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The Lived Experience of Caring for an Australian Military Veteran With Posttraumatic Stress Disorder

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Abstract

There is limited literature on the experience of caring for an intimate partner with a mental health condition. Posttraumatic stress disorder (PTSD) is a common mental health condition for military veterans; yet, little is known about how partners experience and cope with these caring relationships. Using an interpretive phenomenological approach, we collected data through individual interviews with 20 female partners of male veterans diagnosed with PTSD living in South Australia. We found the emotional features of caring to be directly derived from the strength of commitment these carers had to their relationships. We show that lack of understanding of carers’ lives, particularly by health providers and government, has resulted in a sense of social disconnect and invisibility that has contributed to stress and is a barrier to coping. Of vital importance to these carers was that partners of younger veterans do not have to suffer the same experiences.

Keywords
caregivers / caregiving, lived experience, phenomenology, posttraumatic stress disorder (PTSD), South Australia, qualitative

A significant amount of literature has been generated on the adverse psychological effects of caring for another person (Stalker, 2003) highlighting that caring is associated with inequalities in health, regardless of illness or disability (Pinquart & Sörensen, 2003; Savage & Bailey, 2004). Although political recognition for carers has been gradually achieved through the work of carer movements (Cass & Yandle, 2009; Eley, 2003), the extent and diversity of caring is not adequately reflected in policy or the literature, and it is particularly apparent that there remains a limited focus on the experience of caring for an intimate partner with a mental health condition. This is surprising given that the existing literature suggests that this caring experience may result in poorer carer psychological health outcomes than for other relationships (Pinquart & Sörensen, 2003; Savage & Bailey, 2004).

Intimate partners of military veterans with posttraumatic stress disorder (PTSD) are a sub-group of mental health carers whose lives and relationships have been disrupted by trauma experienced through military deployments. Originally diagnosed in veterans of the Vietnam War, PTSD is also prevalent in Australian veterans of more contemporary military deployments, including Rwanda, East Timor, Somalia, Iraq, and Afghanistan where in excess of 60,000 personnel have served (Department of Parliamentary Services, 2015; Department of Veterans’ Affairs, 2014). There is now a well-documented body of international research associating PTSD in veterans with changes in personality and behavior resulting in interpersonal difficulties that have a direct impact on the lives and mental health of their intimate partners (Calhoun, Beckham, & Bosworth, 2002; Dekel & Monson, 2010; Renshaw et al., 2011; Taft, Watkins, Stafford, Street, & Monson, 2011). Female partners of male veterans with PTSD are confronted with long-term and continuous stress, reporting symptoms of depression, anxiety, social isolation, low self-esteem, feelings of hopelessness, and guilt many years after veteran trauma exposure, across different military cohorts and in different countries (Ahmadi, Azampoor-Afshar, Karami, & Mokhtar, 2011; Al-Turkait & Ohaeri, 2008; Ben Arzi, Solomon, & Dekel, 2000; Dirkzwager, Bramsen, Adler, & van der Ploeg, 2005; Franciskovic et al., 2007; Sherman et al., 2005).

Although there is a paucity of Australian studies in this area, those published support the findings of overseas research (Westerink & Giarratano, 1999).

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Research on this sub-population of carers has been predominantly quantitative, seeking cause–effect explanations by focusing on measures of carer burden or secondary traumatization. This is not surprising given that much of the research emanates from the Veterans Administration in America and the Israeli Defense Force Medical Corps. These research approaches have been clinically focused on the care of the veteran, positioning the partner as the primary source of support, and from behavioral paradigms that tend to view the mental health of the partner in terms of how it affects the veteran’s ability to cope with their PTSD symptoms (Galovski & Lyons, 2004). Despite the valuable contribution of this clinical research to building the sound evidence base about the impacts of PTSD on the veteran’s intimate partner, there has been limited attention to understanding how partners experience and cope with the challenges of caring, although the need to address this issue has been identified (Galovski & Lyons, 2004). This is particularly concerning given the impact of PTSD on the dynamics of the relationship as well as dependency on the partner to provide emotional support to the veteran.

The gap in knowledge about how partners of veterans with PTSD experience and cope with their situation also stands in stark contrast to research into caring in general that has seen a wealth of literature on coping. Much of this literature has utilized the theoretical perspective of Lazarus and Folkman (1984), which considers both the impact of the environment on the individual and the psychological and the emotional resources of the individual within environmental constraints. Examination of coping strategies is considered particularly relevant in caring for someone with a mental illness where caring can take a long-term, fluctuating, and unpredictable course (Saunders, 2003). There is a considerable amount of literature on the range of coping strategies used by carers in general and how these affect stress levels (see Bauer, Sterzinger, Koepe, & Spiessl, 2013; Chen & Greenberg, 2004; Williamson, Simpson, & Murray, 2008). A significant influence on carer coping is the extent to which carers’ own needs are recognized and met (Jeon & Madjar, 1998), with factors such as emotional support, education, respite, social support, and financial assistance identified as important (Chen & Greenberg, 2004; Kersten, McLellan, George, Mullee, & Smith, 2001; Van Der Voort, Goossens, & Van Der Bijl, 2007). There is, however, very limited literature that specifically examines the needs of partners caring for a veteran with PTSD. Even the limited numbers of qualitative studies undertaken with partners (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Kimhi, 2013; Lyons, 2001; Verbossky & Ryan, 1988) are mainly based in clinical settings providing treatment for veterans and address need in terms of recommendations for counseling and therapy. Lack of research into needs of partners as perceived by the partners themselves could result in suggestions for interventions or services that fail to meet need.

In summary, historical bias toward the use of quantitative research methodology and the clinical context of veteran mental health care, while emphasizing the psychological impacts on partner health, restricts understanding of the subjective perceptions and experiences of the partner. The year 2015 is the Centenary of the role of the Australian and New Zealand Army Corp (ANZAC) at Gallipoli, and there is a strong public focus on Australia’s military history during this commemorative year. With Australia’s history of military deployments and the ongoing bipartisan commitment of the Australian Government to military support in the Middle East, it is important, not just to focus on commemoration of the dead but to give voice to those who are currently caring for psychologically injured soldiers, to understand the nature of their particular caring experiences so that they, and future carers, may be appropriately supported. The purpose of this study was to explore the multidimensional nature of experiences of caring for Australian veterans with PTSD from the perspectives of their intimate partners, with an emphasis on understanding coping. In doing so, it helps to reduce the gap in knowledge about this important sub-population of carers.

Method
We used an interpretive phenomenological approach, based on the philosophy of Martin Heidegger (1962), because we wanted to examine what the experiences of caring for a veteran with PTSD were like and gain a deeper understanding of the nature or meaning of these experiences, as seen through the eyes of the participants. An interpretive phenomenological approach aligned with our perspective that knowledge about caring for a veteran partner with PTSD is subjective and situated in the individual’s experience of their lifeworld. Lived experience is the lifeworld as it is lived, felt, and made sense of (Schwandt, 2001). It can be recalled and reflected upon because it is “soaked through with language” (van Manen, 1990, p. 38). This was not a “pure” phenomenological study, however, because we included a focus on carer coping.

Sampling and Recruitment
Purposive sampling was undertaken to recruit participants who were caring for a veteran partner with PTSD and willing to share their knowledge in a face-to-face interview.
Recruitment was conducted through advertising in quarterly newsletters of veteran and carer organizations in South Australia and the Facebook page of an organization supporting young veterans and their families. Despite attempts at recruiting a diverse sample, of the 20 recruited, 19 were female partners of male Vietnam veterans and 1 the female partner of a male veteran of a post 1990 military deployment (name of deployment de-identified for privacy reasons). Participants were aged between 48 and 69 years (median = 63). The length of each relationship ranged from 15 to 52 years (median = 42). Fifteen relationships were first marriages. Eighteen participants commenced their relationships before the veteran had been formally diagnosed with PTSD. Two participants were working at the time of the interview, and all others had retired from the paid workforce.

Procedure and Data Collection
The study was approved by the Flinders University Social and Behavioural Research Ethics Committee.

In-depth semistructured face-to-face interviews were selected as the primary method of data collection because the only way to know what partners of veterans with PTSD experience is to experience it as directly as possible through their sharing of their experiences in their own language (Patton, 2002). This method for gathering narrative material enables a conversational style, the establishing rapport and empathy, and development of trust, given the sensitive nature of the topic (Patton, 2002; van Manen, 1990).

All interviews were conducted by the first author, once participants gave their informed consent, and took place either in a private room at a veteran organization in Adelaide (9), the participant’s home (6), Flinders University (1), a rural hall (3), or a coffee shop (1). Given the sensitive nature of the topic, the researcher provided all participants with information about the Veterans and Veterans Families Counseling Service. An interview guide was developed, consisting of open, nondirective questions. For example, each participant was asked to describe a “good” day and a “bad” day in relation to caring for their veteran spouse, enabling them to talk about the nature of their daily lives, which is close to the experience as lived, and in turn offered prompts for further investigation (Finlay, 2009). Field notes were made after each interview. Consistent with interpretive phenomenology, the first author, as part of the shared lifeworld, rather than an objective observer, did not eliminate or suspend (bracket) her culture, tradition, or point of view (Wojnar & Swanson, 2007). Prior knowledge, personal experiences, and prejudices, acknowledged as having an influence on understanding of the phenomenon and important in interpretation (Dowling, 2007) were recorded in these field notes. Interviews averaged 1 hour, were recorded on a digital voice recorder, and subsequently transcribed verbatim. Participants were given the opportunity to review the transcription of their interview for accuracy and to make any comments or changes.

Analysis
Thematic analysis of the transcripts and field notes was conducted primarily by the first author with the third author, carer of a spouse with a mental illness, undertaking independent analysis of the first five interviews as a form of intercoder agreement (Cresswell, 2003). All coding and interpretation was discussed and validated by the three authors.

Analysis followed the methodological framework suggested by van Manen (1990) and involved a process of reading the relevant field notes and then the transcript several times before going from parts of the text to the whole using detailed, or line-by-line, and holistic approaches. The line-by-line approach required reading each sentence or sentence cluster separately and asking what it reveals about the phenomenon or experience being described (van Manen, 1990). This enabled us to look in detail at description, use of language, and concepts as well as any emotion, silences, and gestures. The holistic approach was used to reflect on the interview as a whole, incorporating the themes extracted from the interview and words that had stood out in transcribing. We initially analyzed each transcript of interview. With the emergence of new themes, we reviewed the previous transcripts to clarify whether these ideas had been submerged within that particular data. The 20th interview contained no new themes, and we deemed that theoretical saturation was satisfied for the sample recruited.

We used van Manen’s (1990) four phenomenological existentialities of lived space, lived body, lived time, and lived human relation to deepen the analysis, merging themes into categories aligning with these existentialities. This process highlighted the interconnected nature of the lifeworld. It revealed the complexity of the experience of caring for a veteran partner with PTSD by highlighting the different aspects of the overall experience.

Results
Although we have not reported on health effects in this article, participants revealed the impacts of long-term stress on their bodies and diagnoses, including depression, anxiety, panic attacks, and PTSD, which is consistent with previous literature.
This article focuses on the main themes captured in the existentialis of lived time and lived human relation because these were essential to the structure of the experience of caring for a veteran with PTSD and without which this experience loses its fundamental meaning (van Manen, 1990).

**Lived Time**

Lived time not only refers to the temporal dimensions of past, present, and future but also infers that lived experience affects how time is also perceived (van Manen, 1990). Participants described their experiences of caring in a long-term relationship that had existed for a significant part of their lives and had become “a lifetime.” Through their reflections, participants described a long “journey” of coming to terms with, coping with, and reaching a level of understanding about, the changes in their partner’s mood and behavior.

They revealed particular challenges in the early years and, although the nature of the struggles varied between participants, overall, they included managing the veteran’s unpredictable anger and/or emotional detachment, protecting the children, taking responsibility for the household finances, keeping the family unit together, and dealing with his alcohol dependence and his physical and psychological violence toward her.

Common to all narratives was a sense of social isolation with participants blaming themselves or the relationship for difficulties experienced:

I had no idea it was that and I had no idea that anyone else had ever been through this. I thought it was just us. I thought it was just him.

...I thought it was my problem. I thought there must have been something wrong, that I was doing something wrong all the time.

All participants had reached a level of resigned “acceptance” of the effect of their veteran partner’s PTSD on their relationship. Associated with acceptance was a sense of powerlessness that they had been unable to change or make the situation better. This acceptance had come over time as participants adjusted their own ways of thinking and interacting with their veteran partners. There was, however, a deep and intense level of grief, anger, and resentment pervading their narratives. This was apparent in the considerable stress displayed through their choice of words, emotional responses to questions, and body language. They conveyed a sadness that went beyond an acceptance of their partners’ PTSD. For most of the participants, there was an acceptance that the long-term challenges of being in a relationship with a veteran with PTSD had defined their lives and that nothing could be done to change that fact:

...It’s just the way it is [pauses] I just think we will continue on the way we are [laughs].

I’ve come to the conclusion that this is the way it is and this is the way my life is.

This resigned and reluctant acceptance of the course of their own lives was translated into intense concern and worry that the partners of younger veterans with PTSD would experience a repeat of their own difficult journeys through life:

... they’re gonna have major problems [pauses] I don’t want them to go through what we’ve gone through.

Accepting that they cannot change the situation, participants described “learning to cope over time” by suppressing their own opinions, feelings, and responses, and by walking away from any potential confrontations. They highlighted the feelings of anger and frustration that accompanied this need to suppress themselves:

I guess that’s what I find the most frustrating thing, is there’s just nothing I can do. Nothing you can do, nothing I can say to change it. ... When he gets really upset I just walk away. I don’t get involved, I just walk away.

I get pretty frustrated. I get very angry but these days I just walk away whereas in our younger days it wasn’t like that at all [pauses].

Several participants used the words “easier” and “easy” to illustrate that this learned coping mechanism of avoidance was less difficult than living with the consequences of being themselves:

... so you’ve got to learn to control your tongue and be careful what you say. If you want to have an easy flowing lifestyle.

It’s easier to just bite my tongue.

Life is centered round the needs of the veteran, and “time for myself” emerged as one of the strongest themes in this study and represented the most important coping strategy. Participants expressed this not only through their language and choice of words but also from body language which exhibited a lifting of weight of responsibility just by reflecting on opportunities to separate themselves physically and mentally from their caring situation. The theme of “time for myself”
highlighted the critical importance of retaining some control over their own lives and reinforcing their sense of self-identity. One participant’s description of time away both reinforces the importance of time for her as well as the intense pressure and lack of control she lives with in her daily life:

... it was just beautiful! It was just me and I could make up my mind what I wanted to do and where I wanted to go and nobody else!

The challenges of being a partner of a veteran with PTSD were reinforced by the use of words such as “escape,” “release,” and “savior” when describing time for themselves:

I love my voluntary work, just love doing that. Those things are probably all escapes for me but good escapes.

The importance of time out to retain some control over their lives was emphasized in descriptions of how they would feel if they lost this time. One participant described how she would feel if she could no longer do the voluntary work which provides her with immense satisfaction:

I guess I suppose devastated [emphasized] because that would totally be the end of any control I’ve got over my own life and that would be it and I couldn’t do anything about it.

Another participant also evoked strong imagery in describing how she would feel if she lost time for herself:

I think I would feel as if I was suffocating [pauses] mm.

The image of not being able to breathe reinforces the potentially overwhelming nature of caring for a veteran partner with PTSD.

Lived Human Relation

The phenomenon of caring for a veteran partner with PTSD was essentially one of relationality. PTSD affected all the relationships for participants in this study: veteran partner; the family, friends, and social relationships, health providers, including the Australian Government Department of Veterans’ Affairs (DVA); and broader society in general. A number of themes emerged from consideration of each of these relational areas.

Relationship with their veteran partner. “Commitment” to the relationship was particularly strong for this group of partners. Marriage vows and the moral responsibility perceived by participants as inherent in this commitment, were important and reflected the gendered expectations of, and for, this age demographic. Love for the veteran was frequently expressed, and participants spoke of their partners with respect, tenderness, and compassion:

... I’ve thought about it over some parts of my life, walking out the door and never coming back, but I think “I can’t. ... I’ve always loved him—I still love him—he’s still my man.”

Reinforcing a sense of moral responsibility for the veteran was a sense of guilt if they “abandoned” their partner, because he would be left alone:

A lot of it is I feel that responsibility. If I give up on Jack who’s there for him? Because I can see how down he gets, how isolated he feels and I think other than the dogs he really doesn’t have anyone.

Fortifying commitment to the relationship was the acceptance of the dominant paradigm that views PTSD as a pathology, externally caused through traumatic exposures during military service. This enabled the participants to perceive their veteran partners as blameless victims, and assisted them in finding a deeper meaning in the relationships that had presented them with significant challenges for a considerable part of their lives:

People say leave and I turn around and ask them if they would leave if their husband got diabetes. PTSD is just an illness like a physical illness.

You know, he hasn’t done anything wrong. It’s not his fault.

It’s not his fault that this has happened and maybe I was put here to be his carer.

Participants identified shifting roles within the couple relationship which had evolved over time as the PTSD symptoms had emerged. All participants identified aspects of their caring that had been long term, such as keeping the peace and minimizing stress for their partner. Several described age-related health issues for their partners, including increasing forgetfulness or cognitive processing difficulties. The sub-theme of “vigilance” emerged as intrinsic to the caring role and was described as taking two different forms. First, participants described the needs of their veteran partners to have life “run smoothly” with order and predictability and the consequent pressure on them to be constantly vigilant to any triggers that may cause stress for their partner:
You’ve got to keep your eyes open the whole time, and your ears, to make sure that they’re travelling along well and that they’re not [pauses] and that you can stall any things that might go wrong [laughs]. You are constantly alert I guess.

Not only were they vigilant to their partners mood, but they were also vigilant to his overall health. All participants described daily monitoring of medication and treatment appointments because of their partner’s forgetfulness. However, this vigilance was done with care, respecting his identity as the partner in the relationship, and attempting to minimize his sense of dependency. Through the language used, participants also expressed the sense of “responsibility” that they felt for monitoring their partner’s health:

First thing is that I have to make sure that he takes his medication.

Feelings of guilt were expressed about their veteran partner’s experiences of ill health, reinforcing the sense of responsibility these women felt for the care of their partners:

Sometimes I feel a bit guilty about that, that I’ve sort of let things slip so that they slip so much that then he gets really unwell.

Entwined with vigilance and responsibility was “protectiveness.” The world and people in it could be a threatening place for veterans with PTSD, and the participants’ descriptions indicate that they wanted to protect their partners from this world:

I have to accompany him to most places. Have to be there if he decides to have a [pauses] not a turn, if he gets wound up you sort of calm him down.

Of primary importance was the relationship with their veteran partner, and participants described various ways in which they attempted to retain the partner role rather than becoming consumed by the caregiving role. A major theme to emerge was the “separation of the person from the illness.” Participants separated their descriptions of their partner from the behaviors symptomatic of PTSD and, in this way, revealed a search for the connection with their partner. The imagery of “Jekyll and Hyde” was evoked in several stories, as participants described the notion of PTSD as the “stranger” encasing the real person underneath:

I just said to him, “When you get up in the morning I don’t know what I’m going to get. I don’t know whether I’m going to get my husband, a stranger or anything in between.”

I know it’s not him as a person, it’s his disorder. I mean underneath there’s quite a soft person, very generous and so forth.

However, they described their relationships as different to others, eliciting the theme of “it’s not a normal relationship.” Strongly influencing this concept was the degree of control that participants reported as exerted by their veteran partners over their lives. This issue of control was both explicit and implicit in all the interviews. Participants described consistently making compromises in the relationship to “keep the peace” and to “make life easier.” By doing this, they constructed themselves as not having the lives and couple relationship they considered to be the norm. One example concerns the shouldering of responsibility for household tasks because “it is easier” regardless of the inequality of roles they perceived in the relationship:

He doesn’t see that the washing up needs doing; if I ask him to cook a meal, it’s a stressful event so it’s easier not to.

The symptoms of PTSD have additional consequences for the intimate relationship. Participants described their veteran partners as being unable to understand their needs or the effect of their partner’s behavior on them. Along with this theme of “lack of understanding” was a sense that all participants were striving for an emotional connection with their partners, trying to break through the barrier of emotional detachment that is a feature of PTSD in veterans. A deeper connection with, and more communication from their partner, was expressed as an intensely felt need by participants in this study. This absence of emotional intimacy as a facet of PTSD in male veterans was acknowledged by participants and illustrated the sense of grief that existed for the loss of a “normal” intimate relationship:

Um I don’t know what normal is [sighs].

You just don’t have the kind of life other people have.

This use of the word “normal” by the participants symbolized a sense of “abnormality” in their own lives and couple relationship. This theme flowed into their relationships with broader society and evoked a sense of separation and difference.

Relationships with others. PTSD affects the veteran’s ability to develop and maintain social relations outside the home and can have direct social consequences for the partner in the couple relationship. Participants described the behaviors of their partners, both social and avoidant, which were interpreted by others as rude or
brusque, and the consequential loss of important relationships and increased social isolation. One participant described her partner’s rude and abusive behavior to members of the general public in the small rural community in which they lived and the consequential impact on her and her sense of self-identity at that time:

I’d walk into a shop and people would say to me, “Oh you’re that bastard’s wife” you know?

Recognition and understanding of the nature of their lives as partners caring for a veteran with PTSD emerged as a dominant and essential need. The lack of understanding by others reinforced the sense of disconnect from mainstream society, non-disclosure of disclosure of their lives in social interactions with the non-veteran community, and construction of their lives as “different”:

... you can’t go to normal people, they just don’t understand.

Participants had connections with other partners of veterans and described an unspoken understanding and acceptance that permitted coping strategies of venting frustration, use of black humor, honesty, and social support in a safe environment:

There’s just that sense of “yeah these people get where I’m at without having to sort of explain.”

Relationships with health providers and government. This theme of “lack of understanding” flowed through this aspect of the existential of lived relation together with a related sub-theme of “invisibility” and represented a major barrier to coping. Participants described their hurt and anger when health providers failed to acknowledge the impact of PTSD on their own lives. One participant described her invisibility during her partner’s compensation claim process with the DVA:

... I said I would go with him and I would let him talk. I wouldn’t say too much. But when I would say something, everybody would say “I’m sorry this is not your matter! This is nothing to do with you!” and that really [pauses], no wonder I went through a big hole because to me that was just an absolute insult because I was there for him and I was doing lots for him and cared about him but no it was “Nothing to do with you.”

Her narrative reveals the impact on her own mental health of the repudiation of the totality of her caring for her partner and of her role as a partner in the struggle against his PTSD. For this participant, a lifetime of caring and support for her partner was rendered insignificant in this government process.

Weaving through the descriptions of invisibility of their own needs was a varying degree of resentment. Several participants talked about the loss of their careers and subsequent loss of income and superannuation because of the need to care for their partners. More than that was resentment that the ongoing impact of caring for a veteran partner with PTSD on their own lives was not recognized or understood by the Australian government:

I’m sure that I’m going to die before Kevin because I’m the one that’s been looking after him. He’s been getting the best of care all these years and I feel with us, the wives, we miss out [pauses] and I think more, not so much counseling, more understanding of the wives and what we go through.

I would like to see the government understand better how hard and difficult it is to care for somebody like that. Money’s not the issue. It’s just [pauses] I can see that it’s never going to get any better.

Discussion

This article highlights the major themes in the lived experience of caring for a male veteran partner with PTSD for a group of participants in long-term relationships. To date, the literature has concentrated on the health impacts and less on the caring experience.

In terms of coping, participants adopted a variety of emotion-focused strategies consistent with other literature on mental health caring. “Acceptance” is an example of emotion-focused coping being used to reduce or manage negative feelings in circumstances where there is little control over the situation (Chakrabarti & Gill, 2002; Lazarus & Folkman, 1984) and is reflected in the wider mental health carer literature (Goossens, Van Wijngaarden, Knoppert-Van Der-Klein, & Van Achberg, 2008; Karp & Tanarugschacko, 2000). However, this is not to suggest that “acceptance” represented a stage of resolution of emotions and feelings, as suggested by some authors (Karp & Tanarugschacko, 2000; Wynaden, 2007). The powerful emotional loss expressed by our participants reinforces literature finding that this type of care relationship is intense, complex, and different to others (Goossens et al., 2008).

Concern for “newer” carers is a theme found in the mental health caregiving literature (Muhlbaier, 2002; Wynaden, 2007). Our study highlights that the intense concern for partners of younger veterans with PTSD is not born simply out of successfully attaining a stage of acceptance of the PTSD or out of a sense of personal growth or empowerment as suggested by other authors (Muhlbaier, 2002; Wynaden, 2007). Rather, the concern
for others emanates from the perspective that although nothing can be done to effect change in their own lives, others should not suffer the same lives and tumultuous emotional experiences in living with a veteran with PTSD.

Key to coping was learning over time to avoid conflict, which has been identified in previous literature about partners of veterans (Frederikson, Chamberlain, & Long, 1996; Lyons, 2001; Outram, Hansen, MacDonell, Cockburn, & Adams, 2009) as well as in broader carer literature, particularly in ongoing and long-term caring situations (Bottorff, Oliffe, Kelly, Johnson, & Carey, 2014; Gerson et al., 2011). However, the use of such strategies has been negatively labeled as a maladaptive form of coping (Chakrabarti & Gill, 2002) and as partner accommodation by some authors (Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014). Despite the consequences for their own psychological health, participants in our study identified this coping strategy as the “easier” option for keeping the peace they want in their lives. Consistent with the theoretical approach of Lazarus and Folkman (1984), the value of a coping strategy requires consideration of the context in which it is used. We argue that this avoidance can be construed as a tactic to survive within the relationship, because it provides a sense of self-protection and control over the situation. This argument is supported by the literature on intimate partner violence which points to a high use of avoidant coping strategies among women who experience abuse (Calvete, Corral, & Estévez, 2008). Similarly, participants in our study described continually making compromises in the relationship to “keep the peace,” including the shrouding of responsibility for household tasks. A similar finding has been noted in other studies of partners of veterans with PTSD. However, some authors have described such coping as “overfunctioning” (Franciskovic et al., 2007; Lyons, 2001), framing it as both dysfunctional and co-dependent (Verbosky & Ryan, 1988). These are negative interpretations of motivations and behaviors, possibly reflecting the clinical paradigms in which these studies were undertaken, rather than acknowledging how partners cope with their everyday lives within these relationships.

The importance of “time for myself” as a coping strategy is also consistent with other literature examining caring (Karp & Tanarugsachock, 2000). This self-preservation strategy is learned over time when the carer realizes that there is nothing they can do to change the situation or make the person better, and that they are in danger of losing themselves and their identities in the care situation (Goossens et al., 2008; Hansen & Buus, 2013; Karp & Tanarugsachock, 2000). Similar findings have been made in other studies of partners of veterans with PTSD, although they have framed them within the theoretical perspective of secondary traumatization (Dekel et al., 2005; Lyons, 2001). We argue that time for activities away from, and independent of, their veteran partners functions to preserve the relationship, a finding also made in other studies in mental health caring (Bottorff et al., 2014; Goossens et al., 2008). The critical importance of “time for myself” as a coping strategy was powerfully illustrated through equating loss of this time with loss of life itself. Again, this reflects previous research, with Dekel et al. (2005) concluding that “personal space and independence were as necessary as air” (p. 30) for partners of Israeli veterans, reinforcing our finding that time away was a fundamental survival strategy. We suggest that veterans’ aging and declining health has significant implications for the partners in continuing to cope through finding time for themselves.

“Commitment” to the relationship was a key theme in this study, reflecting a “motivating quality which helps sustain coping effort” (Lazarus & Folkman, 1984, p. 63). “Commitment” was reinforced by a strong moral responsibility, a finding made in other studies of partners of veterans (Dekel et al., 2005; Kimhi, 2013; Lyons, 2001), as well as the acceptance of the dominant paradigm of mental illness. This paradigm views PTSD in veterans as an illness attributable to military service. This reinforces the status of the veteran as the blameless victim who has suffered in service of the country (Quosh & Gergen, 2008). Our study also reflected both the wider mental health caring and veteran partner literature in finding that participants predominantly focused on the intimate relationship and the positive qualities in their life partner that have not faded with the illness, as a means of maintaining commitment to the relationship (Dekel et al., 2005; Goossens et al., 2008; Kimhi, 2013). This commitment was also reflected in the caring activities described by participants and their concern to reduce any dependency that their veteran partner might feel, a finding reflected in other literature involving spouses of people with mental illness (Lawn & McMahon, 2014).

Coping is strongly influenced by the environment. The theme of “lack of understanding” illustrates how the social environment can be a source of stress for these carers and a key barrier to coping (Lazarus & Folkman, 1984). Conversely, appropriate social support can have a positive impact on coping through conveying understanding and reducing feelings of social isolation (Jeon & Madjar, 1998). Participants in our study were consistent in their comments about the support they found with other partners, over and above more general carer support, highlighting the very specific nature of being in a relationship with a male veteran with PTSD. This need for specific peer support is a consistent theme in the literature (Outram et al., 2009; Sherman et al., 2005).
“Lack of understanding,” together with a related sub-theme of “invisibility” was particularly pronounced in participants’ descriptions of their experiences with health providers and with the DVA. Lack of understanding of caring is a consistent theme in the literature with researchers finding that the lack of value accorded to the carer, through interactions with health professionals and organizations, affects feelings of loneliness and increases stress and the disconnect with society (Jeon & Madjar, 1998; Wynaden et al., 2006). This finding in our study is consistent with the research conducted by Outram et al. (2009) who highlighted the lack of recognition and understanding of veteran partners’ experiences, particularly by the DVA. Lack of understanding is a barrier to coping because it is the strength of commitment that makes a person vulnerable to stress (Lazarus & Folkman, 1984, p. 58). This constituted a failure to recognize the strength of commitment by our participants to their relationships and the value they placed on their identity as partner. Therefore, to enable partners to cope, it is vitally important to recognize that they are not simply a resource in veteran health care but that their own lives and health are profoundly affected by the military trauma experienced by their veteran spouse. The participants in our study did not articulate wanting monetary compensation for their suffering. They wanted recognition and understanding.

Strengths and Limitations
The key strength of the research is the nature of the semistructured in-depth interview process, the rapport generated, the rich data it produced, and the consistency of the major themes with existing literature. Despite the insights generated into the complexity of caring for a veteran partner with PTSD, there are limitations. The culturally homogeneous nature of the sample group means that the findings are heavily biased toward the perspective of female partners of male Vietnam veterans in long-term relationships. However, this homogeneity also strengthens the findings in relation to the lived experience of caring for Australian Vietnam veterans, who currently represent the largest number of veterans with PTSD. It is recommended, however, that future research focus on recruiting a more diverse sample in terms of age, gender, and length of time caring.

Implications
The findings indicate that coping strategies need to be contextualized rather than individualized, and that a key barrier to coping is the social environment. Findings highlight that, despite policy and service improvements for carers in general, there remains a gap in recognizing and understanding the lives of female partners of male veterans with PTSD. There is clearly a need for continuing education of health providers, government staff, and the general community about the nature of PTSD and its impacts on relationships, particularly the intimate type. The importance of this recommendation is strengthened by both the increasing rate of PTSD in veterans of Iraq and Afghanistan and the deep concern expressed by our participants that younger partners do not suffer similar lived experiences. As well as clinical implications in understanding the nature of coping strategies for this older group of long-term carers, there are practical implications in ensuring that appropriate support is made available to ensure that they can continue to cope. An example would be suitable respite tailored to individual circumstances to enable the carer to continue to have time for themselves as both they and their veteran partner age. Finally, it is important that programs developed to support partners of veterans with PTSD incorporate recognition that caring is an inextricable part of the intimate relationship and that the strength of commitment to the relationship then affects the coping strategies developed.

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