

## Exploring the Experiences of Partners of Veterans with Mental health Difficulties Attending a Group Psychoeducation Support Intervention: A Qualitative Study.

Lucy Spencer-Harper<sup>1,\*</sup>, David Turgoose<sup>1</sup>, Dominic Murphy<sup>1,2</sup>

<sup>1</sup>Combat Stress, Leatherhead

<sup>2</sup>UK Department of Psychological Medicine, Kings Centre for Military Health Research, Institute of Psychiatry, Psychology and Neuroscience, Kings College London, London, UK

### Abstract

#### Background

Research has demonstrated that partners living alongside veterans with mental health difficulties are at high risk of developing mental health difficulties themselves and secondary trauma. A variety of interventions have been developed to support partners. Research to date has relied on quantitative methodologies to evaluate the efficacy of such interventions with less emphasis on learning about the experiences of individuals on the courses.

#### Objective

The aim of this qualitative paper was to understand the experiences of partners who engaged in a five-week structured support intervention, 'The Together Programme' (TTP) which had been piloted across UK cities. This programme involved tailored psycho educational materials adapted to the needs of veteran's partners living alongside PTSD. Further the potential mechanisms of change for participants engaged with the programme were explored as well as the impact of treatment on their relationships.

#### Methods

Eight female partners were recruited from an original sample of 57 partners who were intimate relationships with treatment seeking veterans with mental health difficulties. These participants had completed TTP. Qualitative data was collected using a semi structured interview and explored using Interpretative Phenomenological Analysis.

#### Results

Three key themes emerged from the data, these were self-growth, changing role in relationships and connecting with others. The themes included several sub themes. Self-growth sub-themes were mastering the 'inner judge', 'confidence in ability to cope' and 'taking care of my needs'. Changing role in relationship sub-themes were 'acceptance and understanding' and 'improved communication in relationship'. Connecting with others was described by the sub-themes of 'knowing I am not alone', 'peer support' and 'hope'.

#### Conclusions

This study suggests there were three key areas where the structured evidence-based support programme had an impact on participants experiences. These were factors that helped participants to normalise their experiences and increase participants understanding and interpersonal skills that promote changes in relationship functioning with the veteran.

**Corresponding author:** Lucy Spencer-Harper, Combat Stress, Tyrwhitt House, Oaklawn Road, Leatherhead, Surrey, UK, Email: [lucy.spencer-harper@combatstress.org.uk](mailto:lucy.spencer-harper@combatstress.org.uk)

**Keywords:** mental health, trauma, PTSD

**Received:** Mar 22, 2019

**Accepted:** Mar 27, 2019

**Published:** Mar 29, 2019

**Editor:** Alaa Ali Mohamed Elzohry, Lecturer of Anesthesiology& Pain Management South Egypt Cancer Institute Assiut University, Egypt.

## Introduction

### *Mental Health of Military Partners*

It has long been recognised the challenges military veterans face in terms of physical and mental health difficulties upon their return from conflict. A recent study of veterans who have served in conflict zones suggests the number of veterans in need of support is growing<sup>24</sup>.

Less attention has been given to the impact of veterans' partners. However, there is a growing body of literature which suggests veteran's mental health difficulties to have an enduring impact on partners mental health, caregiving burden and secondary<sup>13,15,16</sup>. This implies military stress is experienced both individually and systemically<sup>3</sup>.

In greater appreciation for the needs of partners and supporting the veteran's family as a whole, there has been a wide range of psychological support-based interventions developed which incorporate a variety of formats including; individual, group, psycho education couple-based and family-based support interventions. They appear to have promise and have been found to improve partners mental health and relationship satisfaction, veterans' rates of engagement in therapy and their treatment outcomes<sup>10,27,14</sup>.

### *Support Interventions for Military Partners*

The US has taken a leading role in providing group-based support interventions for veterans and their families. Examples of three interventions which have been trialled include SAFE (Support and Family Education)<sup>19</sup>, REACH (Reaching Out to Educate and Assist Caring, Healthy Families)<sup>21,22</sup> and SAH (Strength at Home)<sup>5,25,26</sup>. REACH and SAH share similarities in that they both contain couple-based formats and do not

include children whereas the SAFE programme is widely available to all family members living or caring for veterans. The SAFE programme is non-diagnostic specific and is available for any carer of family member living alongside a veteran with mental illness. Although REACH and SAH were not explicitly developed to tackle PTSD, they are sensitive to mental health and relationship difficulties that are likely to have been incurred as a result of the veteran serving in military.

All three programmes vary in length and format from nine to 18 sessions on a weekly or monthly basis. The common components of these interventions are that they strongly feature psychoeducation and include didactic and group exercises, in addition to home activities for the family to complete. All programmes covered the following topics; Communication skills, Problem solving and anger management. However, the SAH programme covers more material on relationship management and the impact of PTSD on the relationship. Self-care is reinforced in the SAFE programme and is achieved through practical skills training.

Findings from evaluations of these programmes are promising with improvements in areas of caregiver burden, knowledge of mental illness/PTSD and ability to self-care<sup>19</sup>, relationship satisfaction and conflict management<sup>25</sup>. Similar findings have been reported for residential based programmes designed to target veterans and their partners and highlight the benefits of incorporating wellbeing activities. For instance, in an intervention whereby meditation was delivered in addition to core aspects like psychoeducation and individual or couple therapy, significant improvements in partners mental health outcomes like depression, anxiety, anger and stress were observed<sup>11</sup>. Another study which measured clinical levels of PTSD in partners

before the intervention also measured a significant drop after completing this lifestyle programme<sup>4</sup>.

### *The Together Programme (TTP)*

Few interventions that have been developed are solely designed to support veterans' partners. Given the evidence reporting the unique challenges military partners face in their role as a caregiver and what barriers they may encounter in accessing support for themselves compared with other caregiving relations<sup>13</sup>, may suggest partners needs are being overlooked in these programmes offering broader support. This evidence highlights some of the complexities that may arise because of the structure and function of the partners intimate relationship with the veteran which may be less problematic or not exist at all in relationships with other family members. This is supported<sup>1</sup> who suggest that partners who are in a family system where there are more rigid rules, may be less receptive to change in therapy. This gap in research has paved the way for the recent development of a UK evidence-based support intervention, TTP. This programme provides partners with understanding of PTSD and mental health strategies to support the veteran partner. It also affords partners the opportunity to develop coping strategies for themselves. The efficacy of this pilot study has been reported elsewhere and suggested improvements in participants symptoms of common mental health difficulties, secondary PTSD symptoms and relationship satisfaction<sup>14</sup>.

Overall psychoeducation-based programmes like those described including the TTP have been consistently been well received among the military population and has been found to be effective<sup>15,19</sup>. However, much of the research looking at the effectiveness of family support interventions to date have relied heavily upon quantitative measures<sup>20,25</sup>. The evidence is limited by the relative lack of qualitative research and therefore little is known about the mechanisms of change which may be experienced as a result of attending interventions of this kind. Of the qualitative studies<sup>8</sup> which have examined the experiences of US military spouses who were taking part in support-based interventions either group based or online, findings are restricted to the experiences of spouses during military deployments. Therefore, the

changes partners experienced may not be comparable to partners of veterans who are no longer serving in the military and are seeking treatment for mental health difficulties. The impact of attending support programmes on a partner's relationship with the veteran and their interpersonal functioning may not be fully understood. The specific elements of these multifaceted programmes and how partners relate to these are also not known. Literature in this area would benefit from capturing the experiences of partners engaging in these programmes and learning why particular aspects or components are more influential.

In the current study a qualitative methodology of Interpretative Phenomenological Analysis (IPA) was used to gather an in depth understanding of the mechanisms of change and transformation participants may have experienced whilst attending a pilot of a psychoeducation support programme for partners living alongside veteran with mental health difficulties.

## **Method**

### *Participants*

The current study recruited participants from those who had completed TTP<sup>15</sup>. Participants were included in this study if they had completed TTP (Attended >four out of five weeks). One potential participant was excluded as their partner had dies and it was deemed insensitive to include them

The size of this qualitative study was determined using IPA as a method for analysis. Research indicates small samples of between five and ten to be the most ideal<sup>23</sup> and sufficient for saturation in data and for themes to emerge<sup>17</sup>. Initially, a random number was generated for each eligible participant. These random numbers were then ordered numerically, and attempts were made to contact participants down this list. In total, eight participants who had completed TTP were contacted about participating in the qualitative interview. Eight completed in total.

### *Data Collection*

A semi structured interview was developed to allow for flexibility during data collection. The interview schedule was initially developed and then peer reviewed by several military mental health professionals who had experience conducting qualitative research.

Five questions were asked regarding participants experiences of TTP: Did the group have a long-lasting impact on your wellbeing? What things could be improved? What were the main things you would highlight to a friend or another partner? What were the key things you took away from the group? And did you notice a change during the group? Prompts were used like; 'what do you put this down to?' and 'tell me more about that' to expand meaning of the topics described. Interviews were conducted over the phone and lasted between 20- 40 minutes. Digital recordings were made and transcribed verbatim. Demographic data including age, relationship type and level of education was also collected using a questionnaire administered prior to starting the programme.

#### *Data Analysis*

IPA<sup>23</sup> was selected as the most appropriate method because the study aims to understand the experiences of participants who engaged in the programme, and what changes there may have been in their intimate relationships. IPA seeks to make sense of individuals experiences by understanding their subjective perspective as opposed to describing their objective account. Therefore, this inductive methodology is well matched for the study's aims and for researching an area that has not been explored before. Further, IPA has been found to effectively provide insight and in depth understanding of the experiences of partners living alongside veterans with mental health difficulties<sup>6,12</sup>.

Analysis of the transcripts was conducted using guidelines for IPA<sup>23</sup>. This top down approach was used to analyse all eight transcripts and followed the process of six stages; Firstly, the researcher becoming familiar with the transcripts, secondly, re reading the text and noting frequency of words used. The lead author (LS-H) then used these notations to look for repeating themes which emerged from surface text. These sub themes were then labelled. Finally, these sub themes were clustered into groups based on their connections into overarching themes or a super ordinate category. Quotations were extracted from the text to evidence sub themes. Only themes which were grounded in the text were included and those with insufficient evidence were removed.

A number of steps were taken during data analysis to uphold<sup>17</sup> procedures for demonstrating rigor in qualitative research. For example, to ensure themes were accurately derived from the data, sub themes were discussed with co authors (DM & DT) for triangulation.

#### *Ethics*

Approval for this project was granted by the Combat Stress Research Committee. Informed written consent was obtained from each participant prior to the interview. The lead author also discussed with all participants about how their data would be used in accordance with GDPR standards and debriefing would be provided after completing the interview. In addition, guidance around accessing further support was provided.

#### **Results**

##### *Overview of Hemes*

Three key themes were yielded using IPA analysis (Table 1): self-growth, changing role in relationship and connecting with others. Quotes are presented to illustrate the themes and experiences of participants. (Table 2).

##### *Key Theme One*

Self growth This theme encompasses the process of inner growth and transformation participants experienced during and after completing the five-week structured support intervention.

##### *Subtheme One*

Mastering the inner judge Participants described a change in how they judged themselves in relation to their veteran partners behaviour. Many participants described learning not to blame themselves for any of the mental health symptoms and behaviours the veteran would present with:

*"Wow, it's not me, Thank God it's Not me." (Participant 1).*

*"I always thought it was my fault, it was something I said that made him angry or depressed." (Participant 5).*

This new understanding and reasoning for where the veteran's symptoms come from helped participants to 'not take it personally' and diffuse

Table 1. Demographic data

Participant	Sex	Age	Living with partner	Dependents	Length of relationship	Served in UK military	Employment status	Education
1	Female	61	Yes	No	16+ years	Yes	Retired	O Levels/GCSEs/ NVQ 1 & 2
2	Female	61	Yes	No	16+ years	No	Full time	O Levels/GCSEs/ NVQ 1 & 2
3	Female	37	Yes	No	0-3 years	No	Full time	O Levels/GCSEs/ NVQ 1 & 2
4	Female	38	No	Yes	10-15 years	No	Not working due to ill health	Postgraduate
5	Female	62	Yes	No	16+ years	No	Retired	O Levels/GCSEs/ NVQ 1 & 2
6	Female	43	Yes	No	16+ years	No	Full time	Degree/NVQ Level 4-five
7	Female	32	Yes	Yes	16+ years	Yes	Part time	A Levels/HNDs/ NVQ 3 Highers
8	Female	44	Yes	Yes	4-6 years	No	Full time	A Levels/HNDs/ NVQ 3 Highers

Table 2. Overview of themes

Key Themes	
Kay Theme	Sub theme
Self-growth	Mastering the inner judge Confidence in ability to cope Taking care of my needs
Changing role in relationship	Acceptance and understanding Improved communication in relationship
Connecting with others	Knowing I am not alone Peer support Hope

individually. For instance:

"I thought it was just me not handling it properly. The other wives were actually in the same boat that I was." (Participant 5).

This increased understanding and diffusion also resulted in some participants feeling a greater sense of compassion and patience for their veteran partner:

"Sometimes it's not always their fault. You feel like they can help it when they can't." (Participant 3).

Having other participants share similar experiences during group sessions helped to reflect more helpful appraisals for themselves. For instance:

"It's all about me, I am the only person that has this going on. Its actually a revelation to discover, she is going through exactly the same thing as me." (Participant 2).

Participants also talked about the non-judgemental responses they encountered in the group to be a contradiction to the stigmatising experiences they had previously experienced externally. Again, this may have helped challenge some of these self-critical beliefs:

"You've never told anyone else. Peoples immediate reaction would go; What on earth are you doing with someone like that for?" (Participant 1).

In addition, participants highlighted the value of having the opportunity to be reflective of one's own experiences and learn from oneself as a means of discovering new meaning and new ways of coping. For instance:

"I have learnt a lot about myself and how patient people can be, how patient I can be. This has made me look at both sides of the coin." (Participant 6).

#### *Subtheme Two: Confidence in Ability to Cope*

Participants talked about improved confidence in their ability to cope and support their veteran partner in managing their symptoms successfully:

"It showed us that we can do this, and we can achieve what we need to do." (Participant 3).

Participants often talked about their improved confidence that derived from sharing with other participants who had been in similar scenarios. In fact, many group members spoke about hearing other

people's stories which helped them to feel reassured they were on the right track and reminded them of the things they were doing well:

"Just being able to have those conversations and listen to people's stories made me feel really strong." (Participant 8).

In some cases, hearing from other participants whose veteran partners were at earlier stages in the journey helped to reaffirm the progress they had made and, in some cases, enabled them to feel they were able to offer support to others:

"I felt I could give them some help because I was further down the line and were able to tell them it does improve." (Participant 5).

#### *Subtheme Three: Taking care of my Needs*

Several participants described a deeper appreciation for needing to look after their own needs within the relationship. They reflected on the importance of maintaining balance in looking after their veteran partner and their own needs as a way of maintaining the family's mental health:

"Its kind of like we are important too and if we break down and if we are breaking down and the family unit is breaking down, I mean you are stuffed really." (Participant 4).

Moreover, some of those interviewed described the obstacles or roadblocks for looking after their own needs being challenged during group sessions:

"Learning about your identity and learning you are not being selfish, learning to do things for yourself." (Participant 4).

Several participants highlighted they were more likely to assert boundaries within their relationship following the programme. Some participants were more likely to have previously held back from asserting their needs and boundaries in their relationship to protect the veteran, prevent things becoming worse or preserve the relationship:

"I think that came from your sessions because doing things I would have shyed back from and now I am better at saying something. But I had to ask the question." (Participant 2).

It could be interpreted that over time this

short-term solution for coping becomes embedded into participants daily interactions and their ability to assert their needs and boundaries in their relationship becomes more difficult.

*Key theme two: Changing Role in Relationship*

Changes in aspects of the participants role in their relationship with the veteran were commonly described, such as greater acceptance and understanding for some of veteran's behaviours and symptoms. In addition, adjustments in the style of communication being used in the relationship were noted.

*Subtheme One: Acceptance and Understanding*

Greater acceptance in participants' roles as carers was noted frequently during interviews. This involved moving from wanting to fix or cure to having more realistic expectations around the veteran's recovery. It is illustrated in the quotations below the greater acceptance and understanding participants reached after completing the programme:

"I know when he gets a bad day, I don't have to say oh heck, what am i going to do or should I do this. I know its all part and parcel of it." (Participant 1).

Some participants mentioned their attendance to the programme also had a positive impact on the veteran's wellbeing:

"Being able to talk to him about what we were learning kind of made him kind of realise I was getting it, so he kind of softened towards me." (Participant 8).

*Subtheme Two: Improved communication in relationship*

Changes in communication between participants and veterans during the programme were commonly reported. Many participants instigated discussions with veterans about content of sessions or shared group resources:

"We communicate much more. He will tell me how he is feeling." (Participant 6)

*Key Theme Three: Connecting with Others*

This theme emerged from all interviews where there were positive discussions surrounding the peer support received during sessions and the comfort this brought participants in terms of not feeling alone and knowing support is available.

*Subtheme One: Knowing I am Not Alone*

Sharing experiences with those who 'get it' or understand the complex and arduous journey for a partner supporting a veteran with mental health difficulties was an important experience of attending the group programme. This has been repeatedly and clearly expressed in all eight interviews:

"It made you feel like you are not the only one which you do before you start." (Participant 3).

Connecting with other participants who have shared experiences in living alongside veterans and with little professional support for themselves appeared to enable the process of normalisation of feelings and situations:

"It's quite normal for them to behave in that way. Its normalising their behaviour." (Participant 6).

Despite many participants veteran partners being at different stages of their treatment and the breadth of the mental health difficulties presented, this did not appear to disrupt the normalisation that took place:

"Being with other people who are going through exactly the same things all be it at different stages." (Participant 1).

*Subtheme Two: Peer Support*

Being socially isolated is one of the most significant challenges faced by partners and was echoed by all participants in the study. It appeared having support of peers helped them to feel less isolated. It allowed them to feel safe and heard:

"Everybody understood, everybody was given a chance to talk and listen to what people were saying." (Participant 8).

Face to face contact with others in the group and sharing knowledge and experiences appeared essential for building trust and increasing perceived levels of support.

"I know that you can probably google it and get it online so essentially the education is still there but sitting in a group of people and talking about your feelings and emotions and that kind of stuff that comes with it makes it more real than just looking at something on a computer." (Participant 8).

As substantiated;

“As a PTSD partner, it was nice to have people around you who were the same.” (Participant 3).

This quotation also reiterates the importance of face to face contact or the physical presence of others for feeling not alone and emotionally contained.

This increased sense of support however, seemed to be limited to the group. Many participants continued to experience stigma associated with veteran’s mental illness and feeling misunderstood by others outside of the group during and after completing the programme:

“I won’t talk about things in relation to (Fiancé) because I don’t want people to think badly of him.” (Participant 8).

Thus, although participants reported feeling less alone and more supported by their peers, this did not seem to generalise outside of the group setting. This implies one of the greatest resources of support and help for partners is the peer support they can offer each other.

Feeling safe to talk openly and honestly within this context appeared to help participants create new relationships in the group. Several participants spoke about ongoing peer support they had received from each other after completing the programme:

“From our group, the group you took up here, we’ve actually got a WhatsApp group and we actually keep in touch still now.” (Participant 8).

Some participants discussed how the ongoing peer support after completing the group has been beneficial in terms of problem solving.

“We have gotten on so well with each other and we remind each other of the course as well.” (Participant 4).

#### *Subtheme Three: Hope*

Several participants reported the experience of attending the programme to have engendered more hope and changed their view about living alongside mental health difficulties:

“You are not on your own and things can get better.” (Participant 6).

Hope was raised by participants perceiving more

support being available to them.

“There is support available.” (Participant 6).

Other participants recalled the opportunity to impart hope to others to be important aspect for their role in the group.

“Oh yes, it does improve, and they can’t appreciate that but further down the line things do improve.” (Participant 5).

## **Discussion**

This study explored the experiences of partners of treatment seeking veterans who attended a UK support intervention (TTP) aimed at improving their mental health and relationship quality.

To the best of our knowledge this approach exploring participants experiences and the impact on their relationship had not been undertaken before in the UK. We identified three key subordinate themes relating to participants experiences whilst attending the groups; ‘Self growth’, ‘changing role in relationship’ and ‘connecting with others’ who are living alongside a veteran with mental illness.

### *Superordinate Theme One: Self Growth*

Many participants spoke about how over the course of the programme they were able to better understand and conceptualise why their partner was behaving in such a way and formulate the maintenance cycle of their symptoms. Being able to rationalise and make sense of why their partner is behaving in a certain way, meant participants were able to cognitively diffuse themselves from self-critical thoughts such as taking things personally. Subsequently, this allowed participants to be more patient, empathic and accepting. This seemed to allow them to adopt more helpful coping strategies derived from Dialectical Behavioural Therapy (DBT) skills like, mindful attention, cognitive reframing and distraction. This suggests teaching participants distress tolerance skills were a core element in facilitating self-growth during TTP. Furthermore, this could translate to other psychoeducational support for partners of veterans.

Veterans appeared to also benefit from the awareness and understanding that participants gained from attending the programme. Participants talked about developing a shared understanding with their

veteran partner which previous research has suggested can allow corrections to be made without misunderstanding why people behave in the way they do. It is possible that after the process of being freed from misconceptions about each other, family members could communicate with greater empathy, which fits well with many accounts in this study. Furthermore, many participants described a profound sense of acceptance and non-judgement from other partners within the group. This implies the process of partners modelling acceptance within the group may also help to challenge stigmatising beliefs about themselves.

Participants expressed taking care of their own needs was of greater importance to them after attending the programme. Although participants spoke about difficulty of enduring feelings of guilt in this process, they were able to conceptualise the long-term consequences of being solely focused on their caregiving responsibilities.

Further, participants reported greater confidence in their ability to cope. These findings appear to be linked to participants reporting less avoidance type behaviours and improved self-care which may be indicative of changes in participants locus of control.<sup>2</sup> veteran spouses with high levels of internal locus control despite not being able to control their husband's PTSD would be able to recognise they were in control of how they dealt with stress in the marriage. Conversely, the spouse with a high external locus of control is more likely to perceive themselves to be a victim of circumstance and have no control. This theory suggests that participants may have developed greater internal locus control, therefore improving their confidence in their own ability to cope.

#### *Superordinate Theme two: Changing Role in Relationship*

The theme describing changes in participants role in their relationship during and after completing the programme was attributed to increased communication and a shift in the way they perceived the journey of caregiving for the veteran. Participants reported feeling more confident to express their own needs and approach their partner to discuss difficulties after completing the programme. These findings are indicative of changes in interpersonal patterns of communication.

These findings align with previous research which proposes veteran partners, in their attempt to protect the veteran from further distress, are more likely to collude in their partners avoidance or other safety behaviours<sup>28</sup>.

The increased dialogue reported by participants in this study also seemed to be aided by a noticeable shift in attitudes around caregiving responsibilities. The majority of participants seemed to adjust their expectations about length of recovery time to accepting the long-term nature of the veteran's illness. These observations fit with Karp's' 4 stages of caregiving experience model<sup>7</sup> which described carers moving through a series of stages from fear and confusion to recognition that the caregiver cannot control the individual's illness and thus has greater acceptance of the illness. In view of this model participants at the end of TTP appeared to be more affiliated with the final stage of the caregiving experience model.

#### *Superordinate Theme Three: Connecting with Others.*

A common theme for all participants was 'knowing I am not alone'. This was a highly valued aspect of the programme. One reason for why participants felt more connected with others and less isolated was because sharing their experiences helped them to discover the challenges they had been facing alone were experienced by others. This seemed like a revelation to most participants and helped to normalise their distress and confusion. Participants spoke about feeling safe to discuss difficult emotions like guilt and frustration which research has found to be natural reactions when feeling helpless in caring for a veteran who is suffering<sup>9</sup>.

After completing the programme, participants reported being able to perceive more hope, knowing support was available to them. Participants commonly described not receiving any support prior to attending the group and being heavily reliant on themselves to source resources and help manage the challenges faced living alongside veterans with PTSD or mental health difficulties. These findings support previous research evidencing prolonged social isolation among military partners in their roles as caregivers<sup>18</sup>.

## Strengths and Limitations

A limitation was participants in this sample were all female and in heterosexual relationships. As such, minority groups within this population (male partners, not in heterosexual relationships) were not included which could limit the generalisability of the findings.

Moreover, only partners' perspectives about the relationship with the veteran during and after the programme was captured. Thus, in the absence of accounts from partners attending TTP it was not possible to fully explore the couple's interactions and understand their appraisals and relational responses to the skills and understanding partners may have acquired during the course. Having more information about the couples interacting cognitions and behavioural responses after completing the programme will allow researchers to better understand the impact of the programme on relationship dynamics and thus learn how to adapt the group intervention to be most effective.

## Conclusions

This study is the first of its kind in the UK to qualitatively evaluate the experiences of partners living alongside veterans with mental health difficulties who attended a structured group support programme. TTP seems to have a positive impact on many aspects of partners wellbeing and relationship with the veteran. Other implications of the findings reinforce previous literature, such as the role of psychoeducation and skills-based training to be essential in helping promote partners coping and interpersonal skills in their relationship with veterans. We have suggested the combination of having psychoeducation and peer support helps a partner to build a formulation of the veteran's symptom behaviours which enable more acceptance and helpful appraisals to be developed. This suggests the need to further understand the psychological processes underlying the group processes on veterans of partners engaging in support interventions.

## References

1. Baucom, D, Stanton S, & Epstein N. (2003). Anxiety. In D. K. Snyder & M. A. Whisman (Eds.), *Treating difficult couples* (pp. 57-87). New York: Guilford Press.
2. Botello J. *Combat Related Post Traumatic Stress Disorder: Locus of Control and Marital Satisfaction* (Dissertation). Walden Dissertations and Doctoral Studies. 2015.
3. Dekel R, Goldblatt H, Keidar M, Solomon Z, Polliack M. Being a Wife of a Veteran with Posttraumatic Stress Disorder, *Family Relations*. 2004; 54: 24-36
4. Devilly G. The Psychological Effects of a Lifestyle Management Course on War Veterans and Their Spouses. *Journal of Clinical Psychology*. 2002 58; 9:1119-1134
5. Hayes M, Gallagher M, Stavitsky, Gilbert K, et al. Targeting Relational Aggression in Veterans: The Strength at Home Friends and Family Intervention. *Journal of Clinical Psychiatry*. 2015: 76;6: 774-778.
6. Henry S, Smith D, Archuleta K. Trauma and Couples: Mechanisms and Dyadic Functioning. *Journal of Marital and Family Therapy*; 2011;37: 319-32
7. Karp Tanarugsaothock D. *Mental Illness, Caregiving and Emotion Management*. *Qualitative Health Research*, 2000; 6-25. Anglia Ruskin University Library Website (hyperlinked with <http://libweb.anglia.ac.uk>).
8. Kees M, Nerenberg L, Bachrach J, Sommer L. Changing the Personal Narrative. A Pilot Study of Resiliency Intervention for Military Spouses. *Contemporary Family Therapy. An International Journal*. 2015; 37: 221-231.
9. Kreutzer J, Stejskal T, Godwin, E, Powell V, Arango-Lasprilla, J. A Mixed Methods Evaluation of the Brain Injury Family Intervention. *Neurorehabilitation*; 2010: 27, 19-29.
10. Lester P, Liang L, Milburn N, Mogil C, Woodward K, Nash W, et al. Evaluation of a Family-Centred Preventive Intervention for Military Families: Parent and Child Longitudinal Outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*; 2016: 5:514-24.
11. Monk J, Ogolsky B & Bruner V. Veteran Couples Integrative Intensive Retreat Model. An Intervention for Veterans and Their Relational Partners. *Journal of Couple and Relationship Therapy*. 2016; 2: 158-176
12. Murphy D, Palmer E, & Busuttill, W. *Mental Health*

- Difficulties and Help Seeking Beliefs Within a Sample of Female Partners of UK Veterans Diagnosed with Post Traumatic Stress Disorder. *Journal of Clinical Medicine*. 2016; 5.
13. Murphy D, Palmer E, Hill K, Ashwick R, Busuttill W. Living Alongside Military PTSD. A Qualitative Study of Female Partner Experiences with UK Veterans. *Journal of Military Veteran and Family Mental Health*. 2017; 3
  14. Murphy D, Spencer-Harper L, & Turgoose D. Exploring the Feasibility of an evidence-based support programme for military partners living alongside veterans with PTSD and mental illness: A pilot study of The Together Programme. *Journal of Family Medicine*; 2019: In Press.
  15. O'Toole B, Outram S, Catts S, Piers K. The Mental Health of Partners of Australian Vietnamese Veterans Three Decades After War and Its Relation to Veteran Military Service, Combat and PTSD. *Journal of Nervous and Mental Disease*. 2010: 841-856
  16. O'Toole B, Orreal-Scarborough T, Johnston D, Catts S, Outram S. Suicidality in Australian Vietnam Veterans and their Partners. *Journal of Psychiatric Research*. 2015; 65: 30-36.
  17. Pope C, Mays N. Critical Reflections on the Rise of Qualitative Research. *British Medical Journal*, 2009; 339 Nelson GBS, Crow JR, Reisberg AMJ, Hamilton S. The Impact of Individual Trauma Symptoms of Deployed Soldiers on Relationship Satisfaction. *Journal of Family Psychology*. 2007; 21: 334-353.
  18. Ruiz S, Stadlander L. Social Media as Support for Partners of Veterans with Post Traumatic Stress Disorder. *Journal of Social, Behavioural & Health Sciences*. 2015; 9: 1-18.
  19. Sherman, M. Updates and Five-Year Evaluation of the S.A.F.E Program: A Family Psychoeducational Programme for Serious Mental Illness. *Community Mental Health Journal*. 2006; 213-219.
  20. Sherman M. SAFE program. Mental Health Tools for Families. Support & Family Education. 18 Session Family Programmes for People who Care About Someone Living with Mental Illness or PTSD. 3rd Edn. Oklahoma City Veteran Affairs. South Central MIRECC. 2008.
  21. Sherman M, Fischer E, Bowling U, et al. A new engagement strategy in a VA-based family psychoeducation program. *Psychiatry Services*. 2009a 60; 2:254-7
  22. Sherman M, Fischer E, Sorroco K & McFarlane W. Adapting the Multifamily Group Model to the Veterans Affairs System: The REACH Programme. *Professional Psychology: Research & Practice*. 2009; 6: 593-600.
  23. Smith J, Osborne M. Interpretative phenomenological analysis. In: JA Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*. London Sage. 2008; 53-80.
  24. Stevelink S, Jones M, Hull L, Pernet D, MacCrimmon S, Goodwin L, Macmanus D, Murphy D, Jones N, Greenberg N, Roberto R, Fear N, Wessely S. Mental health outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: a cohort study. *The British Journal of Psychiatry*. 2018; 1-8.
  25. Taft C, Howard J, Monson C, et al. "Strength at Home" intervention to prevent conflict and violence in military couples: Pilot findings. *Partner Abuse*. 2014 5; 1:41-57.
  26. Taft C, Creech S, Gallagher M, et al. Strength at Home Couples' Program to Prevent Military Partner Violence: A Randomized Control Trial. *Journal of Consul Clin Psych*. 2016 84; 11:935-945.
  27. Whealin J, Yoneda A, Nelson D, Hilmes T, Kawasaki M, Yan O. A Culturally Adapted Family Intervention for Rural Pacific Island Veterans with PTSD. *Psychological Services*. 2017; 14: 295-306
  28. Monson C, Fredman S. *Cognitive- Behavioral Conjoint Therapy for PTSD*. 1st edn. The Guilford Press. New York. London. 2012.