



“Their pain is our pain”: The lived experience of intimate partners in Veteran recovery from PTSD

Elaine Waddell^a, Sharon Lawn^a, Louise Roberts^a, Julie Henderson^b, Anthony Venning^a, Paula Redpath^a and Tiffany Sharp Godwin^a

ABSTRACT

Introduction: Social support, particularly support from an intimate partner, is both a significant protective factor for trauma-exposed Veterans and critical for recovery in mental health, yet we know little about the experiences and support needs of their partners, particularly in the Australian context. This study examined the multidimensional nature of experiences of being an intimate partner of a contemporary Veteran with posttraumatic stress disorder (PTSD). **Methods:** We used a qualitative phenomenological approach to conduct an inductive thematic analysis of data collected through individual interviews with a purposive sample of 10 partners of contemporary Veterans living in Australia. Interviewees were recruited through a range of community support organizations. **Results:** Analysis revealed intimate partners are crucial participants in supporting the recovery journey for traumatized Veterans, effectively managing day-to-day care, encouraging autonomy and instilling hope. However, descriptions highlighted that lack of understanding of partners' daily lives, and particularly their commitment to maintaining their intimate relationship, by health care providers and government results in a sense of invisibility and is the key barrier to receiving the support they need in order to support recovery in their Veteran partners. **Discussion:** The findings underscore the importance of recognizing the role of intimate relationships in trauma recovery and of responding to the support needs of intimate partners. In particular, the findings have clear implications for improving the engagement by health care providers of partners of Veterans with PTSD in Veteran clinical treatment. More formal recognition of the indirect impact of PTSD on partners of Veterans is also needed within organizational policies and procedures. Finally, there is clearly a need for continuing education of health care providers, government staff and the general community about the nature of PTSD and its impacts on relationships, particularly the intimate type.

Key words: caregiving, intimate partners, lived experience, PTSD, recovery, Veteran

RÉSUMÉ

Introduction: Le soutien social, notamment celui des conjoints, est à la fois un facteur protecteur important pour les vétérans exposés à des traumatismes et un aspect essentiel du rétablissement de la santé mentale, mais on sait très peu de choses sur les expériences et les besoins de soutien des conjoints, particulièrement dans le contexte australien. La présente étude porte sur la nature multidimensionnelle des expériences des conjoints de vétérans contemporains en état de stress post-traumatique (ÉSPT). **Méthodologie:** Au moyen d'une approche phénoménologique qualitative, les chercheurs ont réalisé l'analyse thématique inductive des données colligées lors d'entrevues individuelles auprès d'un échantillon sélectionné de dix conjoints de vétérans contemporains vivant en Australie et recrutés auprès de plusieurs organismes de soutien communautaire. **Résultats:** L'analyse a révélé que les conjoints sont une source de soutien essentielle au parcours de rétablissement des vétérans ayant vécu des traumatismes, car ils gèrent les soins quotidiens, favorisent l'autonomie et inspirent l'espoir. Cependant, les descriptions ont démontré que les professionnels de la santé et le gouvernement comprennent mal le quotidien des conjoints, notamment leur détermination à préserver leur relation, ce qui entraîne un sentiment d'invisibilité de la part des conjoints et représente le principal obstacle au soutien dont ils ont besoin pour soutenir le rétablissement de leur partenaire vétéran. **Discussion:** Les résultats font ressortir l'importance de reconnaître le rôle des conjoints dans le rétablissement des traumatismes et de répondre à leurs besoins de soutien. Notamment, ils démontrent clairement que les professionnels de la santé doivent s'engager davantage auprès des conjoints des vétérans en ÉSPT dans le cadre du traitement clinique. Les politiques et les procédures organisationnelles doivent également tenir compte plus officiellement des effets indirects de l'ÉSPT sur les conjoints de vétérans.

^a College of Medicine and Public Health, Flinders University, Adelaide, Australia

^b Nursing and Health Sciences, Flinders University, Adelaide, Australia

Correspondence should be addressed to Elaine Waddell at elaine.waddell@flinders.edu.au

De toute évidence, il est nécessaire d'offrir un perfectionnement continu aux professionnels de la santé, au personnel gouvernemental et à l'ensemble de la population sur la nature de l'ÉSPT et ses répercussions sur les relations, notamment les relations intimes.

Mots-clés : conjoints, ÉSPT, expérience vécue, rétablissement, soins, vétérans, Australie

INTRODUCTION

Clinical recovery in mental illness is measured by improvement or remission in clinical symptoms based on explicit criteria of levels of signs and symptoms.¹ Personal recovery, on the other hand, is subjective. It is an attitude and a journey, rather than an outcome, built around a sense of hope and agency.¹ Personal recovery occurs within the social context of a person's daily relationships, as it is well recognized that positive social relationships improve mental health and well-being.² Relationships are vital to recovery because experiences of connectedness, hope, identity, meaningfulness, and empowerment emerge from the interactions that individuals experience within their social environments.³ However, it is also well documented that caring for a person with mental illness can result in adverse psychological effects for the care provider.⁴

The importance of positive social relationships for recovery in posttraumatic stress disorder (PTSD) is highlighted by the clinical research literature on the role of social support as a mitigating factor in the development of PTSD,⁵ in encouraging help-seeking,⁶ and in treatment outcomes.⁷ However, research has also found that the symptoms of PTSD, particularly anger and emotional distancing, appear to strain and erode support over time, with this lack of support conversely viewed as a risk factor for worsening of PTSD symptoms.⁸

The negative impacts of PTSD in Veterans on interpersonal relationships, particularly on the mental health of the intimate partner, have been well documented. For example, there is now a substantial body of predominantly clinical international literature highlighting that female partners of male Veterans can experience significant psychological distress, including depression and anxiety.^{9,10} However, partner psychological distress has been viewed as a barrier to social support for the Veteran, with research recommendations generally limited to individual mental health treatment or couples counselling.^{10,11} A small number of international studies have explored the lived experiences of partners of Veterans of recent deployments to the Middle East, reporting considerable challenges in their daily relationships and highlighting particular needs around individualized

support.^{12,13,14} While these studies illuminate the importance of supporting the partner in the care and recovery journey for the Veteran, recommendations are again limited – overwhelmingly – to clinical interventions. In comparison, general mental health literature suggests intimate partners of people experiencing mental illness have needs that are broader than individualized treatment, such as peer support and respite.^{15,16} In this way, they receive the support they need in order to support the person in their recovery journey.

The nature of military service in the Australian Defence Force (ADF) over the last two decades has been characterized by a number of high-tempo and diverse operations. Studies have documented the significant prevalence of PTSD, compared with the general population, particularly in recently transitioned military personnel.¹⁷ Previous research examining the effects of PTSD on relationships in Veterans suggests that many families are also impacted. There is, understandably, an ongoing focus on best-practice treatments for PTSD, yet there is limited research about the lived experience and support needs of the intimate partner, particularly in the Australian context. This is a concern, given the vital importance of social support in PTSD treatment and in the Veteran's personal recovery journey.

The current study is a subset of a larger study that included partners of emergency services first responders.¹⁸ This study aimed to explore the multidimensional nature of experiences of intimate partners of contemporary Veterans with PTSD and learn what helps or hinders their ability to support their partner – that is, to examine what intimate partners need to support their own mental health and well-being and what resources are essential and helpful to them.

METHODS

Design

The purpose of the study was to better understand the lived experiences of intimate partners from their point of view. Therefore, we used an interpretive phenomenological approach underpinned by the philosophy of Martin Heidegger, who used the concept of the “life-world”

to express the idea that an individual's reality – their lived experience – is influenced by the everyday world in which they live.¹⁹ This philosophical approach is then useful for developing an understanding of how lived experience is influenced, structured and sustained by the context, enabling direction for practice and policy recommendations.¹⁹ The interpretive phenomenological approach has been used in previous studies with partners of Veterans.^{11,12} It involves in-depth interviews with individuals with the personal and nuanced experience under examination as the best means of enabling them to tell their stories.²⁰

Recruitment procedures and participants

We used a purposive sampling strategy to recruit participants who experienced the phenomenon of being in an intimate relationship with a contemporary Veteran with PTSD. For this study, a *contemporary Veteran* was defined as someone who undertook military service from 1999 onward. The participants' partners were not required to have an official or formal diagnosis of PTSD, allowing for the potentially extended time to diagnosis, and the challenges in help-seeking for those experiencing symptoms of PTSD. Recruitment occurred through the distribution of written study information to a range of ex-service, support and advocacy community-based organizations that support contemporary Veterans and/or their families.

Data collection

Data was collected through individual face-to-face, in-depth, semi-structured interviews with partners of Veterans with PTSD. All interviews were conducted by one author with a background in social work and extensive experience in working with the Veteran community. An interview guide was developed through a review of the literature and input from a Veteran partner. The guide used open-ended, non-directive questions focusing on the participants' experiences of daily life, the impacts of PTSD on their own health and on the intimate relationship, the support they received, and any areas of unmet need. Interviews averaged 1 hour and were digitally recorded and subsequently transcribed verbatim by a professional transcriber. All transcripts were de-identified, with all names, places, and any individual identifying data changed before analysis to ensure confidentiality. Pseudonyms were used. The tenth interview contained no new themes, and it was deemed that theoretical saturation was satisfied for the sample recruited.

Ethical considerations

Ethical approval was obtained from the human research ethics committees of Flinders University and the Australian Government Departments of Defence and Veterans' Affairs. Participation was voluntary. A participant consent form was emailed to each participant when arranging an interview time, with written informed consent obtained at the interview before asking any questions. All participants were provided with details about *Open Arms – Veterans & Families Counselling*, given the possibility of distress through discussing personal experiences. A gift voucher was provided at the end of the interview, but this was not advertised in the recruitment material.

Data analysis

The interview transcripts were analyzed thematically following the method of Braun and Clarke,²¹ which involved generating initial codes that were then collated into themes. Analysis commenced after the first interview. All transcripts were read by three members of the research team, bringing a broad perspective to identify common themes, meanings and issues. Each transcript was independently coded by at least two of the researchers with initial codes and provisional codes generated across the whole dataset. Tentative themes were then explored at regular meetings between research team members. A coding frame was developed to assist with further analysis of transcripts and the generation of meaning. The coded transcripts were then entered into the qualitative research program NVivo 11 to assist with organizing the whole dataset into themes and sub-themes, supported by team discussions. The extracts of data selected for the report were reviewed by all six members of the team to ensure they provided a concise, coherent, and logical account of the lived experience of the participants, as told by the data.²¹

RESULTS

Ten female partners of male Veterans participated in an interview. [Table 1](#) provides demographic information about the participants and their Veteran partners.

All Veterans were described as having served in the ADF and had been actively deployed. One Veteran was still serving; two others were employed in civilian positions and the remaining seven described as unable to work because of PTSD. All participants stated that their Veteran partners had a formal diagnosis of PTSD and were receiving clinical care.

Table 1. Participant demographics

Participant (pseudonym)	Age bracket (years)	Length of relationship (years)	Dependents at home (yes/no)	Paid work (yes/no)	Age bracket for Veteran (years)
Alison	50–59	24	no	no	50–59
Bridgit	40–49	14	yes	no	30–39
Claudia	40–49	4	yes	no	50–59
Edwina	40–49	14	no	yes	40–49
Fiona	30–39	18	yes	no	30–39
Helen	40–49	4	yes	yes	40–49
Isobel	40–49	25	yes	no	50–59
Laura	40–49	26	yes	no	40–49
Catherine	40–49	2	yes	no	40–49
Narelle	30–39	18	yes	no	30–39

Three inter-related themes were generated: (1) protecting the family unit, (2) the need for support, and (3) barriers to support. By protecting the family unit, the Veteran was both supported and encouraged in their recovery. Despite the strength of commitment, the participants conveyed to maintaining the well-being of their families, they needed support to do this and described considerable cultural and organizational barriers to accessing much sought-after support.

Protecting the family unit

Protecting the family unit was revealed as paramount, underpinned by a strong emotional commitment to their Veteran partners. This theme encompassed three sub-themes: (1) the impact of PTSD on the relationship, (2) the change in roles, and (3) the support provided to the Veteran.

Impact of PTSD on the relationship

Participants described challenges the symptoms of PTSD can bring to a relationship, with symptoms of withdrawal and emotional numbing commonly expressed as particularly difficult, given they can close down intimate communication, expression of feeling and closeness between a couple:

And he'll tell me that he might feel numb today. And numb to him is that he can't feel any emotions. He can't – he says 'I love you but I can't feel that love. Well, no, what it is, I know that I love you but I don't feel it, and I just feel numb.' And when he first told me that, that was really hard to swallow. (Isobel)

He won't talk or – there's no communication so the intimacy where we used to sit and laugh and joke, not there anymore. (Laura)

Despite the impact of these symptoms on the relationship, participants emphasized the vital importance of striving to retain a level of emotional intimacy:

... the medication and the PTSD he has no libido, he hasn't done for 5 years so there's no sex but intimacy which I think is more important.... As long as you cuddle me, kiss me, tell me that you love me then that's all I need. (Edwina)

(Sexual) intimacy is few and far between these days [laughs] but we always hug and kiss each other and all that sort of thing ... (Alison)

Change in roles

Together with managing the intimate relational impacts, participants revealed changes in relational dynamics, which meant assuming new roles and responsibilities that ranged from household tasks, providing an income, caring for their partners, as well as becoming the primary decision-makers across many life issues in the family unit. Several participants described being in a carer role and the sense of dependency they felt their partners had on them:

I became the mum and the dad. I became the carer. You know, it was like he was away (on deployment) but I actually had another child to look after. (Isobel)
... quite often he'll forget his appointments and, you know, so I've gotta be on top of that. I've got to be on top of everything. (Claudia)

I'd give him a list of things to get (at the shop) and he'll forget things. Like every time he goes to the shops, he rings me with stuff ... I feel like he uses my brain to think. (Bridgit)

Participants' descriptions revealed that, despite this dependency, they strove to protect their partners' sense of

identity and self-worth, given the significant impacts that PTSD can have on a Veteran's identity. A key role undertaken was that of a cheerleader. They described how they both encourage the Veteran to engage in activities within their coping capabilities and encourage help-seeking when necessary.

I've just got to encourage him without pushing him too hard ... And I put on the calendar when his appointments are and, the day before I will just mention, 'on the way to your appointment can you drop me here' rather than saying, 'Have you remembered?' I try and incorporate into what I'm doing so he's helping me do something. (Edwina)

While encouraging independence, participants described a constant vigilance to any changes in their partner's mood and behaviour, and particularly to triggers for worsening of PTSD symptoms and an awareness of when treatment was required.

Ah, he becomes very unmotivated. He becomes a lot snappier, he becomes cold, he becomes distant. And that's when I know he is struggling. (Claudia)

I'm very, very aware and I'm very engaged in his ups and downs and the idiosyncrasies of the disorder ... and I know they're all signs that his mental state is not right. (Isobel)

Support provided to the Veteran

The role of advocate with health care and other providers was revealed as a consistent and critical role in supporting well-being and recovery in Veterans. In many cases, participants advocated on behalf of a partner who was reluctant, or unable, to disclose to a health care provider how they were faring:

You know, there's some days where things aren't great but – and I've already picked those and I will then get him in to see the GP... (Isobel)

I talk to his psychiatrist whenever I feel that the drugs aren't working properly. (Claudia)

Of prime importance to the participants was for their partner to be as well as they could be and to get the necessary support they needed for the treatment and care of their PTSD. This reinforces participants' need to preserve their intimate relationships. Several expressed a sense of hope that the right treatment would restore aspects of the pre-PTSD relationship:

... to make him well again ... because he'd be the man I married and we'd be happy again. (Edwina)

Need for support

In participants' descriptions of day-to-day emotional struggles, the need for support was a central feature. They expressed their emotions and moods as being intertwined with those of their partner:

We suffer. Because we take on the burden of our partners. Not their – not the burden of them but we love them so their pain is our pain ... (Fiona)
... so, if he's happy I'm happy. (Alison)

Therefore, finding the right treatment for their partners, being involved and accepted as critical in their partner's recovery, essentially supported them, as well. However, descriptions also revealed that finding and retaining the right treating provider could be fraught with difficulty:

And we tried two previously, two other psych's and they were useless and the third one we got onto, and she was brilliant. (Catherine)

The psychiatrist was rubbish so I got him another one. The counsellor wasn't very good so I got him another one. (Laura)

Participants described their own needs for support, but a prevalent frustration and fear of being judged by others pervaded the descriptions, in particular, with the experience or perception that they would be asked why they stay in the relationship:

I've had people come up to me and go, why are you still with him? Did you know he was sick when you married him? (Fiona)

And my GP actually said, why do you stay with him? I just looked at him. I said, what kind of question is that? (Laura)

They all described needing their own support from other partners dealing with PTSD to enable acceptance and understanding:

... you walk on eggshells and he's going to explode so you just have to go and do something else and wait for him to calm down. People just don't understand that. And suicide, you know, going out to work in the morning and thinking, am I going to come home to find him hanging in the garage? People don't understand those things. So, you want to talk about them. ... you want to be in a group of people who are experiencing the same things. (Edwina)

However, participants described the difficulties they experienced in finding peer support, reflecting on the

critical importance of learning from others and how this might have helped them in the early days.

... I think one of the biggest needs is that there needs to be more support around the partners so what you're doing, I didn't find anything like that early on ... (Isobel)

Financial support emerged as an area of unmet need. Only two participants described having their own employment, with most having taken a backseat to their partner's military career. They described complex, long-term, and stressful interactions with the Department of Veterans' Affairs (DVA) in navigating the compensation systems:

... But he wanted to give up after day one ... I wasn't going to give up, I kept fighting but I know there's a lot that just give up at the first hurdle ... (Edwina)

One participant described how the impact of medical discharge and navigating the compensation system resulted in the loss of the family home:

I would say the first 6 months of him being medically discharged was just a complete blur. I didn't know what was going on. Because we lost our house as well because we couldn't afford to pay the mortgage ... (Laura)

Several participants described relying on external financial support to meet the school needs of their children:

... they now give me \$X a month for education, they assist with if the kids are doing sport. ... They give us money twice yearly for electricity ... (Bridgit)

Barriers to support

Considerable barriers to accessing essential support pervaded the descriptions. The need for social support was underpinned by a fear that a lack of understanding by others would result in judgement of participants and their relationships. The sense of being invisible, forgotten, and overlooked emerged consistently through the interviews; it was evident in descriptions of a lack of services and lack of concern for the participants and their children, and most intensely felt from government and health care providers.

Steve served the country and our lives were ruined. ... We are not acknowledged at all. ... I feel quite bitter and angry that I am not recognized and my children are not recognized. (Bridgit)

There's nothing for the women at all. It's crazy ... And you have to fight for everything. And we, again, are the forgotten person. All the time. (Laura)

Commonly described was a lack of recognition of the intimate relationship by health care providers. There was a prevailing sense their intimate relationship with their partner was invisible in health care settings and they were acknowledged only as a support person and provider of task-focused care. Several participants described how they felt about interactions with their partner's mental health care provider, illustrating their perceptions of an attitude of exclusion from their partner's care:

I felt like an irritation as opposed to somebody that could actually contribute. (Edwina)

... he (the psychiatrist) was never really interested in what we've got to say. I think I was a little bit of an annoyance. (Bridgit)

This invisibility within health care settings extended to specialist Veteran mental health services, which were described as lacking understanding of the lived experience of partners of Veterans with PTSD.

I went to the (counselling service) once – it was a guy and he told me I was being a martyr. And I was 'All right! No thanks. If this is what I actually have to do in my daily life and I'm telling you what I do in my daily life -that doesn't make me a martyr. That just makes me telling you the facts.' (Fiona)

I went to one of the psychologists coz I was startin' to feel – you know, with everything being on top of me ... her whole answer was it was my posture ... She had no clue. (Claudia)

One participant described her frustration with a specialist group program:

I said, 'You haven't talked about the financial pressures, you haven't talked about sexuality and issues with libido. You haven't talked about suicide. You haven't talked about the impact of PTSD on children ... You haven't done any of that.' (Edwina)

DISCUSSION

This study examined the lived experience of partners of Australian Veterans with PTSD. Three inter-related themes were generated: (1) protecting the family unit, (2) the need for support, and (3) barriers to support. Findings suggest that the partner is a critical component of a Veteran's personal recovery journey, as they are

highly invested in preserving the couple's intimate relationship. This is in contrast to previous studies on Veterans that viewed the intimate relationship as an isolated factor, barrier, or enabler in recovery^{7,22} rather than the most significant and integral aid in the recovery process.

Despite considerable challenges for the relationship due to distressing symptoms of PTSD, consistent with other studies,^{6,23} and changes in roles and responsibilities within the family unit, this study found participants strove to retain a degree of intimacy with their Veteran partners. The sensitivity with which they described supporting their partners in their daily lives to maintain their identity and sense of self-worth again indicated the importance of preserving the relationship. While there are task-focused components to caring, such as monitoring medication when necessary, this is done with an understanding of the partner and promoting independence and autonomy. These findings are also consistent with the broader literature examining the lived experience of partners of people with mental illness,¹⁶ and in the limited literature concerning partners of Veterans with PTSD.^{11,12,14}

The concept of hope is a core component in recovery.²⁴ Findings from this study suggest that participants retained hope that their Veteran partners would make a personal recovery and regain aspects of their former relationship. In comparison, literature examining the lived experience of partners of Australian Vietnam-era Veterans with PTSD found a resigned acceptance of the PTSD.¹¹ This suggests that retention of hope could be attributed to the age of participants and/or the relatively recent onset of PTSD symptoms. While the concept of hope is not explicit in recent studies with partners of contemporary Veterans with PTSD,^{12,14} other studies found that belief in a person's capacity to recover is, in itself, a critical source of hope for those with mental illness.²⁵ Studies have also highlighted that, while sources of hope for carers can vary, treating health professionals have a vital role to play, as they can potentially support and sustain hope, or destroy it.²⁶ This again reinforces the importance of actively recognizing intimate partners in the treatment process.

Given the non-linear nature of the recovery process, this study found that participants adopt a key role in facilitating help-seeking and advocating for treatment through daily vigilance to their partner's health. This is consistent with findings in other studies examining the experiences of partners of Veterans with PTSD.¹⁴ Participants identified a critical need to access appropriate

and supportive treatment, thereby engendering a partnership with the provider, the value of which is also the recognition that the partner has a greater understanding of the reality of daily life for the Veteran. This finding is consistent with recent literature examining carer engagement in specialist mental health care for Veterans.²⁷ This is also an implicit finding within other recent literature reporting that partners of Veterans with PTSD want greater involvement in treatment and the opportunity to offer insight.^{13,14,28} Conversely, the finding of the perceived lack of value and recognition placed on the participants by treating professionals is a common theme in general mental health literature.²⁹ While it is not an explicit finding in international literature about partners of Veterans with PTSD, it is consistent with other Australian research.^{11,27} It remains a significant and concerning finding because it renders the partner, and their key role in recovery, invisible within the systems of care and support they navigate on behalf of Veterans.

Participants expressed considerable concern that about facing judgement by others for remaining in relationships with their partners, and this is a finding consistent with other recent studies of partners of Veterans with PTSD.^{11,12,14} Not only does this imply a need for health care providers and general community mental health literacy, but it renders the needs of the partner invisible and is a barrier to accessing support. The finding that early access to peer support enables learning from others, understanding and acceptance, is also a finding in general mental health studies.³⁰ Although recent Veteran-partner literature has also highlighted the need for partner social support and education,^{12,31} recommendations are generally limited to professionally-driven, rather than peer support, strategies.

The finding of unmet needs for financial support is consistent with the general mental health carer literature,³² although it is not an explicit finding in the international literature examining the lived experience of partners of Veterans with PTSD. This finding might reflect the relatively young age at which the Veterans associated with this study were medically discharged, with the complexity of the legislation regarding compensation through DVA and the financial stresses more readily experienced in contemporary society. As well, the majority of participants in this study were not in paid employment. Not only are there financial implications for a medical discharge, but there exist potential implications for the relationship with this additional

stress, on top of the stresses of living with a Veteran with PTSD.³³

Strengths and limitations

Key strengths of this study are the nature of the semi-structured, in-depth interview process, the rapport generated, the rich data produced, and the rigour in using a multi-researcher approach to the analysis. However, some limitations should be noted. The phenomenological methodology does not permit generalizations to be made because the study described and interpreted the reflections of only 10 individual participants at a moment in time; however, one strength is that its themes are consistent with the existing literature exploring the lived experience of partners of contemporary Veterans with PTSD. Also, it should be noted that, as all participants were female partners of male Veterans, the findings are biased toward the perspective of female partners in heterosexual relationships. While this homogeneity also strengthens the findings in relation to the experience of a female living with a contemporary male Veteran with PTSD, future research should focus on recruiting a more diverse sample, including male partners and those in LGBTQI relationships. Further, the participants were all partners of Veterans with a formal diagnosis of PTSD who were recruited through community-based organizations, having reached out for support. However, the concerning nature of the findings for this group of help-seeking participants reinforces that partners of Veterans with undiagnosed PTSD could be in an even worse position.

Implications

The findings from this study have implications for health care providers, the general community, and policy development. Many of the needs expressed by participants relate to alleviating barriers to support and improving awareness, access, PTSD health literacy, and communication with services. Underpinning each of these needs is the need for recognition of the partners, not only in their “role” of providing informal support and care but as intimate partners directly impacted by the person’s PTSD. Therefore, more formal recognition of the indirect impact of PTSD on partners of Veterans is needed within organizational policies and procedures. In addition, there is clearly a need for continuing education of health care providers, government staff and the general community about the nature of PTSD and its impacts on relationships, particularly the intimate type.

The findings have clear implications for improving the engagement by health care providers of partners of Veterans with PTSD in Veteran clinical treatment. The findings suggest that partners need to be included as part of the treatment team, along with the Veteran and the health care provider. The requirement for mental health services to engage in partnerships with carers is embedded in Australian mental health legislation and policies at national, state, and territory levels.²⁷ This is also consistent with a current attempt in Australia to shift away from an individualized model of care for Veterans to a psycho-social model that recognizes the role of the family and their own needs for support.³⁴

Peer support groups provided important emotional support for partners. More focus on making explicit the value of family peer support groups or networks in promoting well-being and resilience is needed, and more work to understand what they could, and should, look like.

The financial impacts of PTSD on the family unit are an additional stress with unmet financial need currently being addressed as a gap in service by a community-based organization. Therefore, with the increasing number of young families experiencing financial distress as a result of Veterans’ medical discharges from the ADF, there is an urgent need to raise this issue with government services.

Conclusion

Partners of Veterans with PTSD have implicitly adopted a recovery orientation in striving to preserve their intimate relationships, encouraging their partners to have a quality of life with a sense of purpose, meaning, and relationships. Yet, they face considerable barriers in accessing the support they need. Considerable work is needed by government and healthcare providers, in particular, in recognizing, acknowledging, and supporting partners in their key roles in Veteran recovery from PTSD.

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AUTHOR INFORMATION

Elaine Waddell, DrPH, MPH, BSocAdmin., BA, has a background in social work and public health. She has over 30 years' experience working with the Veteran community in the areas of research, policy, and service delivery.

Sharon Lawn, PhD, MSW, DipEd, BA, is a researcher in the College of Medicine and Public Health at Flinders University, South Australia. She is also the lead South Australian Mental Health Commissioner. Sharon's work focuses on health care service systems and includes consumer, career, and work force perspectives.

Louise Roberts, PhD, is a lecturer in the College of Medicine and Public Health at Flinders University, South Australia. Her main research focus has been in the area of out-of-hospital mental health care, particularly care provided by paramedics to the community, and the effect on families of emergency first responders.

Julie Henderson, PhD, is a health sociologist with a long-standing interest in mental health policy and service delivery.

Anthony Venning, PhD, works with the Discipline of Behavioural Health at Flinders University, South Australia, and has worked as a psychologist in private, defence, and school environments. He has delivered presentations and been published, both nationally and internationally, in the area of positive psychology, mental health, and cognitive behavioural therapy.

Paula Redpath, MMHS, is the Discipline Lead – Behavioural Health and Course Coordinator of the Cognitive Behaviour Therapy postgraduate courses. Paula educates and researches in the areas of interdisciplinary clinical supervision, integrated behaviour change modalities, and translation of evidence-based supports and treatments tailored to enhance individualized recovery outcomes for people experiencing mental health and related conditions.

Tiffany Sharp Godwin, BHLthSc, BA, has 19 years' experience in the Defence and Veteran community, spending the last 8 years assisting Veterans and former and current partners experiencing a military DV relationship and/or relationship breakdown. Tiffany has worked in counselling centres as a clinical nutritionist. She is currently completing a master in human nutrition.

COMPETING INTERESTS

None declared.

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CONTRIBUTORS

All authors conceived and designed the study. Elaine Waddell acquired the Veteran partner data. All authors analyzed the data. Elaine Waddell drafted the manuscript. All authors revised the article for important intellectual content and approved the final version submitted for publication.

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