(Partners name) engaged well in the groups and reported them to be helpful. We will invite (Partners name) to complete a set of outcome measures three months after completing the programme to monitor progress.

Please do not hesitate to contact us should you require any further information.

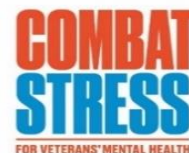
Yours sincerely,

*LS-Harper*

Lucy Spencer-Harper

Project coordinator

01372 587191 / [Lucy.Spencer-Harper@combatstress.org.uk](mailto:Lucy.Spencer-Harper@combatstress.org.uk)



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Dear

**Supporting veterans' partners group, 3 months follow up**

I'm writing to see how you are getting on after having finished the partners group 3 months ago. I hope things are settled.

I have attached some measures that we are using to assess the outcomes of the pilot programme. These measures are really important to ensuring we have evidence to keep running groups and supporting other partners as well as helping us to see what we should change.

We know filling in questions can take time and be a bit boring but we would be really so grateful if you could fill these in and return them in the freepost envelope. All the information we collect is anonymous. In return, to thank you for your time, we will send you a **£10 amazon voucher**.

If you need any help filling them in, please give me a ring or email me.

Best wishes,

Lucy Spencer-Harper  
Project coordinator  
01372 587191 / [Lucy.Spencer-Harper@combatstress.org.uk](mailto:Lucy.Spencer-Harper@combatstress.org.uk)















