"YOUR SON IS FOR LIFE": A PHENOMENOLOGICAL STUDY INTO MOTHERS' EXPERIENCE OF CARING FOR THEIR SON INJURED IN COMBAT.

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A THESIS SUBMITTED IN PARTIAL FULFILMENT FOR THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY AT THE UNIVERSITY OF CENTRAL LANCASHIRE

MAY 2019

STUDENT DECLARATION

I declare that while registered for the research degree, I was with the University's specific permission, an enrolled student for the following award:

Doctor of Philosophy

I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work.

David Sacree

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Type of Award PhD

School of Nursing

ABSTRACT

TITLE: "YOUR SON IS FOR LIFE": A PHENOMENOLOGICAL STUDY INTO MOTHERS' EXPERIENCE OF CARING FOR THEIR SON INJURED IN COMBAT.

Aim: Using semi-structured interviews and IPA, explore mothers' experiences of wellbeing during the different phases of their sons' recovery and rehabilitation

Background

This thesis reports on the deleterious effect on six mothers' wellbeing as a result of their son's traumatic combat injury during deployment to Afghanistan between 2008-2009.

Method/ Methodology

Six mothers were recruited to the study by purposive sampling. The mothers were interviewed on 2 occasions using a semi-structured interview schedule. Analysis adhered to an Interpretive Phenomenological Analysis (IPA) approach, which seeks to uncover the meanings of participants descriptions of their lived experiences. Each mother's transcript was analysed separately to reflect the idiographic element of IPA. Three superordinate themes emerged from the cross-case analysis of the mothers' narratives: "The stressful event unfolds", "The support of others", "Life after the stressful event." The emergence of a dialogue between my interpretations of the mothers phenomena and psychological concepts found in the extant literature, provided a link between the mothers lived experiences and Attachment Theory, Coping Theory, Social Suppport Theory and the Myth of Motherhood.

Findings

A son's Traumatic Combat Injury has the potential to impact on the relationship between mother and son during the son's recovery and rehabilitation. Mothers who had a close relationship with their son called upon a range of adaptive coping strategies to help them mitigate the stressors they encountered during their son's recovery and rehabilitation.

Support of family and friends was helpful to the mothers who had a close relationship with their son, depending on the mothers' coping strategies, predispositions towards motherhood and the quality of the relationship with their son. Mothers who had a poor relationship with their son and daughter-in-law demonstrated withdrawal from the relationship, maladaptive coping strategies and relied less upon the support of family and social networks.

Contribution to knowledge of the subject

This is the first study to examine the impact on a mother's wellbeing whose adult son has been traumatically injured in combat. The relationship between mother and son and the type of coping strategies called upon by mothers who adopt a caring role should be heeded. It is recommended that running concurrently with a son's recovery and rehabilitation programme, all mothers should receive emotional support from a counsellor who specialises in psychodynamic family therapy. Drawing upon attachment and coping theory will enable the counsellor to identify the psychosocial stressors associated with caring for their injured son and concomitantly lead the counsellor to an earlier treatment strategy and level of support appropriate to the mother's needs. Additionally, medical staff at role 4 of the son's care-pathway should receive interpersonal skills training to maximise the emotional support they provide to mothers and other family members during a son's recovery in hospital. Army Welfare Staff should also be familiarised with the findings of this study so that they are equipped to support the emotional and instrumental needs of mothers adjusting to their son's traumatic injuries during their initial recovery in hospital. Mothers would also benefit from being signposted to the Armed Forces charity Soldiers, Sailors, Airmen and Families Association (SSAFA) , who provide specific support to family members of wounded, injured or sick (WIS) service personnel.

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ACKNOWLEDGEMENTS

I began this research with a push in the back from Dr. Paul Castle who was one of several lecturers who had guided me through my Bachelor of Science in Sport and Exercise Psychology. Several years later and nearly twelve months into the start of my doctorate, I had to make the difficult decision to transfer my studies to benefit from the knowledge and experience of academics familiar with veterans' research and who were able to advance the academic boundaries of my studies.

I would first of all like to thank my Director of Studies Professor Mike Thomas. His capacity to direct my studies as well as carry out his many other responsibilities in the role of Vice Chancellor served to motivate me to finish my studies during a difficult period of my research. More than this, Mike introduced me to the wisdom of Irvin Yalom and with it enlightenment and understanding.

My thanks also go to my two supervisors. Firstly, Professor Karen Margaret Wright, whose generosity was limitless. Her timely words of support and encouragement helped me to embrace the complexities of Phenomenology and sustain the mental demands of analysis and interpretation. Secondly, Professor Alan Finnegan, who like me had served in the British Army, gave me access to his extensive knowledge and experience of the complex evolution of care to service personnel and the veteran community. His 'military mindset' also provided me with respite and points of anchor throughout difficult stages of my research.

Being in the right place at the right time can result in unexpected opportunity. I have experienced this on at least three occasions during the completion of my thesis. Firstly, I am very grateful to meeting Veronica in 2014 who accidentally decided to tell her story at a conference which I had been hesitant about attending. Secondly, Dr. Celia Hynes who I was introduced to at a veterans' conference in Salford in January 2016 and who later was responsible for organising a meeting with the people who would become my supervisory team. Thirdly, my sincere thanks go to the mothers who took part in this study and how their stories have contributed to my enlightenment and the shape of my future aspirations.

Finally, a thank you to my wife, Jane. Her generosity in allowing me to give priority to this research at inconvenient times and the support she has given throughout all the twists and turns of the past three years has been limitless. Her generosity is matched by my love for her.

David Sacree, August 2018

GLOSSARY

Confidentiality: This means that research subjects are protected by remaining unidentifiable.That is,their names may not be used in any written material concerning the research or in discussions of the research project, and all interview materials are stored in a safe place that no one save the researchers can access.

Disclosure: A researcher may or may not reveal, or disclose, his or her identity and research purpose. In accordance with ethical considerations, we advocate full disclosure whenever possible.

Ethical codes: These are codes of conduct set in place to protect the research subjects and their setting—neither of which should be harmed by the research process. Professional associations have specific codes of ethics that spell out a set of rules governing research and based on moral principles.

Gate Keeper: Someone who is able to grant or refuse access to the research participants Informed consent: Informed consent aims to ensure that the participant is fully voluntary and informed, based on an understanding of what the study is about, what its risks and benefits are, how the results will be used, and the fact that participation is voluntary and can be stopped at any time and that identity will be protected.

Institutional review boards (IRBs): Institutional review boards (IRBs) ensure that studies using living subjects are ethical and will not cause harm.

Improvised Explosive Device: A device placed or fabricated in an improvised manner, which incorporates destructive materials designed to destroy and harass

Medical Emergency Recovery Team (MERT): This comprised of a specialist doctor and nurse and two paramedics who gave immediate medical treatment to casualties during their evacuation by Helicopter to Bastion Hospital.

National Health Service (NHS): The NHS is the publicly-funded healthcare system of the United Kingdom. It is primarily funded through the taxation system, is overseen by the (Department of Health and Social Care, and most services are free to individuals at the point of use.

Veteran: Everyone who has performed military service for at least one day and drawn a day's pay.

Non veteran population: The non-veteran population is defined as those aged 16+ who have not served in the UK Armed Forces or are currently serving.

ABBREVIATIONS

BH	Bastion Hospital
CAQDAS	Computer-assisted qualitative data analysis software
CBT	Cognitive Behavoural Therapy
CTS	Complex Treatment Service
DMS	Defence Medical Services
GAD	Generalised Anxiety Disorder
HC	Headley Court
IED	Improvised Explosive Device
LLSM	Living with Limb Loss Support Model
MERT	Medical Emergency Response Team
MH	Mental Health
MOD	Ministry of Defence
NH	Norton House
NHS	National Health Service
NOK	Next Of Kin
PTSD	Post Traumatic Stess Disorder
PWLL	Person With Limb Loss
QEHB	Queen Elizabeth Hospital Birmingham
RBL	Royal British Legion
RDMC	Rehabilitation Defence Medical Centre Headley Court
SO	Selly Oak Hospital Birmingham
SSAFA	Soldiers, Sailors, Airmen and Families Association
TCI	Tramatic Combat Injury
TILS	Transition Intervention Liasion Service
WIS	Wounded Injured and Sick Service personnel

Chapter One: Introduction to the thesis and the origin of the study

1.1   Introduction to the thesis

The purpose of this Interpretive Phenomenological Analysis (IPA) study was to explore the experiences of six mothers whose sons sustained traumatic combat injuries (TCI) during their deployment on Operation HERRICK (Op HERRICK). This was the name for the UK operations in Afghanistan which commenced on 1 April 2006 and ended on 30 November 2014.

In Chapter One, the context and academic rationale for the study is positioned by demonstrating the absence of research in this topic area. This study also draws upon topics which give an insight as to how mental illness or traumatic brain injury of young or adult children can threaten the mental health of mothers. The aim of Chapter Two is to orientate the reader to the care pathway for trauma care which evolved in response to the number of trauma casualties in Iraq during operation TELIC (Op TELIC) and in Afghanistan during operation Herrick (Op HERRICK). This care pathway revolutionised the provision of care to injured service personnel from the point of injury through to their rehabilitation and, in most cases, discharge from the military. This chapter is pivotal in understanding the different trajectory taken by the development of trauma care, compared to mental health care for service personnel after discharge from the armed forces during the past decade. Chapter Two, as well as Chapter One, also helps to distinguish the differences in the mental health services available to veterans, compared to that of their family members and, subsequently, in Chapter Nine, serves to contextualise the experiences of the mothers.

Chapter Three is important in understanding the link between the epistemological stance taken in this research, the qualitative research paradigm and the IPA methodology which guided the collection and analysis of each mother's verbatim transcripts. Chapter Four describes the design of the study and the different stages of analysis used in the IPA approach, including the importance of the interaction between the hermeneutic cycle and reflexive practice. Chapter Five describes how interpretation and reflexive practice together facilitated the dialogue between the mothers' shared themes and psychological constructs found in literature. This provided an additional lens with which to gain an understanding of the mothers' idiographic experiences.

The outcome of the analytic and evaluative processes described in Chapter Five was the emergence of three superordinate themes: "The stressful event unfolds", "The

support of others" and "Life after the stressful event". The analysis and discussion of these superordinate themes are discussed in Chapters Six to Eight and represent the mothers' similarities and differences viewed experientially and theoretically.

These similarities and differences also create a dialogue with Chapters One and Two and bring into focus the discrepancy between the innovation responsible for the increased survivability of injured service personnel and their improved trauma care, and a key finding of this study, notably, the absence of support to the mothers during their son's rehabilitation. Each mother responded to this absence of support differently and to the situational and relationship stressors they encountered during their sons' recovery and rehabilitation. The insight each mother gained from their experiences reflects the quality of the relationship with their son and the meaning they attributed to their experiences.

Chapter Nine consolidates the previous eight chapters of the research and the insight gained from recent studies in relation to the contribution made by the current study to existing knowledge. Comment is also made about the relationship between Attachment Theory and how this is evident in current day initiatives implemented by the Government to support parents in how they raise their children. Implications for policy and practice, the strengths and limitations of the study are also discussed. The chapter is concluded with my personal reflections.

1.2 Introduction to Chapter One

This first chapter is divided into two parts. In Part One, I outline the origin of the study, the academic rationale for the study and my personal and professional interest in conducting the study. The aim of the second part of this chapter is three-pronged. First, the search strategy and how it supported the academic rationale for the study is discussed. Secondly, specific studies which are considered relevant to the aims of this study are examined, and thirdly, the relevance of studies related to the association between amputation and poor wellbeing is investigated, as well as an examination of mothers in the general population caring for injured or sick children. This is followed by an analysis of the studies, along with analysis of their relevance to the aims and objectives of the study, up to the point of receiving ethical approval for the study to begin. Three studies were published during the latter stages of my study and are therefore, discussed later in Chapter Nine. The chapter finishes with the aim and objectives of the study and a guide to the chapters that follow.

1.3 Part one

1.3.1 The context of the study

This study is retrospective in that the participants recalled experiences which began in the middle of 2009. At the time of the study each of the mothers was in a position to reflect on the stressful encounter they experienced because of their son's TCI and not be visited by the distressing emotions they encountered during the critical events which characterised their stressful event.

1.3.2 The origin of the study

The origin of this study was born out of a personal interest in the transition of veterans who are leaving the British armed forces. This influenced the decision to attend the inaugural conference of Anglia Ruskin University's 'Veterans and Families Institute' (VFI). This conference brought together researchers in mental health and social care to discuss current and future research into the needs of veterans and their families (Anglia Ruskin 2014). During the conference, the attendees were introduced to 'Veronica', who was given the opportunity to present a brief overview of the small self-support network she had recently established in the south of England to provide emotional support to mothers of sons and daughters who had either sustained combat injury or combat illness during the British Army's deployment to Afghanistan.

A copy of Veronica's presentation is not available. However, in essence, the presentation conveyed the distress experienced by mothers when learning of their son's TCI; visiting their son in hospital during initial recovery; and the strain imposed on their relationship during their son's period of rehabilitation. The mother's experience was compounded by the deleterious effect it had on their wellbeing during the protracted stressful event of their son's recovery and rehabilitation.

Several weeks after the conference, I met with Veronica to discuss the research proposal with her. It is important to mention that this research focused specifically upon sons, and not daughters, since during the recruitment of participants, only mothers with sons volunteered to take part. This issue is discussed further in Chapter Five.

1.3.3 Academic rationale for the study

The content of Veronica's presentation and the subsequent meeting with her had highlighted the likelihood that little, if any, research had been conducted into the impact of TCI on mothers or indeed family members generally. In contrast, the research community has conducted a wide range of studies investigating how the deployment of service personnel and the reintegration of service personnel to family life after deployment can result in emotional and behavioural difficulties in children (e.g. Creech,

Hadley & Borsari, 2014; Faber, Willerton, Clymer, MacDermid & Weiss, 2008). In addition, research has been carried out on service personnel diagnosed with post-traumatic stress disorder (PTSD) and how this can have a detrimental effect on the health and behaviour of the spouse and children (e.g. Dekel & Solomon, 2005; Kilmer, Eibner, Ringel & Pacula, 2011; Murphy, Palmer, Hill, Ashwick & Busuttila, 2017; Renshaw, & Campbell, 2017; Renshaw et al., 2011).

1.3.4   The researcher's personal and professional interests

My interest in the topic began as a second-year undergraduate studying for a degree in Sports and Exercise Psychology. During this time, a visiting lecturer presented a short review of research she had conducted into the challenges faced by elite sports athletes making the transition into retirement after a lifetime of sport (Park, Lavallee & Tod, 2013). The psychological constructs associated with these challenges resonated with my personal experience of the transition into civilian life after a long military career. These similarities prompted an investigation into the general theory of transition and an examination as to how this related to the broad range of challenges encountered and experienced differently within the veteran population. It is useful, therefore, to understand that, initially, Veronica's story was also viewed as a 'transition', as well as that of her son. However, to have viewed Veronica's experience through the lens of transitional theory alone lacked compassion and empathy, which threatened to conceal the depth and breadth of each mother's individual experience of their stressful encounter with their son's TCI.

Additionally, capturing these 'experiences' suggested an "interplay between researcher and data" (Strauss & Corbin, 1998: p.13) and therefore, the need to ask process-related questions, which would seek to tap into the social phenomenon of each mother's experience of her son's TCI from the insider's perspective. It is the specific focus on processes and social relations that guided me to adopt a qualitative approach to this study. This approach is supported by the views of Green & Thorogood (2004, p.5) who state that "the most basic way of characterizing qualitative studies is that those aims are generally to seek answers to questions about the 'what', 'how' or 'why' of a phenomenon, rather than questions about 'how many' or 'how much." This is also reflected in the views of Bryman (2004, p.15) who points out that "qualitative research strategies are inductive, constructionist and interpretivist".

This awakening of how to capture each mother's experiences encouraged the crystallisation of an epistemological stance and how, in adopting the role of qualitative

researcher, an 'instrument' of the research is created (Creswell, 2013; Morrow & Smith, 2000). My epistemological stance and the methodology adopted for this study is discussed in detail in Chapter Three.

1.4 Part 2: Search strategy

A preliminary search of the literature revealed no prior research into the relationship between a mother's wellbeing and her son's TCI within an armed forces environment. It should be acknowledged that, in similar circumstances, where a topic is under-researched or represents a new area of research, it is advisable to conduct a narrative review, given the need to discover the nature or dimension of the phenomenon. In turn, and in the context of this study, a narrative review created the opportunity to integrate a wide range of issues about the mothers' phenomena and the strong possibility of identifying gaps in the literature (Bryant, 2003). Before conducting the search strategy, insight into the topic area was also sought from members of my supervisory team.

1.4.1 Search terms

The search strategy was developed by taking account of the range of injuries Veronica had shared in relation to the mothers she had spoken of in her presentation. These injuries included lower limb amputations, traumatic brain injury (TBI) and respiratory injury. Within the literature, a variety of interchangeable terms are used when referring to the types of injury encountered in a combat zone. The term 'blast injury' was included in the terminology, because of the range of four mechanisms of injury covered by the term 'blast injury'. These four basic mechanisms are primary, secondary, tertiary and quaternary.

The term 'blast injury' is often interchangeable with polytraumatic injury and TBI. This served to obfuscate the most effective terms to use in the search to identify only amputations. For example, polytrauma is defined in the literature as "two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability" (Poorman et al., 2009, p. 42). As the majority of polytrauma evacuees are predominantly treated for TBI (Griffin et al., 2017; Wyse, Pogoda, Mastarone, Gilbert & Carlson, 2018), using the term 'blast injury' identified polytrauma, amputation or TBI studies. The inclusion and exclusion criteria was then applied to identify studies solely reporting on amputees.

There is a similar lack of consensus amongst researchers (and the NHS and other health providers) in relation to the conceptualisation of 'family'. In some studies, the

term 'relative' is used when referring to adult family members. In other studies, the term 'family' includes children. To complicate matters, in other research both terms are used interchangeably, with the ambiguous use of 'mother' and 'father' when referring to parents within families. As a result, there exists a degree of conceptual confusion as to what constitutes 'family' in studies which investigate injury or illness within the 'family setting'. For this reason, 'family', as well as 'mother', 'father', 'parents' or 'sibling' were included in the search terms. Table 1 represents the search terms used divided into Facet 1, 2 and 3.

Table 1: Key words considered relevant to the research question

Facet 1	AND	Facet 2	AND	Facet 3
Wife	OR	Soldier*	OR	"Combat injur*"
Spouse		Ex-soldier*		"Combat illness*"
Mother		Veteran*		"Blast injur*"
Father		"Ex-service Personnel"		"Blast trauma*"
Parent*		Sevicem?n		Polytrauma
Children		"Military Personnel"		"Traumatic limb loss"
Sibling*				"Traumatic amputation"
"Family member*"				PTSD
				"Post-traumatic stress disorder"

The Boolean connectors 'OR/AND' were used to combine the facets with each other to maximise the search results. This offered the potential to find studies which had investigated a relationship between different family members, military personnel and different terms used for types of combat injury. Articles were selected by locating the search terms in the title, in the abstract or as major or minor keywords in order to reduce the number of articles to those most relevant. A large volume of the articles generated by the search terms, provided very little insight into how mothers might specifically experience the stressful event of a son's TCI. However, the number of articles which were reviewed provided a valuable insight into the research conducted in a wide range of topics related to traumatic injury both in the military and in the general population. This was relevant to the current study, since it provided insight into the deleterious effects of TCI on service personnel. Therefore, each of the son's experience of their TCI had the potential to influence the mothers experience of the stressful event.

The literature search resulted in the identification of 2,041 citations in total. There were 28 references, which were common in two or more of the databases, leading to 1,812 non-duplicated articles. After initial screening, 124 out of 1,812 references remained. In the next stage, the inclusion and exclusion criteria were applied to the 124 references, by reading the abstracts, to reading the full article. From the 124 initial articles, 8 articles (16%) were considered relevant to the study.

1.4.2 Inclusion criteria

No limits were set on the date of publication. The 6 essential inclusion criteria listed in Table 2 were used to select the studies for review.

Table 2: Inclusion criteria

The study was published in English (due to a lack of resources to employ translators)
The study was published in a peer-reviewed journal, providing prima facie evidence of quality
The study used eith qualitative or quantitative methods of data collection
The sample consisted of service personnel who had sustained a traumatic combat injury
Studies had a substantial focus on psychosocial issues surrounding amputation and/or prosthesis use by the service personnel
Studies had a substantial focus on psychosocial issues surrounding the stress experienced by mothers of injured servicemen during their recovery and rehabilitation

1.4.3 Exclusion criteria

A list of the types of studies excluded from the search is detailed in Table 3.

Table 3: Exclusion criteria

Studies which focussed on the experience of stump or phantom limb pain only
Studies which mixed data collected from service personnel with amputations and non-service personnel without amputations (unless interpretations relating to the former could be readily identified)

Where it was not clear from the information provided whether a study was suitable for inclusion, the full text of the paper was read, and the inclusion/exclusion criteria applied. Figure 1 illustrates the number of articles identified in Stage 1 and 2 of the search.

Figure 1: Number of articles identified in Stage 1 and 2 of the search
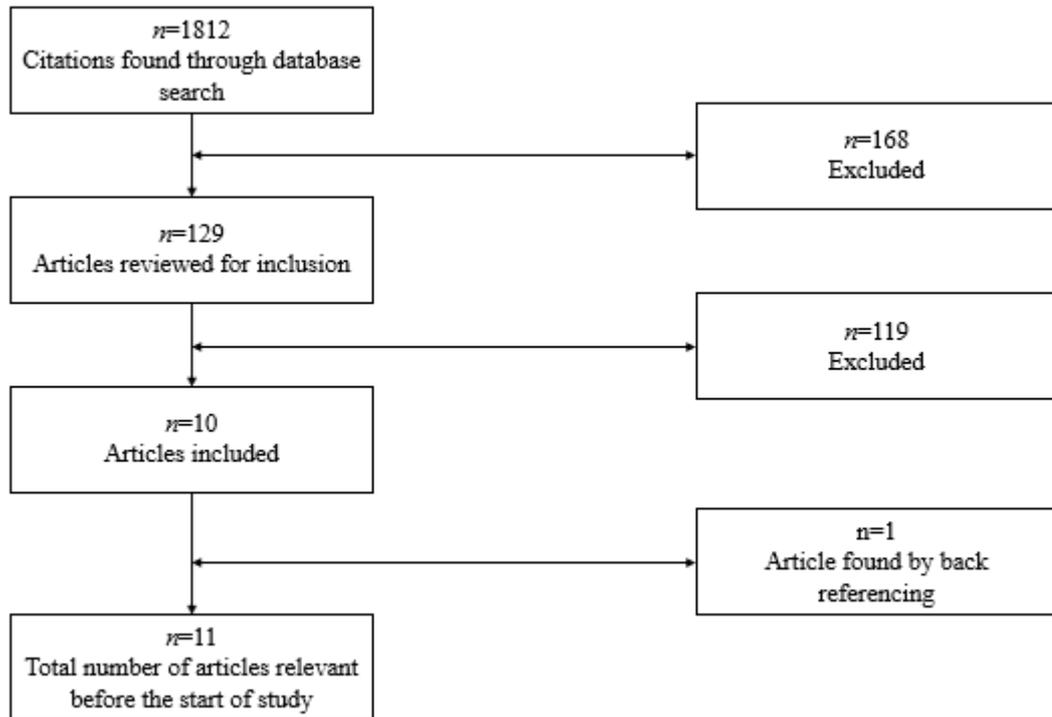
1.4.4   Studies identified as relevant to the study

A total of 11 studies were identified as relevant prior to the start of the study. These are listed in Table 4. Four studies were identified as relevant to my study but after the search strategy was conducted. These are discussed in the context of the findings of this study in Chapter Nine.

Table 4: Articles relevant to the study

Citation of study	Where?	Who?	Study design and methods	Analysis	Key findings
Ferguson, Richie & Gomez (2004)	United States of America	Eighty-five participants (68) persons of limb loss, (10) family members, seven service providers	Semi-structured interviews conducted by US trained social workers	Grounded theory analytic strategies	Recovery was greatly influenced by the individual's resilience characteristics, social support, medical care, economic situation and societal attitudes toward people with disabilities.
Dirkzwager, Bramsen, Adèr & van der Ploeg, 2005)	Holland	Partners and parents of Dutch peacekeeping military service members	Cross-sectional study using the Family Needs Questionnaire (FNQ)	Mixed methods. Cross-sectional survey conducted by mail with peacekeepers. Interviews conducted with partners and parents	Need to look at the article
Friedemann Sanchez, Sayer & Pickett (2008)	United States of America	(56) purposefully selected care providers	Rapid Assessment Programme methodology using	Qualitative	The American Veterans Association are urged to develop and implement strategies to meet the need of traumatically injured service personnel

		from consulting services	self-report questionnaires		
Ebrahimzadeh & Hariri (2009)	Iran	(96) Iranian military amputees from the Iran–Iraq War (1980–1988)	Medical examination and history taking	Descriptive	Fifty-four percent of amputees reported psychological problems; 26% were currently utilizing psychological support services.
Ebrahimzadeh & Rajabi, (2007)	Iran	(27) Iranian soldiers	Medical examination, review of medical records and participant survey	Descriptive	After war-related lower extremity amputation individuals reported long-term pain
Dougherty et al. (2012)	United States of America	(501) participants who had served in Vietnam. (541) who had served in Iraq/Afghanistan with any type of limb loss.	Quality of life comparison between wounded combatants from the Vietnam and recent conflicts	Cross-sectional survey conducted by mail, telephone, or web site during 2007 to 2008	Participants who served in Iraq/Afghanistan and those who served in Vietnam report comparable quality of life. Prosthetic use continues to be a problem, especially as the service member ages.
Schaaf et al. (2013)	United States of America	44 family members of service members and	Cross-sectional study using the Family Needs	Quantitative	The findings provide direction for development of empirically based family intervention models for polytrauma settings.

		veterans with brain injury	Questionnaire (FNQ)		
Griffin et al. (2012)	United States of America	(564) Caregivers of service members with TBI	Cross-sectional survey	Quantitative	Caregivers who provide assistance with either activities of daily living or instrumental activities of daily living may need additional resources to meet the long-term needs of their injured family member.
Hall et al. (2010)	United States of America	(226) Rehabilitation interdisciplinary team members	Cross-site, mixed-method evaluation	Cross-sectional and descriptive	The collaboration of clinicians, programme leaders, and researchers may be useful for fostering complex change involving interdisciplinary teams.
Griffin et al. (2009)	United States of America	The provision of family therapy and support within one of the Polytrauma Recovery Centres		Discursive	The efficacy of the PRC in how it provides a healing environment that promotes self-care, agency, balance, creative coping, and a sense of community for injured service personnel and their families.
Collins & Kennedy (2008)	United States of America	Polytrauma patients and their families supported in a Polytrauma Recovery Centre	Single case study	Discursive	Effective family functioning is an essential outcome of polytrauma rehabilitation.

In October 2014, Anglia Ruskin University published a report commissioned by the British Limbless Ex-Servicemen's Association (BLESMA), Traumatic Limb Loss and the Needs of the Family (Fossey & Hacker-Hughes, 2014). The following questions were considered in the BLESMA report:

1.   What evidence is available on the emotional and psychological impact of traumatic limb loss on families and Service families in particular?

2.   What coping strategies have been adopted by the families?

3.   What interventions have been shown to be effective?

The search terms used by Fossey & Hacker-Hughes included 'traumatic limb loss,' and 'family impact'. In my study, the terms 'family', as well as 'mother' 'father' and 'sibling' were used because of the variation within the literature of the meaning of 'family'. Despite the differences in the inclusion and exclusion criteria and the narrowness of the search terms used by Fossey & Hacker-Hughes compared to the inclusion and exclusion criteria used in the current study, both search strategies identified the same studies. The report concluded "the authors have been unable to identify any published UK research literature concerning the impact of traumatic limb loss on families, either within the military or civilian populations" (Fossey & Hacker-Hughes, 2014, p. 21). A review of the studies identified by Fossey & Hacker-Hughes can be read at Appendix 1.

1.4.5   Additional search

Given the small number of studies identified in Stage 1 of the search strategy, a further search was conducted by back referencing the initial 124 studies considered for inclusion. This involved checking through the 124 articles to establish if there were any additional pertinent articles. A search was also conducted by examining the abstracts of articles in two main military peer-reviewed publications: Journal of the Royal Army Medical Corps (UK – BMJ) and Military Medicine (US – Oxford Press). The inclusion and exclusion criteria were not applied given that the aim of this second stage of the search strategy was to gain insight into the range of social, psychological and wellbeing factors associated with the epidemiology of traumatic injuries. Additionally, how the effect of traumatic injuries on the service personnel may in turn affect the wellbeing of mothers or other family members.

Only one study, conducted by Dirkzwager, Bramsen, Adèr & van der Ploeg, 2005), was considered to have relevance to the current study. In this study Dirkzwager et al., (2005) examined the prevalence of secondary trauma among partners and parents

of Dutch peacekeeping military service members. A total of 1,476 peacekeepers and 1,040 family members (708 partners and 332 parents) participated in the study. Recruitment was completed through a mailed letter to 8,000 peacekeepers; 43% opted to participate. All branches of the Netherlands Military were represented (60% Army, 30% Navy, 7% Air Force). The majority (76%) of participants were below the rank of a non-commissioned officer. Peacekeepers had served a mean of 5.7 months abroad. About 60% of the parents who participated in the study were mothers, with their mean age being 54 years (SD = 6.9, range 41-81). 88% were living with the peacekeeper before the deployment, and more than half were living with the peacekeeper when the study was conducted.

In a critique of the Dirkzwager et al. (2005) study, Fals-Stewart & Kelley (2005) highlighted the weakness of its cross-sectional design and its failure to consider the possible discrepancies between veterans' self-reports and parents' perceptions. Additionally, Fals-Stewart & Kelley (2005) highlighted the implications of the co-variation between the symptoms of secondary stress, the relationship adjustment and the social support, emphasizing that it is impossible to know whether the symptoms reported by family members existed previously, were a sign of general distress, or had been worsened by their veterans' symptoms. In defence of Dirkzwager et al. (2005), Figley (2005) points out that

> the secondary effects of war on the family are widely acknowledged but rarely
>
> studied. Dirkzwager et al.'s testing, confirmation, and report of the secondary
>
> traumatic stress thesis deserves special recognition in consideration of the
>
> careful attention paid to what happens when peacekeeper troops return home to
>
> their families. (p. 227)

1.4.6   Veterans and Post Traumatic Stress Disorder (PTSD)

Traumatic events experienced by service personnel in combat have the potential to lead to post-traumatic stress disorder (PTSD). The American Psychiatric Association (2013, p. 272) defines PTSD as "an Axis I disorder characterized by re-experiencing distressing memories or images of a traumatic event, accompanied by prolonged negative changes in affective state or mood, markedly increased arousal, and avoidance behaviors". Various sequelae are associated with PTSD such as isolation, irritability,

guilt, insomnia and poor concentration, resulting in a significant impact on day-to-day living (Friedemann-Sánchez, Sayer, & Pickett, 2008).

A large body of research has been produced in recent years investigating the different prevalences of post-traumatic stress disorder (PTSD) among military personnel following deployment to Iraq and Afghanistan (e.g. Bartoszek, Hannan, Kamm, Pamp & Maieritsch, 2017; Blais & Boisvert, 2005; Lindsey, Sundin, Rona, Wessely & Fear, 2014; Murdoch et al., 2017; O'Toole & Catts, 2017; Renshaw et al., 2011; Xue et al., 2015). The risk factor literature shows that not everyone who experiences a traumatic event will subsequently develop PTSD and some may resume prior functioning naturally (Elwood, Hahn, Olatunjic & Williams, 2008). Therefore, it has become increasingly accepted that individual vulnerability factors contribute to the development of PTSD beyond the traumatic event itself (Neuner et al., 2004; Yehuda, 1999).

In past decades, studies have shown PTSD to be associated with lower rank, being unmarried, being younger, having low educational attainment and a history of childhood adversity, as well as exposure to potentially traumatizing events, in particular being deployed to a 'forward' area in close contact with the enemy (Defence Committee, 2018; Iversen et al., 2008). Although symptoms of PTSD are experienced by the individual who has experienced a traumatic event, researchers have also investigated the effects of PTSD on the relationship with a spouse or partner, particularly in terms of high levels of marital conflict (Hoge, Castro & Eaton, 2006; McGinn, Hoerster, Stryczek, Malte & Jakupcak, 2017; Monson, Taft & Fredman, 2009; Troxel, DeSantis, Buysse, Germain & Matthews, 2017), as well as intimate partner violence (Iverson et al., 2017; Jones, 2012; Meterko et al., 2017; Sparrow, Kwan, Howard, Fear & MacManus, 2017).

Children are especially at risk of experiencing a variety of negative biological, behavioural, social, and psychological effects due to having a military parent affected by PTSD (Banneyer, Koenig, Wang & Stark, 2017). This includes, the impact of PTSD on children's mental health (Creech, Trotman, Michaelson, Benzer & Copeland, 2017; Dinshtein, Dekel & Polliack, 2011), children's increased levels of hyperactivity (Beckham et al., 1997), attention deficiency (Daud, Skoglund & Rydelius, 2005) and depression (Murphy, Palmer, Hill, Ashwick & Busuttila, 2017).

Previous research findings, when considered in the context of the current study, provide insight to how social and emotional support protect against the development of chronic PTSD in service personnel (Keane, Marshall & Taft, 2006; Schnurr, Lunney & Sengupta, 2004). Conversely, interactions with unsupportive partners are associated

with a lower likelihood of service personnel seeking treatment for PTSD (Meis, Barry, Kehle, Erbes & Polusny, 2010; Mital et al., 2013) and poorer treatment outcomes (Kaniasty & Norris, 2008; Makin-Byrd et al., 2011).

Research in the context of the current study has also shown that family members who adopted the role of caregiver in support of service personnel with symptoms of PTSD, reported a sense of 'caregiver burden', anxiety, depression and frustration, as well as a decrease in self-esteem, particularly in the case of female caregivers (Calhoun, Beckham & Bosworth, 2002; Chen, & Lukens, 2011). Research conducted by Caska & Renshaw (2011); Murphy, Palmer, Hill, Ashwick & Busuttila (2017; Renshaw, Blais & Caska (2011) and Renshaw, Rodrigues & Jones (2008), also found that the levels of depression, anxiety and PTSD in veterans was linked to spouses' symptoms of distress and their perception of burden, highlighting the possibility of a dual-process relationship between veterans' symptoms and their family members.

In 2007, the Ministry of Defence (MoD) implemented a programme of monitoring and recording the mental health (MH) of UK armed forces personnel (MoD, 2017). Despite an overall increase in the rates of personnel assessed with PTSD over time, rates remain low at 0.2% of UK armed forces personnel with PTSD in 2016/17, equivalent to 2 in 1,000 personnel (MoD, 2017). Neurotic and mood disorders remain the most prevalent type of mental health disorder. During the ten-year period 1 April 2007 to 31 March 2017, the Army and the Royal Marines had the highest proportion of personnel assessed to have PTSD. The total number of mental health disorders recorded between 2016 and 2017 was 3,039. The number of service personnel presenting with symptoms of PTSD was 210 or 0.2% of the total (MoD, 2017). The number of PTSD cases reported across the different services of the armed forces is represented in Table 5.

Table 5: Number of reported PTSD cases across the different branches of Armed Forces for the period 2016/2017 (MoD, 2017)

Branch of service	Number of PTSD	Period: 2016/17 (MoD, 2017)
Army	210	Table A3.6, p. 30
RAF	33	Table A4.6, p. 34
Royal Marines	22	Table A2.6, p. 23
Royal Navy	33	Table A1.6, p. 22

The prevalence of PTSD in deployed regulars and reserves did not differ in 2014/16 (7% in each), but non-deployed reserves had lower PTSD rates than non-

deployed regulars (3% and 5% respectively) (Ashcroft, 2017). NHS standard treatments for PTSD have evolved since 2009 (the period of time in which this study is located). Treatments currently include watchful-waiting; psychotherapy; (trauma-focussed) cognitive behavioural therapy (T-CBT); eye movement desensitisation and reprocessing (EMDR); group therapy and counselling; and antidepressants (NHS, 2015a). Guidance on the management of PTSD set out by the National Institute of Health and Clinical Excellence (NICE, 2005) is currently being updated.

The number of cases of PTSD compared to alcohol abuse and neurotic disorders recorded between 2007 and 2017, reflect the original claims of Iversen et al. (2009) and, more recently, the views expressed in a Defence Committee review of MH in the armed forces (Defence Committee, 2018), that alcohol abuse and neurotic disorders are more prevalent in UK Army personnel than PTSD. However, despite the prevalence of PTSD and other MH disorders in armed forces personnel deployed on Op TELIC and Op HERRIC, British troops also reported the benefits of military life and of being deployed, such as increased self-esteem and confidence (Finnegan et al., 2014a; Hacker-Hughes, Cameron, Eldridge, Devon, Wessely, Greenberg, 2005). An evaluation of how veterans access treatments for common MH disorders, including PTSD and the efficacy of these treatments, was recently conducted by (Dalton, Thomas, Melton, Harden & Eastwood, 2018). This evaluation of the services available to UK veterans 'is considered to be long overdue,' given the high degree of comorbidity between PTSD and other MH disorders (Ashcroft, 2014; House of Commons 2018a; Iverson et al., 2009; Nemeroff et al., 2006). The provision of the MH care available to service personnel and veterans is discussed in Chapter Two.

1.4.7   Traumatic limb loss in armed forces personnel

Despite how the traumatic loss of a single or multiple limb in combat results in complex physical and psychological issues (Melcer, Walker, Galarneau, Belnap & Konoske, 2010), there has been limited investigation into the care needs of armed forces personnel who have sustained TCI or research which has considered the care demands placed upon family members (Fossey & Hacker-Hughes, 2015). A study conducted by Grieger et al. (2006) investigated the prevalence of MH disorders in American hospitalized veterans one, four and seven months following physical injury. Findings showed that soldiers under the age of 25 were most likely to be diagnosed with PTSD or depression. At the seven-month follow-up, 15% met criteria for either PTSD or depression, and 6.3% met criteria for both PTSD and depression. In a later study, MacGregor et al. (2009) found that amputees who reported higher rates of physical problems one month

after injury were also diagnosed with symptoms of PTSD and depression at seven months after injury.

Later research conducted by Ebrahimzadeh & Hariri (2009); Finnegan et al., (2014a); Koren, Norman, Cohen, Berman & Klein (2005) and Walker, Clark & Sanders (2010), provide further evidence that military personnel with physical injury, impairment or disability may also experience PTSD.

1.5   Related studies within the civilian population

1.5.1   Amputation

It is difficult to generalize from military to civilian populations due to differences in age, pre-injury fitness, mechanisms of injury, exposure to a combat environment, and access to advanced military medical care (Bricknell & Nadin, 2018) and, as a result of advances in prosthetics (Pasquina et al., 2006). Within the civilian population, the causes of amputation fall into 2 categories: amputation as a result of traumatic accident, and cancer and peripheral arterial disease in diabetic patients (Ikonen, Sund, Venermo & Winell, 2010; Jude, Oyibo, Chalmers & Boulton, 2001; Wheaton, 2017).

Regardless of these differences, the adjustments required due to amputation and the addition of an artificial limb, represent complex physical, psychological and social processes (Gallagher & MacLachlan, 2001). Moreover, both military and civilian amputees face unexpected challenges in using a prosthesis to be able to perform activities of daily living and to resume work and other activities (Sinha, Wim, Van den Heuvel & Arokiasamy, 2014). Psychologically, amputees also have to cope with residual limb and phantom pain (Desmond, Gallagher, Henderson-Slater & Chatfield, 2008; Stockburger, Sadhir & Omar, 2016), changed body image (Senra, Oliveira, Leal, & Vieira, 2012), and possible stigma (Heavey, 2013). Together these challenges have a significantly negative impact on long-term functional outcomes and quality of life (Gallagher & MacLachlan, 2004; Jefferies, Gallagher & Philbin, 2018).

Regardless of whether amputation is the result of traumatic injury, infections, neoplasms or diabetes (Monteiro-Soares, Martins-Mendes, Vaz-Carneiro, Sampaio & Dinis-Ribeiro, 2014), amputees in the general population encounter the risk of developing depression and anxiety (Arango-Lasprilla et al., 2010; Mckechnie & John, 2014; Singh et al., 2009), feelings of loss (Sahu, Sagar, Sarkar & Sagar, 2016), perceptions of poor body image (Durmus et al., 2015), and feelings of denial, anger, and disempowerment (Hashemi et al., 2008).

Findings from the general population also show how traumatic injury has the potential to induce symptoms of PTSD (Hashemi et al., 2008; Sahu et al., 2016). A study conducted by Martz & Cook (2001) investigated the risk of PTSD to individuals with six types of traumatic physical impairments. These included spinal disorders, extensive burns, amputation, heart failure, major chest trauma and cardiac arrest. Likewise, a study conducted by Cavanagh, Shin, Karamouz & Rauch (2006) found that an amputation resulting from accidental injury may lead to a higher prevalence of PTSD because of the emotional stress surrounding the accident. Perhaps the most commonly studied psychological outcome following amputation in the general population is depression. Depression is a key outcome, since it is associated with poorer physical functioning (Horgan & MacLachlan, 2004) and a reduction in quality of life (Asano, Rushton, Miller & Deathe, 2008; Sinha & Van den Heuvel, 2011).

Employability, daily prosthesis use, age and, to a lesser extent, gender have been identified as the most important factors involved in amputees' psychological adjustment and prosthetic use (Sinha, Wim, Heuvel & Arokiasamy, 2014). In addition, the support of friends, family and significant others is considered essential for the psychological adjustment and the return to physical functioning of amputees during their recovery and rehabilitation (Hugo, Rui, Leal & Vieira, 2012; Kacperek & Clarke, 2009; Sperber-Richie, Ferguson, Adamaly, El-Khoury & Gomez, 2002). These findings are salient in relation to the association between amputation and depression and anxiety, which, according to Horgan & MacLachlan (2004), remain "relatively high up to 2 years post-amputation" (p. 846).

1.5.2   Parents of adult children with a severe mental illness (SMI)

Parents who care for an adult child with SMI experience significant emotional and physical distress (Gerson & Rose, 2012; Hill, Shepherd & Hardy, 1998). Meeting the care needs of their adult child and the uncertainty about their child's care needs takes a progressive toll on the health of parents, particularly their psychological well-being (Barker, Greenberg, Seltzer & Almeida, 2012; Ghosh, Greenberg & Seltzer, 2012; Song, Mailick & Greenberg, 2014). Parents also report the interruption of daily routines, distraction from daily activities and tension and conflict among family members (Chang & Horrocks, 2006). Additional challenges include difficulties in obtaining specialized care, meeting basic daily needs and providing financial support (Lysaker & Roe, 2012; Shor & Birnbaum, 2012). Parents also report having to give up careers, having little or no time for themselves or with their partners and lacking time

and energy to devote to their other children (Caples & Sweeney, 2010). In addition, parents also experience stress, as a result of how they perceive stigma (Hasson-Ohayona et al., 2014), fears about the symptoms of their child's illness, and grief over the loss of their child as they were prior to their SMI (Greenberg, Greenley, McKee, Brown & Griffin-Francell, 1993).

Research conducted by Chen & Greenberg (2004) and Stein, Aguirre & Hunt (2013) identified the benefit of social support in mitigating the effects of caregiver distress and caregiver burden in parents caring for an adult child with SMI. Similar research conducted by Kaufman, Scogin, MacNeil, Leeper & Wimberly (2010) found parents also benefit from receiving specific interventions designed to enable them to adopt effective coping strategies for dealing with the demands and stressors of caring. Additionally, recent research conducted by Raymond, Willis & Sullivan-Bolyai (2017) cites the importance of improving parents' access to mental health information, mental health screening, early interventions, violence prevention and various mental health treatment options.

1.5.3   Parents of Children with Traumatic Brain Injury

Traumatic Brain Injury is a multi-dimensional stressor for families, resulting in acute and long-term family burden and distress (Kreutzer, Mills & Marwitz, 2016; Stancin, Wade, Walz, Yeates & Taylor, 2010). These findings support earlier research conducted by Perlesz, Kinsella & Crowe (1999) who found that caregivers of children with TBI showed an increase in distress from three months to five years following the injury and did not show any remission in the distress at seven years post-injury. Additionally, research conducted by Minnes, Woodford, Carlson, Johnston & McColl (2010) found that the time of injury and the severity or degree of the disability of their adult child influenced the intensity of their caregiver distress and sense of burden.

Research conducted by Perlesz, Kinsella & Crowe (1999) and Niemeier, Kreutzer, Marwitz & Sima (2017) found that emotional support, instrumental support and difficulty in accessing appropriate health care were amongst the most frequently unmet needs of parents caring for their adult child with TBI. Conversely, research conducted by Wongvatunyu & Porter (2005), who interviewed seven mothers of young adults with TBI, found that support from the rest of the family can act as a moderator of depressive symptomology, such as anxiety, stress and sleep disturbances. Later research conducted by Backhaus, Ibarra, Klyce, Trexler & Malec (2010); Bushnik, Kreutzer, Marwitz, Sima & Godwin (2015); Damianakis, Tough, Marziali & Dawson (2016) and

Perlick et al., (2011) has shown that families who receive greater support and services, as well as learning adaptive coping strategies, are less likely to experience caregiver distress and caregiver burden.

1.5.4   Admission of a family member to intensive care unit (ICU)

Studies which have investigated the admission of a family member to an ICU suggest that it has an immediate impact on daily family life patterns and on family life in general. A study conducted by Hupcey, Penrod & Morse (2000), using grounded theory, interviewed spouses while their partners were recovering in an ICU. The findings demonstrated how the impact of a critical illness on the family unit moved parental, household, financial and health-related decision-making to the well spouse. In meeting the needs of a partner and children, spouses found that the competing demand of either being with their critically ill partner or attending to children was an ever-increasing burden, despite support from family and friends.

A phenomenological study conducted by Walters (1995) examined the experiences of fifteen females visiting a critically ill family member in a large tertiary hospital in Australia. The study was specifically aimed at "preserving the uniqueness of the ICU experience in providing an ontological understanding of the family's experience during critical illness" (Walters, 1995, p. 25). Two themes of particular significance emerged during the analysis; 'being with' and 'seeing'. The first theme, 'being with', "represented the physical and emotional presence of families and nurses with patients" (Walter, 1995, p. 21). This represented a 'connectedness' between the patient and family members that was important in maintaining the physical and existential bond between family members. For Walters (1995), family reinforces the need to be with a loved one during a critical illness. The second theme of significance, 'seeing', was attributed to how family members give meaning to what is happening, by seeing their family member and, in doing so, they are able to assess the severity of their illness. These two themes were important in providing insight to how the relationship between mother and son and the support of family members may have been particularly salient at the beginning of the mothers' experience of their sons TCI in the current study.

A grounded theory approach was also used in a study by Hughes, Bryan & Robbins (2005) to examine nurses' perceptions of relatives of families in a UK ICU. Several families of brain-injured patients spoke of their 'emotional rollercoaster' as the patient made progress and their perception of how their loved one was different from

the person they knew before injury. 'Information' was another theme that featured in this study, whereby relatives were particularly dissatisfied by the unwillingness of physicians to talk to them about their injured family member which, in part, contributed to the medical staff and the relatives having a different understanding of the patient's situation. This lack of effective communication and information was also identified in a study conducted by Dellinger, Azoulay & Sprung (2004), who found that family members with little information from physicians, as well as no written information, had little understanding of their loved one's critical illness.

1.5.5   The parent-child relationship

The parent-child relationship has the potential to make an important contribution to the findings of this study. The relationship between mother and son remains important throughout the life-course and is characterized by complexity and change as parent and child negotiate the different circumstances they individually and collectively encounter during the course of their lives (Birdett, Fingerman & Zarit, 2010; Kaufman & Uhlenberg, 1998; Treas & Lawton, 1999; Vassallo, Smart & Price-Roberston, 2009). Despite these changes in the relationship, research suggests that the relationship between parents and children, nevertheless, remains important throughout their lives (Fingerman, Hay & Birdett, 2004). A key change is how the adult child's view of the relationship evolves from one based upon dependence to one that is more equal, characterised by mutual support and interdependence (Fingerman, Pitzer, Lefkowitz, Birditt & Mroczek, 2008; Hagestad, 2003; Vasallo et al., 2009).

Studies by Fingerman et al. (2008), Greenfield & Marks (2006) and Kaufman & Uhlenberg (1998) have shown that the number of adult children's problems is associated with poorer parent-child relationship quality and family relationship strain. This is based on the premise that parents and children experience "linked lives .... (occupying) mutually influential developmental trajectories that extend throughout life" (Greenfield & Marks, 2006, p. 443). Cumulatively, adult children's greater number of problems might jeopardize their parents' well-being, by violating parents' normative expectations for their children (Collins & Russell, 1991) and by hindering parents' and children's achievement of mutuality or inter-dependence and egalitarianism in their relationship (Nydegger, 1991).

1.6   Conclusion

The search strategy adopted prior to the start of this study was valuable on three levels. Firstly, the search terms and inclusion/exclusion criteria underlined the absence of

research which has investigated the impact of a son's traumatic injury on the wellbeing of his mother. Secondly, the findings of the studies identified in Stage One of the study provide an insight into the association between amputation and PTSD on service personnel, their care needs, and the potentially deleterious effect on the wellbeing of the spouse or partner in caring for their loved one. Thirdly, to compensate for the small number of studies identified in the search strategy, the search was extended to include amputation and the association between amputation and PTSD in the general population. In addition, studies were also examined relating to mothers who had adopted the role of caregiver to an adult child with either SMI or TBI, relating to the critical illness experiences in family nursing, and to the experiences of nurses caring for traumatised patients.

When considered together, the studies reviewed in this chapter have provided an insight into the nature and differences in TCI, and how the scope of these injuries and associated MH disorders is broad and deep. Extending the search strategy to include illness and injury in the civilian population has allowed further insight into the prevalence of MH disorders, including depression and anxiety, as well as caregiver burden, which is common among family members who adopt the role of caregiver. These findings, combined with the absence of research regarding mothers and their sons' TCIs supports the academic rationale for this study and was essential in helping to 'set the stage' (Charmaz, 2006). This, therefore, guided the aim and objectives of the study, along with the composition of the interview schedule used to collect the data, which will be discussed later in Chapter Four. The findings of the study will be discussed in the final chapter.

1.7   Overall Aim

The overall aim of the current study was to use the IPA methodology outlined by (Smith et al., 2009) and conduct semi-structured interviews to explore mothers' experiences of wellbeing during the different phases of their sons' recovery and rehabilitation. The study explored three topic areas:

1   each mother's subjective meaning and appraisal of the critical events which characterised the different stages of their sons' recovery and rehabilitation;

2   the effect of these critical events and the influence of other immediate or extended family members on mother's wellbeing; and

3   the role of social support throughout the different phases of the son's recovery and rehabilitation.

1.8   Outline of the chapters

In Chapter Two, a background is provided to the 'military community' and a description of the different stages of the care-pathway implemented when service personnel are injured on the battlefield, their medical repatriation to Selly Oak Hospital (SO), which was the dedicated military hospital in 2009 and their rehabilitation at Headley Court (HC). The various agencies involved in delivering the medical care at Selly Oak Hospital are discussed, as well as the origin and evolution of the procedures and protocols implemented over several years, and which were relevant during the period in which this study is located. The role of HC rehabilitation centre is discussed, as well as the future plans of government to replace and update this facility. A brief history of the role of veteran charities is outlined, in particular, the major charities which supported veterans and their families in 2009, as well as the recent charities that have been established between 2009 and the present day.

Chapter Three outlines the methodology of the study and my epistemological positioning. A brief historical overview of phenomenology and the development of IPA is also provided. The rationale for using IPA is discussed by comparing IPA with other qualitative methodologies, including descriptive phenomenology, grounded theory and discourse analysis.

In Chapter Four, the study design and method are described for the two phases of the study. Recruiting, the selection criteria and gaining the consent of the participants is discussed, as well as the ethical considerations of collecting data from vulnerable participants. The structure of the interview schedule is discussed in relation to the aims of the study, as well as the absence of existing research into this area. The practicalities of applying an IPA are discussed, with emphasis placed on the analytical phase before the start of the study, as well as the author's experience of applying the 'hermeneutic-cycle' and 'reflexive practice' during the stages of analysis. Attention is also given to a manual analysis of the data, as opposed to using computer-based programmes, along with the identification of themes in a single case study, during the first order of analysis and then across cases in the second order of analysis. The measures taken to demonstrate the validity of the research complete the chapter.

In Chapter Five, I present an overview of the dialogue between the lived experience of each mother and psychological constructs found in literature. This dialogue emerged during the analysis and the strong association between Attachment Theory, Coping Theory and Social Support Theory. The relationship between attachment theory and society's socially constructed views of motherhood are also

introduced. The chapter concludes by placing attachment theory in the context of current government initiatives to support parents in bringing-up their young children.

In Chapters Six to Eight, I present my interpretation of each mother's lifeworld and the theoretical dialogue which emerged during the analysis of each mother's transcripts. In assigning a chapter to each of the three superordinate themes, the reader is presented with "an understanding of the participant's point of view, and a psychological focus on personal meaning-making texts" (Smith & Osborne, 2003, p.79).

In Chapter Nine, the relevance of recent research and reports are examined, and the importance of the findings of this study and how it adds to existing knowledge is discussed. Recommendations are made for future research, for existing health services and for public perception and policy. An evaluation of the methodology is also given, as well as the contributions this study has made to the theories which emerged from the dialogue between the mothers' narrative and psychological constructs found in the extant literature. The strengths and limitations of the study are also considered. The chapter finishes with a personal reflection of conducting the study and how it has influenced the researcher's future aspirations.

1.9   Summary

This chapter began by discussing the origin of the study and the academic rationale on which the study was underpinned. The chapter progressed to detail how a narrative search strategy was conducted. The absence of research into the topic of this study has guided the examination of research which has extensively investigated the prevalence of PTSD within the military community. In looking at topic areas of research beyond the military, an insight was gained into the social, psychological and health factors that mothers and family members are exposed to when caring for an adult child with SMI or TBI. Although the scope of this chapter did not permit a literature review of all the topic areas which came into focus during the search strategy, the range of studies provided an insight which, when viewed in the context of the parent-child literature, guided the researcher to establish the academic rationale for the study, the aims and objectives of the study, the design of the study and the interview schedule.

The next chapter provides a background to the nature of combat injuries and the care pathway received by injured service personnel from the point of injury to the completion of their rehabilitation and discharge from service. I also provide an overview of the mental health service provided to armed forces personnel during their

military service and as veterans after discharge. The chapter finishes with an overview of the support provided by third sector charities to veterans and their families.

Chapter Two: Background

2.1   Introduction

In the previous chapter, an overview of the origin of the study was provided, along with the search strategy used to determine the academic rationale for the study, and a discussion of the papers which were deemed relevant to the aim of this study.

Part 1 of this chapter begins with the political reasons for the British Armed Forces' commitment to Op TELIC (2003-2011) and Op HERRICK (2001-2014), which serves to provide the setting in which the sons of each of the mothers sustained their TCI. Next, the nature and extent of the traumatic injuries caused by the Improvised Explosive Device (IED) are described. This is followed by the four levels of care which make up the trauma care pathway provided by the Defence Medical Services (DMS). The DMS is made up of the uniformed and civilian medical and dental personnel from all four services. The primary role of the DMS is to promote, protect and restore the health of service personnel to ensure that they are 'fit for task' or ready and medically fit to be deployed in the UK or throughout the world.

The trauma care pathway is comprised of the individual role of service personnel (Role 1), the role of the Medical Evacuation Recovery Team (MERT) (Role 2), care in the operational field hospital (Role 3) and the role of the medical repatriation of injured service personnel to the UK, followed by care at SO (Role 4), which was the primary hospital receiving injured service personnel in 2009, before moving to Queen Elizabeth Foundation Trust Hospital Birmingham (QEHB) in 2010. Part 1 finishes with a brief overview of the function of Headley Court Hospital, which was responsible for the long-term rehabilitation of injured service personnel.

In Part 2, the key influential authors and the reports which enabled the development of mental health services for veterans and their families are identified, as well as the deficiencies experienced by veteran amputees in meeting their orthopaedic and prosthetic needs.

In Part 3, I provide an overview of the primary veterans' charities and the functions they perform in supporting service personnel and veterans and their families.

2.2   Part 1

2.2.1   International Security Assistance Force: Mission in Iraq and Afghanistan (2001-2014)

On 12 September 2001, following the attacks on New York, Washington and Pennsylvania, the UN Security Council adopted its Resolution 1368. This condemned the attacks and stated America's intention to' take action' against all forms of terrorism under the Charter of the United Nations. However, the initial invasion of Afghanistan in October 2001 was not conducted with the authorisation of a specific UN Security Council Resolution. Instead, military action against Afghanistan by the United States and the United Kingdom was undertaken under the provisions of Article 51 of the UN Charter (Smith & Thorp, 2010). An International Security Assistance Force (ISAF) comprising British, American and other allied troops was deployed to Afghanistan (2003-2014) to support the North Atlantic Treaty Organization (NATO) mission which included training the Afghan National Security Forces (ANSF) comprising Afghan Armed Forces and Police (Simpson et al., 2014).

The deployment of British Armed Forces was part of NATO's wider operations in Afghanistan which commenced in 2006. At the height of its commitment in 2011, the force was more than 130,000 strong, with troops from 51 NATO and partner nations. The British Armed Forces commitment was 9,500 troops. By the end of the dual campaigns on 26 October 2014, a total of 2,985 British military casualties had been recorded. Seventy-one (2.4%) of these casualties had died of their wounds at Bastion Hospital (Damien et al., 2017). Although Op HERRICK was officially ended in 2014, there remains 500 British troops in support of the NATO train-and-assist mission (House of Commons, 2018d).

2.2.2   Combat Injuries

In 2009, combat operations were located in both Iraq and Afghanistan. This double commitment resulted in an increase in the number of injuries sustained by combat troops caused by ground-emplaced IEDs, also called Dismounted Complex Blast Injury (DCBI) an explosion-induced battle injury sustained by combat troops on foot patrol (i.e. dismounted) that produces a specific pattern of wounds (Ramasamy, Hill, Masouros, Gibb, Bull, & Clasper, 2010). The IED is designed to release a large amount of explosive energy at a short range, aiming to maim rather than to kill.

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Figure 2 illustrates the three distinct zones of injury, resulting in the destruction of traumatized soft tissue and the maximal stresses on the bone damaged by the blast wave of the IED.

Figure 2. The three major zones of injury following the detonation of an IED (Ramasamy et al. 2010)
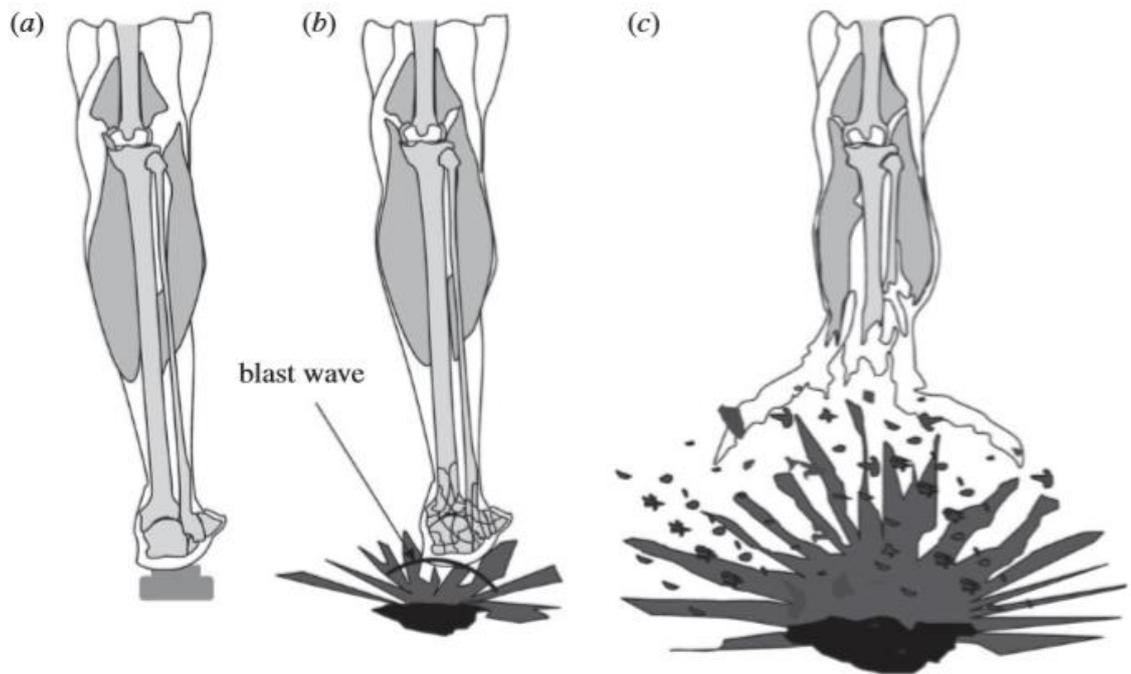
Upon detonation of an anti-personnel mine (a), a blast wave is transmitted to the limb causing a brissance effect on the bones (b). Some 1–2 milliseconds after detonation, the detonation products reach the limb and place huge stresses on the already damaged bone resulting in multiple fractures and potentially traumatic amputation of the affected limb (c) (Ramasamy et al., 2010). The typical injury pattern caused by a DCBI was characterized by amputations, especially of the lower extremities; massive abdominal, pelvic, and urogenital injury, often complicated by haemorrhage, (Ramasamy et al., 2010). Common polytrauma injuries included burns, hearing and eye injuries, and significant pain.

There were 178 deaths (135 due to hostile action and 43 from other causes) and 17 traumatic amputations during Op TELIC, along with 456 deaths and 275 amputations during Op HERRICK (MoD, 2017b). The 1982 trauma injury patients admitted to the BH field hospital had injuries to the extremities, with the largest number of injuries sustained to the knee and lower leg. Injuries to the head and neck accounted for just under a fifth of the injuries sustained. Within each of the injury categories, open

wounds, fractures and fragmentation/shrapnel wounds were the most common types of injury, regardless of the body region affected.

2.2.3 The military approach to trauma care

During military operations, serious casualties received first aid at the point of injury and were evacuated and treated progressively at several echelons of care. These echelons of care are more generally described as 'roles of care' and are set out in the Operational Patient Care Pathway (OPCP: MoD, 2014a) and "set out the protocols for treatment, evacuation, resupply, and functions essential to the maintenance of the 'health of the force' (Antebi et al., 2016, p. 88). In 2010, a review conducted by the House of Commons into how the MoD treated injury and illness arising on military operations congratulated the MoD in how it has "focused its medical care on trauma and has developed a highly effective approach to caring for casualties from the time of wounding through to rehabilitation" (House of Commons, 2010, p. 1). Table 6 summarises the different stages of the military approach to trauma care.

Table 6. The military approach to Trauma Care. (House of Commons, 2010)

Stage of Care	Military system
Individual protection	Body armour
First Aid	Troops trained to give basic first aid from the point of wounding. Use of tourniquet to help prevent blood loss Medical personnel deliver life-saving first aid focused on controlling blood loss
Helicopter evacuation to field hospital	Response teams bring the expertise of the emergency department to the casualty
Field Hospital	Casualties receive consultant-led care with surgeons in the emergency department team Bastion field hospital in Afghanistan is a special trauma centre
Evacuation to UK	Casualties are stabilised at the Bastion Hospital and then aeromedical evacuation to UK is undertaken.
UK Hospital care at Selly Oak	Military medical staff are integrated in the NHS hospital Casualties have access to specialist care at other hospital such as for eye conditions
Rehabilitation Headley Court	Provides unique rehabilitation facilities for soldier with serious and complicated injuries
Welfare	Military patients benefit from being together on the military-managed ward at Selly Oak, in Headley Court and at recovery centres throughout UK The department seeks to involve and support the family throughout hospital treatment Accommodation is available for families to visit patients at Selly Oak and Headley Court

The end-to-end journey made by trauma injured service personnel from first injury on the battlefield to the restoration of their health can encompass both clinical and non-clinical components. All casualties were under the care and governance of trained and specialist clinicians and the care was provided up to 2018 at HC. When injured service personnel were well enough to leave HC they have the choice to complete their care pathways in one of six recovery centres close to where they live. An overview of the trauma cnd-to-end trauma care pathway is illustrated in Figure 3.

Figure 3. End-to-end trauma care pathway of injured service personnel (Adapted from a diagram produced by the National Audit Office, 2010)

Trauma Care Pathway

Armed Forces (Defence Medicine)	First Responders	Emergency Care	Acute Hospital Care	Clinical (In-Patient) Rehabilitation	Community or General Rehabilitation
	Battlefield Casualty Treatment / Air Evacuation	Field Hospital (e.g. Camp Bastion)	RCDM, Queen Elizabeth Hospital, Birmingham	Headley Court (DNRC from 2018)	6 x Recovery Centres
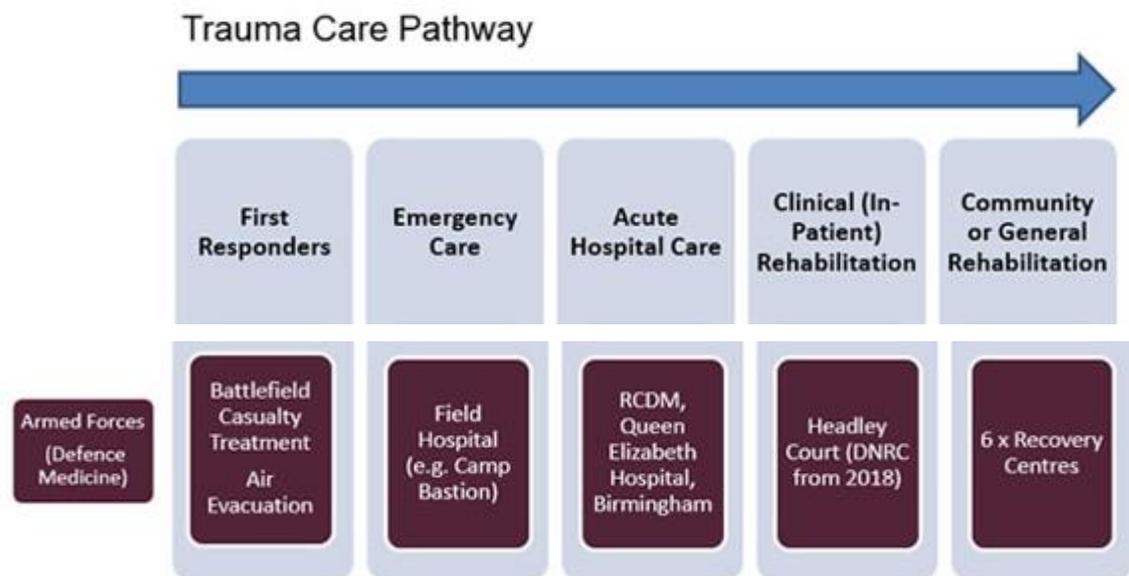
2.2.4   Role 1: First aid and physical protection at an individual level

Uncontrolled bleeding or exsanguinating hemorrhaginng is a critical pre-hospital step to managing trauma victims in military and civilian environments. The combat applied tourniquet Composite Resources South Carolina (CAT) was widely used by the British Army from the point-of-wounding to role 2 casualty care, in particular casualties with bilateral above knee amputations who were likely to require the application of four tourniquets. Prehospital tourniquet use was associated with improved hemorrhage control, particularly in casualties who had suffered TCI and contributed to an increase in survival rates in Iraq and Afghanistan campaigns, (Beekley, et al. 2008). Commercially available 'Ballistic Boxers', or Kevlar underpants, were introduced in 2010 to provide additional protection from blast injury (Wallace, 2012). However, despite the improved effectiveness of body armour, blast resistant ballistic goggles and improved Kevlar

Advanced Combat Helmets, a soldier's face and lower extremities were still vulnerable to traumatic blast injury (Hildreth, 2009; Nyein, et al. 2010).

2.2.5 Role 2: The Medical Emergency Response Team (MERT)

In Afghanistan, the MERT was exclusively delivered by helicopter, but the concept applies to air- or land-delivered teams. The team comprised consultants in anaesthetics or emergency medicine, alongside paramedics and specialist emergency nurses. The MERT was able to offer full pre-hospital anaesthesia, blood transfusion and sedation. It is difficult to attribute a single aspect of the MERT capability to the improvement in survival (Morrison et al., 2013). However, the introduction of MERT was associated with an improvement in patient survival when compared with other pre-hospital systems (Apodaca et al., 2013). Additionally, the introduction of senior medical staff to make key decisions, as well as how MERT enabled the early access of casualties to surgery at Role 3 (Wooley, 2017) was seen to have made a measurable contribution to an improvement in survival rates.

2.2.6 Role 3: Bastion Hospital (BH)

During these conflicts, the UK Defence Medical Services (DMS) implemented a healthcare governance programme aimed at improving the performance of the combat casualty care system (Hodgetts et al., 2007). Bastion Hospital was designed explicitly to respond to the early resuscitation and stabilisation of trauma cases, pending aero-medical evacuation to the UK, rather than for the definitive treatment of casualties (Vassallo, 2015). Service personnel who had been assessed as unlikely to survive their injuries during aero-medical evacuation received immediate surgery as part of the resuscitative process, before a full suite of diagnostic tests were completed. In addition to providing care to UK service personnel, BH also attended to all coalition forces, as well as Afghan National Security Forces and local nationals (Vassallo, 2015). The support elements within BH included emergency medicine, surgery, an intensive care unit, and medium and low dependency nursing care beds. The exact clinical contribution was constantly under review, being mission-tailored to provide the best mix of speciality and support services.

A significant number of British regular and reserve health professionals, largely drawn from NHS hospitals, contributed to the work of the trauma teams at BH, from training and research to the medical innovations developed by medical staff at BH during its operational lifetime. One such innovation which has had a significant impact

on trauma care training in the military and in the NHS was the Hospital Experience Training Programme (HOSPEX). This was introduced in 2003 following Op TELIC 1 and the recognition of the need to radically transform pre-deployment training to make field hospitals fit for role (Hayes & Ryan, 2011; Mercer, Arul & Pugh, 2014). The detail of HOSPEX can be read in a themed edition of the Journal of the Royal Army Medical Corps (Nadin & Mahoney, 2008). In summary, the HOSPEX system used training modelled simulations of casualty flows throughout the hospital to assist in the development of the skills of clinical and command staff, and the MERT, with emphasis on communication, situational awareness, leadership, followership and teamwork (Mercer et al., 2014).

2.2.7   Contribution to the advancement of trauma care

The innovations and medical protocols that emerged because of the medical challenges created in treating trauma injury transformed the clinical care of combat trauma patients. The systematic, multidisciplinary approach to trauma resuscitation, operation and post-operative care led to low in-hospital mortality rates at BH and contributed to an unexpected number of survivors, which was four times higher than trauma cases in the NHS (Russell et al., 2011).

The HOSPEX system has been replicated by other nations (Gill et al., 2015) and was critical to the safe operation of the DMS Ebola Virus Treatment Facility that was deployed to Sierra Leone in 2014 (Gibson, Fletcher, Clay, & Griffiths, 2016). The standard of healthcare delivered on Op TELIC and Op HERRICK, and the resultant patient outcomes, became the baseline from which DMS delivered trauma care on future operations and was largely attributed to the OPCP being managed as a single and coherent end-to-end healthcare system, from point of injury to SO Hospital in Birmingham (Role 4).

Advances in pre-hospital care on the battlefield in Role 1; resuscitation and blood transfusion in Roles 2 and 3; and rapid aero-medical evacuation to Role 4, as well as the experience and knowledge gained by surgeons deployed to BH, have led to the cumulative improvement in the probability of survival of the UK military casualties (Penn-Barwell, Roberts, Midwinter, & Bishop, 2015; Ramasamay et al. 2010). Parts of the trauma system of care implemented by the DMS were regarded as exemplary by the Quality Care Commission (QCC, 2012).

Moreover, the development of the approaches to trauma care have had a significant influence on the implementation of Level 1 Trauma Centres in the NHS in recent years. In the event of a major national incident, the MoD are called upon to make available personnel with recent operational experience from within the DMS to provide expert advice and guidance on the treatment of blast and high velocity injuries "These individuals would be able provide expert advice and guidance on treatment of these types of wounds in the fields of anaesthetics, emergency medicine, plastic and reconstructive surgery, general surgery, trauma and orthopaedics surgery, and radiology (NHS, 2017a, p.10).

2.2.8   Role 4: Selly Oak Hospital Birmingham

In response to this, in late 2006, the University Hospital Birmingham NHS Foundation Trust (UHBFT) was asked to provide a new military managed ward (MMW), in which the nurses and senior nurse in charge would be military personnel. This was highlighted in the views of Lieutenant General Viggers, the Adjutant General, after visiting the RCDM at SO on 21 August 2006, who stated that:

> wounded soldiers wanted to be looked after in a military environment within
>
> which they can be with their mates, be looked after by named military nurses
>
> and be treated like soldiers and which is essential for soldiers' physical and
>
> psychological recovery. (Report of the Iraq Inquiry, 2016)

Several years later, the care received by WIS service personnel during their recovery in SO was later extended to their family members, referred to by Lieutenant General Baxter at a parliamentary review:

> The very reason we refer to the thing we call "the patient group" is to make
>
> explicit the point that it is not just the patient; it is the family, loved ones, that
>
> group that has to be looked at as part of the clinical activity almost. That might
>
> sound not very good. It is to make sure that people recognise that the family are
>
> an integral part, that they are looked after. (House of Commons, 2010)

The needs of the patient group, which was invariably NOK and immediate family members, were met by the Defence Military Welfare Service (DMWC), made up

of civilians from the Red Cross. Additional support came from the unit of injured service personnel who nominated a 'visiting officer' (VO) to escort the NOK to SO. The VO provided an important link between the RCDM, the family and the patient's home unit. The Army Families Federation (AFF) was instrumental in meeting the cost of refurbishing flats opposite SO (originally built for doctors and nurses), so they could be used by the families of injured service personnel for the duration of their recovery in SO. Residential support was also provided for NOK by the Soldiers, Sailors, Airmen and Families Association (SSAFA) at Norton House (NH) established in 2009, while extended family members with accommodated in local hotels arranged by the VO (Thompson, 2011). This was of enormous support to the parents and immediate family members of injured service personnel by providing accommodation without cost for the duration of their stay:

> There are some families who understandably struggle when a loved one is badly injured and Norton Homes gives them time; time without the additional worry of hotel bills, and time with other families so they can support each other and make networks that can be lasting. (Bradbrook, 2016)

Fisher House UK also provided similar residential support close to SO:

> Fisher House enables families to quickly settle into a stable routine, knowing that their loved one is getting the best quality of care at the QEHB and they can remain close at hand. Each of the 18 spacious en-suite bedrooms is a haven for families; everyone equipped with a king-sized bed, fitted wardrobes, desk, chair and sofa bed. Outside is a private garden with space for children to play in, and guest parking is provided on site. (Fisher House UK, 2018)

Figure 4 gives a diagrammatical view of the sequelae of the patient care pathway and the various supporting agencies involved at QEHB.

Figure 4. Patient care pathway (Finnegan, 2015)
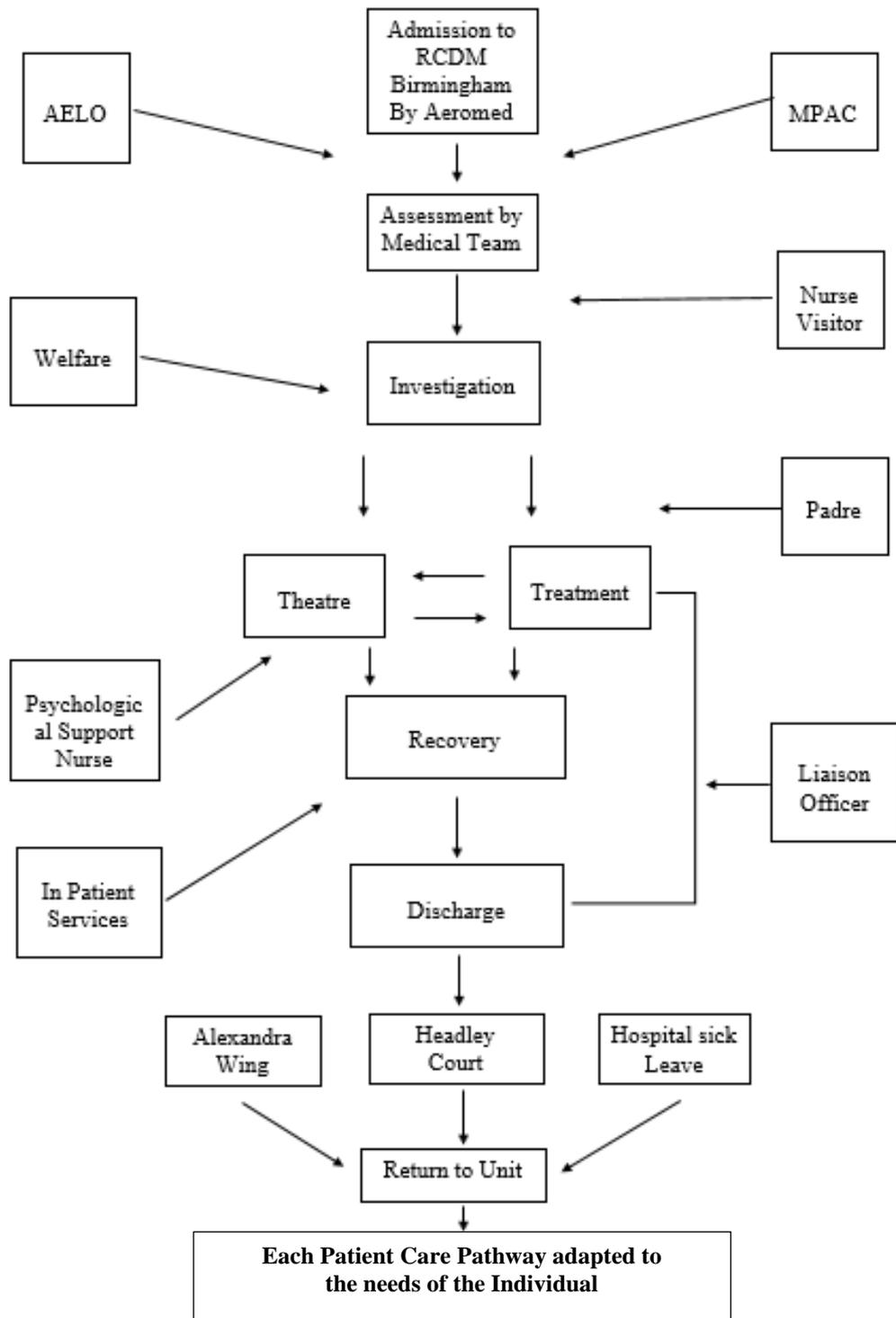
In 2010, RCDM transferred to the Queen Elizabeth Hospital Birmingham (QEHB), becoming the first acute hospital to be built in Birmingham for seventy years (NHS, 2015). Together RCDM personnel and NHS staff treat both military and civilian

patients. The new hospital gave service personnel access to clinical expertise needed to treat highly complex conflict injuries.

2.2.9   Rehabilitation and return to military duty

Although rehabilitation started at QEHB, service personnel requiring complex rehabilitation because of a single or multiple amputation returned home for a short period before admission to HC in Epsom, Surrey. Originally founded as RAF Headley Court after the Second World War for the treatment of injured RAF aircrew, HC has been operational for over 60 years and is part of the Joint Medical Command. The facilities at HC have been augmented by the MoD to provide nine specialist NHS facilities for the purpose of rehabilitation after amputation (Directory of Social Change, 2014).

The facilities and specialist practitioners at HC collectively support patients in regaining their independence and, where possible, their return to military duty. Patients were typically admitted for cycles of approximately four weeks of full-time in-patient rehabilitation, interspersed with periods at home. This process continued until such time that the patient had regained a high level of functional independence and was able to return to military service or discharge (NHS choices: Rehabilitation, 2017). The facilities at DMRC Headley Court were incrementally enhanced from May 2008 onwards, beginning with a government funded upgrade of its facilities at a cost of £28 million, which coincided with approximately 4,000 British troops' involvement in a major offensive against the Taliban. Between 2010 and 2012. The number of beds were increased to accommodate the increase in 'complex trauma patients' from 18 to 66 in a £21 million project funded by Help for Heroes and delivered by Capita (Capita, 2014).

A report published by the QCC in June 2012 recognised the care and rehabilitation given to patients at regional rehabilitation units and at the DMRC as exemplary (QCC, 2012). In February 2013, the UK Government committed £17.5 million to ensure that HC and nine specialist NHS facilities in England would be able to provide both injured personnel and ex-Service personnel with the most technologically advanced prosthetics available, where it is clinically appropriate (MoD, 2013a, p. 20).

2.2.10 Development of a defence and national rehabilitation centre

In 2015, the Government announced plans to replace HC with a new £300 million Defence and National Rehabilitation Centre (DNRC) located at Stanford Hall, near Loughborough (House of Commons, 2015). This much larger site was chosen because it

is geographically well placed to serve all parts of the UK, being close to the QEHB with transport links to the M1 and to East Midlands Airport. The Grade II listed stately home was bought by the Duke of Westminster in 2011, with the sole purpose of establishing Stanford Hall as a state-of-the-art rehabilitation centre. The Duke served in the Territorial Army between 1970 and 2012, rising to the rank of two-star general. After his death in 2016, his estate passed to his grandson, who inherited his grandfather's property empire worth more than £7 billion (Hope, 2015). Despite the late Duke's death, the MoD has stated that the new facility will still be due to open at the end of 2017. All Help-for-Heroes funded facilities will also be transferred to The Defence and National Rehabiliation Centre (DNRC) at Stanford Hall. This will be run by military and civilian consultant-led multi-disciplinary teams made up of prosthetists, physiotherapists, occupational therapists, exercise rehabilitation instructors, social workers and mental health staff. Together they will provide rehabilitation to military personnel and to the general public who have a wide range of musculoskeletal, complex trauma injuries and neurological conditions (DNRC, 2018).

2.3 Part 2: Overview of the development of current policy, context and commissioning, for injured veterans and for their mental health

2.3.1 Definition of Veteran

The UK defines a military veteran as "Everyone who has performed military service for at least one day and drawn a day's pay" (Burdett et al., 2013, p. 752). In the United States (US), the qualifying period to become a veteran is 6 months' service, which equates to the completion of the first phase of training. In a study conducted by King's Centre for Military Health Research, service personnel who had left the armed forces were more likely to identify themselves as veterans if they had served as regular personnel rather than in the reserves. This is in opposition to the official UK Government definition, and which does not reflect the public perception of veterans, which tends to focus on older ex-Service personnel and/or those who served in either of the World Wars (Burdett et al., 2013).

Based on responses provided in the 2016 Annual Population Survey produced by the Office for National Statistics, it is estimated that there are 2.5 million veterans living in Great Britain. Of these, 63% of the veteran population is estimated at being 65-years old or older and contribute to an estimated 190,000 to 290,000 of the "hidden" ex-Service community, living in communal institutions, such as residential nursing homes

(MoD, 2017a). In 2014 the size of the UK ex-Service community (England, Wales, Scotland and Northern Ireland), consisting of adult dependants and minor dependants living in private residential households, was estimated to be just under six million, at 5,913,000 people (RBL, 2014)

2.3.2   The Armed Forces Covenant

The Armed Forces Covenant was established in 2011 and articulates the view "The Armed Forces Covenant is a statement of the moral obligation which exists between the nation, the Government and the Armed Forces in return for the sacrifices members of the Armed Forces make" (House of commons, 2018a). The Covenant asserts that no member of 'The Armed Forces Community' (defined as current and former service personnel and reservists, and their families, including families of deceased service men and women) should face disadvantage when accessing public or commercial services. The Department of Health NHS Constitution was updated in 2015 to ensure that in line with Armed Forces Covenant "those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside" (NHS, 2015a).

2.3.3   The Defence Medical Services (DMS)

From April 2013, the DMS has been responsible for providing primary healthcare to all service personnel and entitled civilians through the Defence Primary Healthcare overseas (DPHC) organisation. The organisation is staffed by around 9,100 personnel (6,900 regulars and 2,200 reserves) and, in April 2014, provided healthcare to 159,630 UK regular forces personnel (MoD, 2014b). The number of regular forces personnel has reduced to 136,770 and relates to the targets outlined in the Strategic Defence and Security Review (SDSR, 2015).

2.3.4   Defence Recovery Capability (DRC)

The DRC is a set of residential facilities and activities established in 2010 to provide support to wounded, injured and sick personnel (WIS) to enable them to return to service or to prepare them for medical discharge from the Armed Forces. The establishment of the DRC was a joint initiative of the MoD, Help for Heroes, the Royal British Legion (RBL) and other charities (MOD, 2016). A key component of the defence recovery pathway is the personnel recovery centres (PRCs). These facilities were introduced in 2012 and are located inside or close to army sites. Each PRC

provides a residential base to enable veterans to access army facilities and support from the army, including existing medical, educational and other garrison facilities (GOV.UK, 2016). Delivery of the services provided by the PRCs is co-ordinated by the MoD through the Defence Recovery Steering Group (DRSG), which consists of service personnel, MoD staff, Help for Heroes and the RBL (RBL, 2018).

Support is given to DRC by members of the Confederation of British Service and Ex-Service Organisations (COBSEO). This provides a single point of contact for interaction with the Government, including local government, and the 'devolved administrations' of the Royal Household, the private sector and other service charities and organisations within the armed forces community (COBSEO, 2017).

The specific needs of military amputees were first highlighted in a report by Murrison (2011) in "A Better Deal for Military Amputees" in which the Government was criticised for how insufficient funding had created a crisis in NHS limb centres. The report's principal recommendation highlighted the urgency of specialist commissioning for the development and supply of prosthetics and the rehabilitation of veteran amputees. Despite the co-operation and shared views of a unmber of organisations, including the Minister of State for Health, the British Limbless Ex-Servicemen's Association (BLESMA), Help for Heroes, COBSEO and the Department of Health, a lack of support to veteran amputees continues to exist.

This lack of support is highlighted in two recent reports. The first of these was conducted by Fossey & Hacker-Hughes (2014) on behalf of BLESMA (discussed in Chapter One), and highlights the lack of progress in relationship to the prosthetic and care needs of veteran amputees and the impact of their needs on family members A later report in 2015, commissioned by BLESMA documented the personal experiences of ex-Royal Marine, Jon White, a former Royal Marines' Captain injured by an IED while serving on Op HERRICK in 2010. He lost both legs above the knee and his right arm at the elbow. This report is the first to have identified the shortfall of the provision of care to veterans, whose combat injuries have resulted in limb amputation, adding support to the claims made by Hynes et al. (2016):

> Trauma has without doubt a major impact on a veteran's life. Survival from traumatic injury leads to wounded soldiers and their loved ones having to face a lifetime of disability. The impact on the person and the family is often overwhelming. (p. 87)

The research discussed in Chapter One highlighted how veteran amputees may also suffer from PTSD. These veterans are, therefore, dependent upon the NHS not only for their continued orthopaedic care and the provision of prosthetics, but also for their MH. However, it is not known how many veterans, who have made the transition to civilian life, subsequently develop symptoms of PTSD or other MH disorder and, as a result, require specialised mental health services (Defence Committee, 2018a; Finnegan, Jackson, & Simpson, 2018). In addition, while it is understandable that attention has been given to service personnel, the overview provided in Chapter One and in the earlier sections of this current chapter, highlights the growing awareness that for every WIS of the armed forces regardless of nationality, the wives, husbands, sons, daughters and parents, are also affected by the stressors and challenges in the veteran's life (Bride & Figley, 2009; Lester et al., 2016; Sheppard, Malatras, & Israel, 2010).

2.3.5   The historical development of specific mental health services for veterans

In 2007, the Government announced a phased national rollout of improving access to psychological therapies (IAPT). The initial funding was allocated to train up to 3,600 new psychological therapists in using evidence-based psychological therapy services across England for people experiencing depression and anxiety disorders. The treatments offered continue to be those presently approved by NICE for treating depression, anxiety and PTSD (NHS, 2018a).

Building on the IAPT model of care for the general population, in 2009 the MoD and NHS piloted and evaluated six enhanced NHS IAPT services across England. This included South Staffordshire, London, Tees, Esk and Wear Valley and Cornwall, Scotland (Lothian) and Wales (Cardiff) comparing them with three other veterans' services provided by Combat Stress, Humber Traumatic Stress Service (NHS), and the UDR/Royal Irish Aftercare Service (Clark, 2011). Following the success of the first three years of the IAPT programme, the government made a further investment of 400 million pounds to enable the NHS to complete and extend the programme over the period 2011–2015.

In 2010, the MoD, in collaboration with the NHS Health Departments for England, Scotland, Wales and Northern Ireland, provided set-up funding for six regional community mental health services pilots for armed forces veterans. The pilots were a direct response to the perception that the NHS did not fully understand the needs of veterans. The aim was to determine what an effective, culturally sensitive, cost

effective and sustainable NHS-led mental health service for veterans would look like (Dent-Brown et al., 2010).

Although the evaluation of the six pilots highlighted how the range of interventions had contributed to veterans' improved mood and social adjustment, as well as the availability of staff who were themselves veterans and experienced in working with veterans, there was doubt about the efficacy of the IAPT model in meeting the broader spectrum of veterans' health needs (Macmanus & Wessely, 2013). Subsequently, the strategic health authority provided funding for two years (1 April 2011 – 31 March 2013) to implement the Military Veterans' Improving Access to Psychological Therapies Service (North West) (MV IAPT). This provided a range of clinical psychological therapies organised to address the specific needs of veterans who struggled to engage with local IAPT services and who were unwilling or unable to access their local primary care/IAPT services. An evaluation of the services conducted by Clarkson et al., (2016) revealed highly significant improvements on all measures with those veterans who completed treatment interventions, showing more and having higher rates of recovery from depression and anxiety than those remaining and those that did not complete their treatment interventions. Recovery rates compared favourably with evaluations of general IAPT services and in addition, exceeded reported natural recovery rates.

Shortly after the Dent-Brown et al. (2010) report, and prior to the MV IAPT, the NHS commissioned a review of mental health services for veterans by Murrison (2010). This set out how the NHS intended to establish twelve mental health services across England to specifically address their mental health needs, as well as directing them to the most appropriate services to support them during the transition from military life to civilian life. This later became referred to as the National Veterans Mental Health Network which became instrumental in making significant gains in acquainting more mental health professionals within the NHS in understanding the nature of service life, and crucially, they were able to support veterans in accessing the most appropriate interventions and support to meet their needs (NHS, 2018c).

The twelve mental health services continue to operate today and are geographically divided into three regions. The North of England is made up of four NHS foundation trusts (or partnership trusts) in Greater Manchester West, Greater Manchester and Lancashire; Yorkshire and Humberside; and Northumberland, Tyne, Wear and Esk Valleys. All except Yorkshire and Humberside report that they have

collaborative working arrangements with third-sector organisations, namely Combat Stress, Walking with the Wounded and the Royal British Legion (NHS, 2016a).

The three NHS foundation trusts in the Midlands all have some level of working arrangement with Combat Stress. Geographical coverage is North Essex, East Midlands and West Midlands. Services for veterans in the south of England are provided by five NHS foundation trusts (or partnership trusts). Geographical coverage is London, Berkshire, Avon and Wiltshire (South West), Surrey and Sussex. In Surrey, arrangements for veterans differ from the other four trusts, in that services are provided by Virgin Care on behalf of Surrey County Council. Additionally, some providers are partnered with third-sector organisations.

The service delivery and models of care provided by the twelve mental health services range in their scope and dimension and generally offer packages that reflect an holistic approach to mental health needs (NHS, 2016a). In most regions, this holistic approach includes assistance with housing, employment and social integration, in addition to specialist mental health support. All providers, irrespective of region, deliver specific psychological therapies including those recommended by (NICE, 2005) such as (cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing (EMDR).

The Centre for Reviews and Dissemination, at the University of York, funded by the National Institute for Health Research (NIHR), conducted an evaluation of the range of services and treatments provided by the twelve mental health services and their efficacy in relation to NICE guidelines (Dalton et al., 2018). In summary, the report identified a lack of standardisation. For example, several providers deliver a broader model of care such as integrated community mental health, early intervention and a range of veterans' liaison services. The report also gave "tentative support for the effectiveness of some models of care and certain treatments currently delivered in UK practice" (Dalton et al., 2018, p. 45). However, the interventions used for the treatment of PTSD, depression or anxiety by the twelve mental health services do not necessarily meet the guidelines set out by NICE (Dalton et al., 2018). Current NICE guidance on the management of PTSD (NICE, 2005) is being updated and is due for completion in December 2018.

2.3.6   Recent changes in the commissioning of services for veterans and their families

Health care (including mental health services) for armed forces personnel whilst still in service is provided by the DMS. Since 2014, services upon discharge (where these have been initiated by the DMS) are now funded by the DMS for six months after discharge. Responsibility for payment and provision beyond six months transfers to the NHS (Dalton, Thomas, Melton, Harden, & Eastwood, 2013).

The NHS conducted two NHS reviews between 2016 and 2017, firstly, the NHS England Strategic Review of Commissioning Intentions for Armed Forces and their families, and secondly, alongside the strategic review, was a stakeholder engagement exercise. The findings of both reviews underpinned the design of the NHS Veterans' Mental Health Transition, Intervention and Liaison Service (TILS) and the NHS Veterans' Mental Health Complex Treatment Service (CTS) which came into service in April 2017 (NHS, 2017c). Both the TILS and the CTS are available across England through four regional areas, including the North of England; the Midlands and East of England; London and South East of England; and the South West of England. TILS is a community-based service for veterans and those transitioning out of the British armed forces. Service personnel approaching discharge, as well as veterans, will be able to either self-refer or request referral via their GP or mental health provider. In addition, they can access the services through any of the primary veterans' charities. An initial face to face assessment will be offered within two weeks and, where appropriate, a clinical appointment two weeks later (NHS, 2017c). The service provides a range of treatment, from recognising the early signs of mental health problems and providing access to early support, to therapeutic treatment for complex mental health difficulties and psychological trauma. Additional signposting and advice will be offered, for example, relating to housing, finances and employment, reducing alcohol consumption, and social support. The service is targeted to treat about 6,000 patients per year for three years but is dependent on non-recurrent London Interbank Offered Rate (LIBOR) fine funding (Ashcroft, 2017).

The CTS is an enhanced service for ex-service personnel who have military attributable complex mental health problems that have not improved with earlier care and treatment. The service provides intensive care and treatment that may include (but is not limited to) support for substance misuse, physical health, employment, accommodation, relationships and finances, as well as occupational- and trauma-

focused therapies (NHS, 2017a). A comprehensive description of how both services will be delivered can be seen at the NHS Choices website. An additional component of both services, not previously available in the Veterans IAPT or through the twelve mental health services, is how the range of services and treatment will be extended to give access to family members, rather than access via their family GP (NHS, 2017b). In addition to the introduction of TILS and CTS, THE MoD and NHS England continue to work together a range of veteran mental health charities, in order to develop models of care to deliver common approaches to assessment, stabilisation and mutual understanding of roles and responsibilities along a patient pathway (Ashcroft, 2017). This strategic approach is still in the process of achieving its aims. In time, it may be successful in addressing the lack of standardisation in models of care and their efficacy, as identified by (Dalton et al., 2018).

Health care (including mental health services) for armed forces personnel whilst still in service is provided by the DMS. Since 2014, services upon discharge (where these have been initiated by the DMS) are now funded by the DMS for six months after discharge. Responsibility for payment and provision beyond six months transfers to the NHS (House of Commons, 2018a).

2.3.7   General Orthopaedic care: 'Getting it Right First Time' GIRFT)

The aims of GIRFT are to drive improvement in the quality of care, and consistency in the standard delivered to the general population, against the cost of delivering that care (GIRFT, 2015). The demographic changes and the increased health needs of the general population also highlight the simultaneous challenges faced by the present-day NHS in providing appropriate and cost-effective orthopaedic care to veterans are also highlighted in the report by White (2015), as well as the mental health needs of the wider veteran population, estimated in 2017 to be 2.5 million (MoD, 2017).

The origin of the GIRFT initiative began in research conducted by Professor Briggs, who is the national director for clinical quality and efficiency in the NHS. He was instrumental in highlighting the ways in which extensive savings and improvements could be made by hospitals in elective orthopaedics, to ensure continuing high-quality care and access for patients within the financial constraints of the NHS (Briggs, 2015). By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will contribute to an improvement in care and patient outcomes. This, in turn, will lead to efficiencies in the

reduction of unnecessary procedures, as well as cost savings (GIRFT, 2015). It is unclear, however, whether the orthopaedic needs of veteran amputees have been incorporated into GIRFT or whether veterans are considered to have a distinctly different set of needs and separate provision. Table 7 represent the measures used to evaluate the effectiveness of the GIRFT measures.

Table 7. Measures of effectiveness of GIRFT (Briggs, 2015)

Short Term	Medium Term	Long Term
Reductions in: • Prostheses costs • Loan kit costs • Re-admission rates • Length of stay • Surgical site infection	Reductions in: • National variation for procedures • Outliers in national registries • Infection/complication rates	Reductions in: • Revision surgery • Re-admissions • Litigation numbers and rates

2.3.8 Veterans Trauma Network (VTN)

The VTN was established in February 2017, with the aim of providing specialist reconstructive care, by using the full suite of 'wrap-around services and skills' available at ten regional NHS major trauma centres and associated centres (Ashcroft, 2017). Growing evidence suggests this is both efficient and effective use of specialist resources, as well as benefitting veteran patients. The VTN also has links to NHS mental health services, including the recently introduced TILS. The VTN also supports research and development of care through centres such as the Imperial College Centre for Blast Injuries Studies (NHS, 2018c).

2.3.9 Part 3: Charities support to service personnel and their families

Long waiting times for the delivery of MH support to spouse/partner or other family member remains primarily with the veterans' charity sector (Cole, Doherty & Robson, 2018; Defence Committee, 2018a). In 2010, volunteers supported more than 1,200 people in all branches of the armed forces, with the majority of referrals relating to families and children (Fossey, 2012). The Big White Wall (BWW) is a mental health and wellbeing service, offering safe, anonymous online support available 24/7. It was established in 2007 and is now commissioned by the NHS, local authorities, employers and universities (BWW, 2018). The service was extended to veterans and their families in 2010 to provide 24 hours a day, seven days a week telephone support.

In 2011, the number of armed forces' charities registered with the Charity Commission for England and Wales (CCEW) was estimated to be 1,818 along with 419 armed forces charities registered with the Office of the Scottish Charity Regulator (OSCR) and 25-armed forces charities in Northern Ireland (DSC, 2014). In 2011, there were 278-armed forces welfare charities registered in England and Wales. In 2012, these charities commanded 55% of the total income generated by charities in Great Britain equal to £479 million (DSC, 2014). The primary armed forces charities divide their activities into welfare services and service funds. The former provides services and/or grants to alleviate distress because of financial hardship, unemployment, homelessness, ill-health, disability, old age or other personal circumstances. Service funds charities provide advocacy, advice and signposting, financial support, peer support, respite, psycho-education, counselling and psychological therapies (Armed Forces Covenant, 2018). The support services provided by the primary charities for veterans and their families in the UK are listed in Table 8.

Table 8. The support services provided by the primary charities for veterans and their families in the UK (Verey et al., 2016)

Name of Veterans charity	Purpose of charity
Veterans UK and the Veterans Welfare Service	An MoD initiative which provides support to enable transition from service to civilian life, assist bereaved families or respond to life events that present welfare needs Third sector organisations providing multiple services for families of WIS personnel.
Help for Heroes (H4H)	Tri-Service organisation providing several interventions for families of WIS personnel, including funding interventions, support groups, respite care, family accommodation at rehabilitative facilities and psycho-education centres.
Sailors' and Airmen's Families Association (SAFA)	Tri-Service organisation providing support for families of WIS personnel, including support groups and networks, grants for adaptations and health and social care.
Royal British Legion (RBL)	Tri-Service organisation providing financial support to veterans, service personnel and their families, and a founding partner of the DRC.
Family Federations Naval Families; Federation Army Families Federation; Royal Air Force Families Federation	Each family federation provides: advocacy, lobbying, signposting and confidential guidance.

Financial assistance and grant making	
Army Benevolent Fund – The Soldier's Charity	Supports army regiments, corps, veterans, their families and relevant organisations by way of financial grants.
The Warrior Programme	Offers 3-day residential training sessions for relatives, dependants or carers of WIS personnel. Support received via services for WIS personnel.
Defence Medical Welfare Service (DMWS)	Provides 24-hour welfare support to families of WIS personnel who are receiving care at military hospitals, recovery centres and field hospitals.
Combat Stress	Offers a 'Partners' Day' and a series of psycho-educational groups via WIS personnel.
British Limbless Ex-Service Men's Association	Indirect signposting and support to family members. Family contact is made via the WIS personnel.
Veterans UK and the Veterans Welfare Service	A MoD initiative which provides support to enable transition from service to civilian life, assist bereaved families or respond to life events that present welfare needs. Third sector organisations providing multiple services for families of WIS personnel.

Insight to the efficacy of the services and interventions these charities provide was made available to the general public for the first time in 2015, with an 'Impact Evaluation Report', conducted by the Directory of Social Change (DSC). The results of this initial report provided the DSC with a substantial grant from the Forces in Mind Trust (FIMT), which enabled the DSC to expand the scope of their initial evaluation project to provide a series of six reports entitled *Focus On*. These reports have provided insightful analysis into the armed forces charities and the efficacy of the services they make available to their beneficiaries.

It is not within the scope of this chapter to discuss the DSC report in depth, however, the DSC identified that three-quarters of charities make provision for PTSD support; over half of charities make provision for depression and anxiety; and over two-fifths make provision for substance misuse. The most common form of provision, representing over two-fifths of charities, was counselling services, with a similar percentage of charities providing therapy services (Cole et al., 2017). Surprisingly, physical health provision accounts for a significantly larger sub-section of the armed forces charity sector than MH and education/employment, both in terms of the number of beneficiaries accessing support and the amount of charitable expenditure dedicated to delivering the provision (Cole et al., 2018). A detailed directory of support listing the

primary agencies, charities and organisations offering support is provided by SSAFA in their publication *Additional Needs and Disability: a guide for service families*.

2.3.10   Concerns regarding the number of charities and the efficacy of the services they provide

Concerns regarding the number of charities and the efficacy of the services they provide was first raised by Fossey (2011) and Murrison (2012) who together share the same views as those of Samele (2013) "nothing is known about the effectiveness, benefits or impact of treatment provided by the numerous voluntary sector services (e.g. Combat Stress) for ex-Service personnel" (p. 44). Some two years later, the concerns of Samele (2013) were echoed by COBESO (2015) "the work done by the Service charities including RBL, as effective as it is, could be more effective and more efficient. Greater rationalisation is needed" (p. 23). In an earlier report by Lord Ashcroft (2014) he was far more critical of the role of charities in supporting the transition of service personnel to civilian life:

> These charities range from the extremely large, such as one with an
>
> income of over £130m, to one-person ventures. They cover a huge
>
> spectrum of need, are a mix of general and niche provision, national
>
> organisations and local, and the very competent to the (frankly)
>
> ineffective. ... While individual charities may believe they are making the
>
> best use of funds as an organisation, collectively they are not.(p. 128)

These concerns are raised again in a third follow up report by Aschcroft (2017, p. 14), which refers to a key finding and states that "[i]t identified concerns about the way money is spent, the way charities are run, and fundraising techniques. One outcome is a steady loss in income, and this is certainly being experienced by some Armed Forces charities".

A recent study conducted by (Cole et al., 2018) on behalf of the DSC, concluded that, of the 1,200 armed forces charities registered in the UK, only 10% make provision for physical health. Moreover, this accounts for 121 organisations, serving over 250,000 beneficiaries. However, the report acknowledges the important contribution made by forces charities in how they provide a diverse range of services, which vary from

clinical to holistic approaches, and which are not readily accessed by veterans or their families through the NHS (Cole et al., 2018). Significantly, the number of charities highlighted in the report suggests a substantial decrease in the number of veteran charities registered with the CCEW in 2011, giving support to the claims and concerns made by Ashcroft (2017) regarding loss of income.

In relation to the standards of practice, evaluation and collaboration within the charity sector, Cole et al., (2017) make two significant judgments, which echo the earlier concerns made by, for example, Ashcroft (2014), Fossey (2011), Murrison (2012) and Samele (2013). The first of these judgments states that "survey data suggests that relatively few armed forces charities working in MH have engaged in randomised control trials (RCTs) as a way to assess the effectiveness of mental health services for beneficiaries" (Cole et al., 2017: p. ix). The second judgment made the claim:

> relatively few charities which deliver mental health services themselves
> also report implementing or working towards common guidelines or
> standards, such as National Institute for Health and Care Excellence
> (NICE) or Care Quality Commission (CQC) guidelines. (Cole, Robson &
> Doherty, 2017, p. xi).

These comments are troublesome and reflect the earlier claims made by Verey et al. (2016) that "it may be of benefit to the families of WIS personnel and the wider armed forces community if frequent, thorough evaluation of support services for families of WIS personnel were undertaken" (p. 345). The need for greater transparency and collaobraiton between veterans' charities and the NHS and MOD was called for some years earlier by the former British Army Chief of the General Staff General Lord Richard Dannatt:

> I think the issue that is perhaps most pertinent to the Service charity
> community is whether in fact there is a case to be made for better co-
> ordination and co-operation between the charities, so that there isn't
> overlap and that people aren't duplicating what someone else is already
> doing. (The Telegraph 2011)

2.3.11 Veterans' Gateway

The Veterans' Gateway (VG) is funded by The Armed Forces Covenant and is made up of a consortium of organisations and Armed Forces charities, including The Royal British Legion (RBL), SSAFA, the Armed Forces charity (AFC), Poppyscotland (PS),Combat Stress (CS) and Connect Assist (CA). Access to the services the VG provide is available 24 hours a day and 7 days a week and includes advice from a range of organisations covering issues from employment, finances and housing, to independent living, mental wellbeing, physical health and families and communities (Veterans Gateway, 2018).

2.3.12 The Armed Forces Regional Partnership Committees

In addition to veteran charities, a number of initiatives have been established by the Armed Forces Regional Partnership Committees that bring together local borough councils, charities and the MoD to establish local initiatives for veterans and their families. The support provided by the partnership includes: education; starting a new career; financial assistance; and access to healthcare (Hull City Council, 2018). Although Dalton et al. (2018), in their evaluation of services provided to veterans across the UK, referred to these as 'community initiatives', it has been difficult to gain public access to a history of the different partnerships which currently provide services to support veterans and their families throughout the UK. In addition, with the exception of those evaluated by (Dalton et al. 2018) to date, there has been no formal independent evaluation to determine the effectiveness of how their services are delivered to their beneficiaries, or as to the outcome of these services.

2.4   Conclusion

Throughout history, military conflicts have led to tremendous advances in medical care. This was no different during Op TELIC and Op HERRICK. The majority of combat injuries were primarily from blast and fragmentation trauma resulting from IEDs, with the extremities being more likely to be injured than any other body region. Several significant improvements have been achieved in the control of blood loss, transfusion, surgical procedures in theatre, aeromedical evacuation, pain management, and the training of surgical teams based in BH.

In the Role 4 stage of care, the collaboration between military staff and NHS nurses in running wards at SO exclusively occupied by military patients, and then the

subsequent transfer to University Hospital Birmingham (UHB), represented a step change in the medical facilities and improvements in care. Gains were also made in the design of prosthetics, as well as therapeutic interventions for patients with limb loss and other traumatic combat injuries during rehabilitation programmes delivered at HC.

The level of support provided to NOK and families during their stay at SO in 2009 also reflected the MoD's recognition of the impact that injured service personnel could have on family members. The combination of military liaison officers and Norton House and 'Fischerhouse' established by SSAFA, reflected the MoD's recognition of veterans' charities, and of how the traumatic injuries of service personnel recovering in SO had the potential to impose enormous stress on NOK and family members.

Although mental health support to amputees remained high during the course of their recovery in SO and their rehabilitation at HC, there is still an absence of information regarding the level of support given concurrently to NOK. The improved services and the level of specialist care for veterans is also available to the general population and came about as a result of considerable government investment.

In contrast, despite the research evidence discussed in Chapter One, and the accountability of the Armed Forces Covenant and the improvements in veterans' MH, support for their family members has not received the scale of innovation or speed of advancement as the improvements in trauma care introduced by the NHS. The MoD and the NHS has, however, come to rely upon the welfare services provided by veteran charities and the emergence of local partnerships to augment the veterans' IAPT services and the twelve mental health services. This over-reliance has, however, taken place, despite reports that have questioned the ethicality and efficacy of the services provided, or an absence of the outcomes to the beneficiaries these charities support.

Moreover, several very recent reports have cast doubt upon the efficacy of the services and the interventions provided by the primary charities and have questioned their unwillingness to engage in the evaluation of their services. In addition, although the introduction of armed forces partnerships in recent years has attempted to bring efficiencies to veterans in terms of accessing mental health support and welfare services at a community level, there is still a lack of evaluation regarding the outcome to their beneficiaries. Overall, despite the insights gained from reports by Ashford (2017) and the recent *Focus on* reports by the DSC in 2017 and 2018, it is unclear whether veteran charities and community partnerships plug a gap or merely duplicate the statutory services provided by the NHS. More importantly, the questions remain as to whether the

large amount of funds generated by the primary veterans' charities is in proportion to the outcomes of their services, and whether there is a lasting and health-changing outcome for their beneficiaries.

Although it was beyond the scope of this chapter to review the orthopaedic and prosthetic needs of veteran amputees, the most recent report by White (2015), as well as the introduction of GIRFT, strongly suggests a need for additional investment by the Government. This investment will help to provide the best possible support to veteran amputees and the challenges they face in adjusting to the use of prosthetics over the course of their life, along with the best possible support to benefit the family members who care for them.

The introduction of TILS and CTS in April 2017 is significant on several levels. Firstly, it suggests that the NHS has taken account of research evidence which supports the efficacy of family-centred interventions. Secondly, it represents an improvement in the efficiencies in service delivery and the standardisation of interventions available to veterans. Thirdly, and most importantly, the introduction of TILS and CTS addresses the shortfall that is long overdue in meeting the specific MH support for spouse/partner and other family members affected by their loved ones' MH disorders, discussed in Chapter One. A review of this type of intervention was beyond the scope of this chapter. However, family-centred care is discussed in the context of the findings of this study in Chapter Nine.

In the next chapter, the rationale which underpinned the choice of methodology is discussed, based on the insights gained from Chapter One, and which in turn guided the aims and objectives of this study.

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Chapter Three: The Methodology of the study

3.1   Introduction

Chapter Two provided the background to the study by outlining the nature of traumatic combat injuries and the care pathway provided to injured service personnel within theatre and after their medical repatriation to SO. The chapter also examined the type of MH support available to injured service personnel during their rehabilitation and to veterans and their families after they have left the armed forces. I also outlined the primary veterans' charities and the range of welfare services they provide.

This chapter is divided into three parts. In the first part, I outline my epistemological stance and its alignment with my initial subjective perceptions of the meeting I had with 'Veronica', discussed in Chapter One. I also discuss other types of prominent qualitative methodology and how they were unsuitable for the aims of this study. In the second part of the chapter, I provide a brief history of the two primary phenomenologist theorists and the fundamental differences in their approaches, and in the third part, I highlight the phenomenologists that have influenced Smith's methodological approach.

3.2   Part 1: My epistemological stance

3.2.1   Introduction

The academic rationale, as well as my personal and professional interest discussed in Chapter One, introduced the topic of this study to the reader. In this first part of the chapter, I introduce my epistemological stance, reflecting the views of Mason (2002) "usually a research topic will express something of the researcher's ontological or epistemological position" (p. 17).

3.2.2   The constructionist-interpretivist approach

Deciding upon the most appropriate qualitative approach required a close examination of my epistemological stance, given how qualitative methods emanate from multiple paradigms, each valid, and each with its own criteria for conducting and evaluating research (Creswell, 1998; Guba & Lincoln, 1994). A 'paradigm', according to Filstead (1979) , "is a set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organized study of that world" (p. 34). According to Morrow (2005), this requires paradigmatic knowledge to enable the researcher to 'anchor the paradigm'. This is achieved, according to Elliott, Fischer &

Rennie (1999) by "owning one's perspective" (p. 221), which involves stating one's guiding paradigm, methodology and personal orientation (i.e. experience with and expectations of the phenomena under study).

The most popular paradigms are positivism, post-positivism, constructivism-interpretivism and critical ideology. The constructivist–interpretivist approach facilitates a transactional and subjectivist stance that positions reality as socially constructed. According to Hamilton (1994), constructivism–interpretivism can be traced back to Kant's (1881/1966) *Critique of Pure Reason* in which he states:

> human perception derives not only from evidence of the senses but also from the
>
> mental apparatus that serves to organize the incoming sense impressions………
>
> human claims about nature cannot be independent of inside-the-head processes of
>
> the knowing subject (p. 63)

The views of Kant highlight a central tenet of constructivist thinking: "you cannot partition out an objective reality from the person or 'knower' who is experiencing, processing, and labelling the reality" (Sciarra, 1999, p.21). Another significant figure in the development of constructivism was Wilhelm Dilthey (1833–1911), who made the important distinction between Naturwissenschaft (natural science) and Geisteswissenschaft (human science) to help distinguish the positivistic and constructivist stances . The goal of Naturwissenschaft is scientific explanation (Erklaren), whereas the goal of Geisteswissenschaft is understanding (Verstehen) or the 'meaning' of social phenomena (Dilthey, 1989). This ontological distinction is critical to understanding the basic difference between positivism and post-positivism (and chiefly, quantitative methods) and constructivism-interpretivism (chiefly, qualitative methods).

3.2.3   Interpretive Phenomenological Analysis

My alignment with 'Verstehen' and its ontological link with constructivism, guided me in making "philosophical assumptions about the research and in the selection of the most appropriate tools, instruments, participants, and methods for conducting the study" (Denzil & Lincoln, 2005, p.15). My philosophical assumptions were best reflected by the IPA approach, "a methodology in its own right rather than simply a means of analysing data" (Smith, 2004, p. 34). Moreover, IPA mirrors the constructivist position in that they both require the researcher to engage in close, prolonged interpersonal

contact with research participants to access the participants' construction and expression of their 'Erlebnis' or 'lived experience'.

This close and prolonged relationship between the participant and the researcher is founded in the views of Dilthey (1989), who believed that the social world or 'lived experience' of the participant occurs within a historical social reality which might exist outside the immediate awareness of the individual but could also be brought to consciousness. It seemed, therefore, incoherent to eliminate value biases in such an interdependent researcher-participant interaction in which the IPA researcher brings the participants 'lived experience' to consciousness.

In Smith's IPA approach, bringing the participant's lived experience to consciousness is achieved during the participant's interview, and again, during the analysis of the participant's narrative in order to gain an insider perspective of the phenomenon being studied. At the same time, the researcher must acknowledge that he/she is the primary analytical instrument (Smith et al., 2009). This enables the researcher to "conduct a detailed examination of the participants' 'life worlds', their experiences of a particular phenomenon, how they have made sense of these experiences and the meanings they attach to them" (Smith, 2004, p. 43).

Philosophically, my epistemological stance has, therefore, been arrived at by bringing together the IPA approach, "offering a theoretical underpinning, a set of methodological procedures and a corpus of studies" (Chapman & Smith, 2002, p.126) with the constructivist-interpretivist research paradigm (Schwandt, 2000). This stance seeks to answer "questions about what happens, why and with what effects at these different levels" (Green & Thorogood, 2018, p. 4). Moreover, in the role of researcher, this interconnectedness guided me in how to "approach the world with a set of ideas, a framework (ontology), that specifies a set of questions (epistemology) that he or she then examines in specific ways (methodology)" (Denzin & Lincoln, 2002, p. 18).

3.3   Other types of qualitative methodology

Before selecting IPA as a suitable methodology for the aims of this study, it was important to consider other types of qualitative methodology. These range from intuitive and non-fragmenting methodologies, such as 'immersion' and 'crystallization' (Smith, Jarman & Osborn, 2008), to those that code data within strict frameworks, such as some types of discourse analysis and grounded theory techniques.

3.3.1 Discourse Analysis

Discourse Analysis (DA) emerged during the late 1980s as a radical critique of the current mainstream social psychology and social cognition (which in turn had arisen from a rejection of Behaviourism). Most types of DA have tended to focus upon the function of language within specific contexts. Like Behaviourism, DA limits its focus to the observable (in this case, linguistic behaviour). Its approach demands a discursive psychology and constructs a textual ontology.

Two approaches to DA exist: Discursive Psychology and Foucauldian Discourse Analysis. Both approaches emphasise the importance of language (Billig, 1997). The former examines the way in which linguistic resources are used in social interactions, and what means they serve within these interactions. In other words, language is seen as a form of social action (Coyle, 2007a; Smith et al., 2009). Foucauldian Discourse Analysis, on the other hand, explores the power relations and dominant discourses which underpin how people talk (Coyle, 2007a). This means that the links between discourse and 'real-world' actions are difficult to make, because the 'real-world' can only be understood as a construction (Edwards et al., 1995). Although DA has demonstrated itself to be a powerful deconstructive tool, several academics claim it struggles to offer a viable basis for intervention in the world despite the valuable gains it has made (Cromby, 1999; Willig, 1999). This is contrary to IPA, which offers applied researchers the opportunity to integrate research and practice (Duncan, Hart, Scoula, & Bigrigg, 2001; 2001; Golsworthy & Coyle, 2001).

3.3.2 Grounded Theory

This aims to develop theory that is grounded in the qualitative data collected from participants, with a view to "generating a focused understanding of the research problem and an (ultimately) coherent account addressing it" (Pidgeon & Henwood, 1997, p.256). This may involve developing explanations for participants' accounts (Smith et al., 2009), which, given the aims of my study would fail to provide depth and breadth to the mothers' phenomena.

Researchers have also modified the grounded theory approach (Glaser, 1992; Strauss & Corbin, 1990) emphasising the various data-analytical strategies that can be used. Glaser & Straus, (1967) attribute the lack of consensus about the objectivity and ontology of grounded theory amongst researchers to how "the constant comparative method is not designed (as methods of quantitative analysis are) to guarantee that two

analysts working independently with the same data will achieve the same results" (p. 103).

3.4   Part 2: A brief history of Phenomenology

Unlike Discourse Analysis and Grounded Theory, Phenomenology is both a philosophy and a family of research methods concerned with exploring and understanding human experience (Langdridge, 2007). Within nursing literature there exists two main phenomenological frameworks rooted in the 20th century philosophical traditions of Edmund Husserl (descriptive phenomenology) and Martin Heidegger (interpretive phenomenology) (Lopez & Willis, 2004). Both approaches share the common outcomes of knowledge that reflect insights into the meaning of the phenomenon under study and the researcher's willingness to listen to the descriptions of the lived experiences articulated by the participants.

Edmund Husserl (1859-1938), a German mathematician, founded the philosophical movement of phenomenology. Husserl believed that it was important for the researcher to shed all prior personal knowledge and suppositions so that attention was given to the lived experiences of those individuals being studied (Creswell, 1994; Natanson, 1973). To understand the world, specifically lived experiences, scientifically requires *das unmittelbare schen* (direct seeing), which Husserl described in *Ideas: pertaining to a pure phenomenology and to a phenomenological philosophy*, as "not merely sensory seeing of experience, but seeing in general as the primordial presentative consciousness of any kind whatsoever" (Husserl, 1913/1980, p.84).

The researcher achieves this condition of consciousness by abandoning his or her own lived reality so that the phenomenon can be described in its pure form. This is facilitated by bracketing, which relies upon the researcher consciously and actively seeking to resist the influence of his or her prior experiential knowledge and personal bias (Tymieniecka, 2003). In doing so Husserl asserts "one must have the courage to accept what is really to be seen in the phenomenon precisely as it presents itself, rather than interpreting it away" (Husserl, 1913/1980, p. 257). This reflects Husserl's belief that the participants are the experts in the phenomenon being investigated and at the same time bracketing enables the researcher to become aware of their prior knowledge and biases.

Husserl's view of phenomenology was further developed into existential philosophy and hermeneutics by his follower, Martin Heidegger (1889-1976) who like

Husserl was also born in Germany. However, although both shared a concern for human experience, Heidegger was openly critical of the way Husserl represented phenomenology, in particular his fundamental emphasis on description rather than understanding (verstehen) (Cohen and Omery 1994). Heidegger considered that the primary focus of philosophy was the nature of existence (ontology), "one must think beyond the statement to the experience itself …to that which strives to be brought forth in language" (Freeman, 2008, p. 387). Husserl's focus was on the nature of knowledge (epistemology) (Cohen and Ornery 1994).

In adopting an ontological stance Heidegger states in *Being and time* (Heidegger, 1962) his reasons for rejecting reduction or bracketing and why he favoured the study of *being-in-the-world*, in which "hidden meanings were sought and interpreted within their respective contexts" (Gearing, 2004, p. 1431). Put more simply "to emphasize how hermeneutic inquiry should focus on what the individual's narratives imply about what he or she experiences every day" (Lopez & Willis, 2004, p. 729) Heidegger also used the term *lifeworld* to express the idea that "individuals' realities are invariably influenced by the world in which they live" (Lopez & Willis, 2004, p. 729). For Heidegger this requires the researcher to call upon their prior understanding or fore-understanding, "one needs to comprehend the mind-set of a person and language which mediates one's experiences of the world, in order to translate his or her message" (Freeman, 2008, p. 386). This not only replaced Husserl's reliance on bracketing (Dahlberg, Drew & Nystrom, 2008) but also, according to Johnson, (2000) emphasised Heidegger's view about the role of the researcher:

> Understanding is never without presuppositions. We do not, and cannot, understand anything from a purely objective position. We always understand from within the context of our disposition and involvement in the world. (p.19)

In the IPA approach, this is achieved by the researcher striving to understand how the participants make sense of their experience through the idiographic data collected during the semi-structured interview (Smith et al., 2009; Giorgi, 2010), In addition, the researcher taking account of how the individual's predispositions influence their perceptions of reality and, therefore, their experience or encounter with a particular phenomenon (Smith & Dunworth, 2003).

3.5   Part 3: Phenomenologists who have influenced Smith's IPA approach

IPA was introduced by Jonathan Smith, in his seminal paper of 1996, as an alternative but complementary approach to the more established quantitative and qualitative methodologies in the psychology field (e.g. qualitative approaches such as Grounded Theory, Conversation Analysis and Narrative Psychology). Smith (1996) has applied IPA extensively in health psychology (e.g., Osborn, & Smith, 1998; Smith 1992; 1995, 1997, 1999), where it has established its suitability in relating research findings to bio-psycho-social theories that dominate thinking within the healthcare professions (Smith, 2004; Willig, 2001) in their interactions with the environment (Smith, Jarman & Osborn, 1999) and understanding the lived experience of a specified phenomenon (Smith, 2004).

The key theoretical perspectives of IPA incorporate phenomenology (phenomena), interpretation (hermeneutics) and idiography (Smith, 2004; Smith et al., 2009). These features are not unique to IPA, but the way in which they have been combined is unique, along with the specific emphasis and techniques used which identify IPA as "…intellectually connected to hermeneutics and the theories of interpretation… and combines an empathic hermeneutics with a questioning hermeneutics" Smith & Osborn, (2003, p.51). One fundamental assumption in IPA is that humans self-reflect (Smith, Flowers & Osborn, 1997; Chapman & Smith, 2002) and, therefore, the aim of the researcher using IPA is to explore this self-reflection by investigating an individual's experience, understanding, perceptions and idiosyncratic views (Reid, Flowers & Larkin, 2005).

The interpretative orientation of IPA draws on the theoretical perspectives of three hermeneutic theorists: Heidegger, Schleiermacher and Gadamer (Smith, 2007; Smith et al., 2009). Schleiermacher's theories had a significant influence on Smith's IPA approach. Schleiermacher was a theologian concerned with the interpretation of biblical texts. He proposed that a detailed and thorough interpretation of a text should be conducted by combining the grammatical or "the vocabulary and the history of an author's age together form a whole from which his writings must be understood as a part" (Schleiermacher, 1977, p. 113) with a psychological analysis (i.e. looking at *what* was said and *how* it was said). This, he believed, would reveal the meaning of the text while revealing something of the (un)intentional motivations of the original author (Moran, 2000a). This would find meaning beyond the immediate claims of the individual to "reveal more about a person than that person is aware of themselves"

(Smith et al., 2009, p. 22). According to Stiver (1996), this corresponds to what Schleiermacher describes as the 'hermeneutic circle', claiming that:

> we cannot understand the meaning of the whole text apart from understanding the meaning of the individual sentences, and even words, in the text. On the other hand, we cannot properly understand the individual parts apart from some grasp of the whole. (p. 89)

Smith (2007) assimilates this view proposing that in order "to understand the whole you have to look at the parts and to understand the parts you have to look at the whole" (p.5). For Smith, this enables the IPA researcher to explore the possibility of uncovering the existence of defensive structures and how these might influence the nature of a stressful encounter, by looking at the participant's narrative through an empathetic and critical lens.

Although Hans-Georg Gadamer criticises Schleiermacher, when examined carefully, Gadamer's view of pre-understanding and subjectivity is similar to that of Schleiermacher and, as noted by Graham (1993) in how Gadamer agrees with Schleiermacher's "brilliant comments of grammatical interpretation" (p. 113). However, Gadamer, (1986) makes the claim in his prominent work *Truth and Method* that Schleiermacher's main problem lies in his statement that the goal of hermeneutics is to "understand the author better than the author (participant) understood himself" (p. 169). Gadamer views the author's original intention in the interpretation of the text as "ultimately superfluous to hermeneutics" (Graham, 1993, p. 109). Moreover, Gadamer's perspective gives significance to the specific circumstances in which the text was written, as well as for whom the text was written. Gadamer further suggests that the researcher should attempt to put themselves in the place of the participant or author in order for the participant to gain a closer understanding.

Gadamer may have been influenced by Schleiermacher who gains a closer understanding of the participant by entering into the creative mind of the original author also known as "the authorial intent" (Stiver, 1996, p. 88), and which Smith reflects in his reference to intention. This similarity in approach by Gadamer suggests that far from dismissing Schleiermacher's psychological interpretation, Gadamer is in fact committing to the same, but gives priority to the reconstruction of the participant's mind and intention by recapturing the "perspective within which he has formed his views"

(Gadamer, 1985, p. 259-260). Gadamer (1993) describes this as a 'union of perspectives' in which "the focus of inquiry… is not on the author (participant) and how the author expresses those ideas but, on the interpreter, and how the interpreter apprehends those ideas in the movement of understanding and interpretation" (p. 112).

According to Graham (1993), Smith creates this "movement of understanding and interpretation" (p. 112) by incorporating both Schleiermacher and Gadamer's methods to gain the highest understanding of a text. This is described by Smith, (2004) as the 'double hermeneutic' in which "the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (p.40). Smith also adopts the empathetic view of Schleiermacher in how he advocates the use of several interpretive stances (Smith & Eatough, 2007).

These interpretive stances centre on either an empathetic hermeneutic or/and the critical hermeneutic. These can be used concurrently by the researcher asking curious and critical questions that further explore the experience of the participants. This takes account of the researcher's "existing conceptions, presuppositions, and previous experiences" (Smith & Eatough, 2007, p. 41), reflecting how Heidegger gave priority to the researcher's "prior understanding or fore-understanding" (Freeman, 2008, p. 393). Smith recognises that hermeneutics without phenomenology is interpretation without context and, therefore, that phenomenology and hermeneutics need to coexist to achieve a 'union of perspectives,' through philosophy, which Heidegger called the lived existence or "Dasein" (Smith, 2009, p. 76).

This opposes Husserl's view that phenomenology attends to the phenomenon itself, describing it as richly as possible standing alone as an extracted, uninfluenced entity. Heidegger later moved his focus away from 'being' as related to Dasein, towards 'being in general' and in particular "poetry as the key to understanding" (Landridge, 2007, p. 29). Moreover, Heidegger asserted that human existence is a more fundamental notion than human consciousness and human knowledge (Dahlberg, Drew & Nystrom, 2008). His philosophy makes it clear that the essence of human understanding is hermeneutic, in other words that our understanding of the everyday world is derived from our interpretation of it. Moreover, the hermeneutic component of IPA reflects the ontic qualities of 'Dasein' and the relationship between the individual's narratives and phenomenological psychology, and the ontological element associated with empirical

investigation, can "be achieved only through philosophy and at the heart of Heidegger's work" (Landridge, 2007, p. 29).

This view resonates strongly with the 'linguistic' component of IPA in that it moves beyond the technical forms of speaking that an individual might use to represent their lived existence or 'Dasein', by using 'metaphors' to add weight or potency to how the individual articulates their lived experience. This is an important component of Smith's use of hermeneutics in that the linguistic component represents a distinct level of interpretation which has the potential to reveal "the way in which the phenomenon is experienced within the context in which the experience takes place" (Smith, 2008, p. 28). In doing so, IPA enables the researcher to find meaning beyond the immediate claims of the individual and reveal more about a person than that person is aware of themselves (Smith et al., 2009).

In taking account of the individual's use of linguistics and metaphors, Smith's IPA approach highlights a key distinction from Husserl's approach, who brackets preconceived opinions in describing everyday conscious experiences (Dahlberg, Drew & Nystrom, 2008). In the IPA approach, researchers adopt a Heideggerian perspective in terms of how they attempt to identify their understandings of a phenomenon but also acknowledge that an awareness of these 'preconceived opinions' may not come to light until the phenomenon has started to emerge (Smith et al., 2009). IPA researchers are therefore encouraged to adopt a "sensitive and responsive approach to data collection and analysis that allows the researcher's preconceptions to be prodded and adjusted by the data" (Larkin, Watts & Clifton, 2006, p.108). This careful attention to the cares and concerns of the participant creates a dynamic or cyclical form of bracketing (somewhat akin to the more familiar processes involved in reflective practice) which occurs as part of the research process (Smith et al., 2009).

3.6   Other Interpretive Phenomenological Approaches

Van Manen's approach to phenomenological research was strongly influenced by Heidegger, and subsequently by Merleau-Ponty, and brings together characteristics inherent in the descriptive and interpretive approaches to phenomenology (Cohen & Omery, 1994; van Manen, 1990). In the descriptive method outlined by Husserl, the researcher makes no interpretations. Rather, the researcher analyses the descriptions given by participants and divides them into meaningful statements identified as essential to the construct of the phenomena being studied. This enables the researcher to describe

the structure of the phenomena (Kleiman, 2004). Van Manen was also influenced by The Utrecht School of Phenomenology. This attracted a number of phenomenologically oriented psychologists, educators, pedagogues, paediatricians, sociologists, criminologists, jurists, psychiatrists and other medical doctors. This collection of scholars often produced "compellingly insightful, textual portrayals of concrete human phenomena" (van Manen, 2007, p. 23), which was also both evocative and poetic. This evocative and poetic style is reflected in how van Manen gives equal priority to interpretive and descriptive phenomenology to sensitively evoke meaning from the text This combined approach originated in the 'phenomenology of sensitive practice' fundamental to the Utrecht tradition (Kockelmans, 1987; Levering & van Manen, 2002). In adopting 'sensitive practice', van Manen (1990) aligns his interpretive approach to be:

> not unlike an artistic endeavour, a creative attempt to somehow capture a certain
>
> phenomenon of life in a linguistic description that is both holistic and analytical,
>
> evocative and precise, unique and universal, powerful and sensitive. (p. 39)

Moreover, van Manen (2017) calls upon 'artistic endeavour' to articulate the "descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying, explaining, conceptualizing, abstracting, or even attributing meaning to it" (p. 2). Although I gained a sense of what van Manen means by 'artistic endeavour' through 'sensitive practice', I sensed that the significance van Manen gives to the use of language had the potential to add something to the phenomenon beyond the meaningful extracts of his participants' phenomenological narrative. In this sense, van Manen's 'sensitive practice' and 'artistic endeavour' moves away from Schleiermacher's second aspect of psychological interpretation, in which the researcher endeavours to reconstruct the "perspective within which he has formed his views" (Gadamer, 1986, p. 259-260). Smith reflects Schleiermacher's approach to psychological interpretation in how he encourages the researcher "to take an active role" (Smith & Eatough, 2007, p.36), "employing a range of skills including intuition" (Smith, 2007, p.4). This allows the researcher to draw upon prior knowledge and insights to interpret and uncover hidden meanings within the individual's phenomenological text with the goal of producing a "vivid textual representation of the phenomenon" (Kleiman 2004, p. 9).

Discarding van Manen's approach is not to dismiss his view of 'phenomenology of practice' or his "methodological theme of the genesis and discovery of meaning" (van Manen, 2014, p. 282) as serendipitous insights, rather, in aligning my epistemological stance to the IPA approach of Smith et al. (2009), I reflect the views of Dowling (2007) "where knowledge is held with judgement, to a world of pure phenomena" (p. 28). In doing so, the practice of 'artistic endeavour' is replaced with the discipline of the 'what', 'when' and 'why', by establishing a dialogue with psychological concepts and "a set of methodological procedures and a corpus of studies" Chapman & Smith (2002, p.126) to enable the researcher to explore and understand the participant's experiences "as the very nature and essence of things in the social world" Mason (2002a, p. 14).

Comparing van Manen's approach also served to refute the criticisms of Coyle (2007b), who accused Smith's IPA approach as leading the researcher to become "analytically immobilized" and preventing him/her following "unexpected paths that can add depth to the analysis" (p. 27). Rather, the hermeneutic component of IPA represents "the manner in which interpretation through understanding is achieved by the circular process of continuous re-examination of propositions" (Rapport & Wainwright, 2006, p. 233). Crucially, this allows the researcher to analyse each participant's phenomenological text independent of each other, until the final stage of analysis. This final stage involves a cross-case analysis, which enables the researcher to build a picture of the general, as well as the particular experiences of the individual (Smith & Osborn, 2008). This feature of the IPA approach is endorsed by Hayes (1997) who argues that:

> on the one hand, we want to compare people's experiences, to find out what
>
> they have in common. Yet, on the other hand, we want to find a method which
>
> allows us to appreciate and acknowledge each person's own experience, and to
>
> recognise different viewpoints (p. 98)

These differing perspectives on the same 'phenomena' reflect the third component of IPA, referred to as idiographic, in which attention is given by the researcher to each participant's individual experience of the phenomena by "standing for, or representing, herself or himself" (Smith, 1997, p.189), Further, they enable the researcher to demonstrate their unbiased interpretation of the participant's 'Erblenis', and the importance of keeping each individual participant in the foreground of the

analysis (Smith & Eatough, 2007). Additionally, these idiographic accounts provide the depth and breadth of the phenomenon and the different forms it can take. This encourages the researcher to organise their thoughts and explore, within the bounds of what is feasible, in the context of the participants' lived experience of the phenomenon. In doing so, Smith et al., (2008)encourage the researcher to:

> capture as closely as possible the way in which the phenomenon is experienced
>
> within the context in which the experience takes place…to discern the
>
> psychological essence of the phenomenon.(p. 28)

3.7   Conclusion

This chapter has outlined my epistemological stance by looking at how it incorporates the research paradigm (constructivist-interpretivist) and how this is reflected in the philosophical underpinnings of the IPA methodology. I have also contrasted the IPA approach with two other popular qualitative research approaches, namely Grounded Theory and Discourse Theory and illustrated the differences which influenced my choice of IPA over the approach of van Manen. I have also sought to demonstrate how Smith's IPA approach has been influenced by Heidegger, Schleiermacher and Gadamer. In addition, I have emphasised Smith's use of the 'double hermeneutic' in which "to understand the whole you have to look at the parts and to understand the parts you have to look at the whole" (Smith, 2007, p.5).

This chapter has also examined how two distinctly different interpretive stances can be employed in using IPA: an empathetic hermeneutic and/or a critical hermeneutic stance (Smith & Eatough, 2007; Smith et al., 2009). Both interpretive stances give the researcher the option to understand the experience from the participants' viewpoint and, at the same time, ask critical questions that explore the participant's 'Erlebnis', as well as giving the potential to provide the researcher with a richer analysis and a more nuanced understanding of each participant's lived experience (Hayes, 1997).

In the next chapter, I describe the study design and method. I begin with describing the recruiting, selection criteria and gaining the consent of the participants, as well as the ethical considerations of collecting data from vulnerable participants. The structure of the interview schedule is discussed, in addition to the advantages and disadvantage of conducting two semi-structured interviews with each of the mothers. The practicalities of applying IPA are examined, with emphasis placed on the analytical

phase before the start of the study and on the author's reflection of how the stages of analysis were applied. Attention is also given to the author's preference for using a manual analysis of the data, rather than utilising computer-based programmes. Chapter Four is completed with a description of the measures taken which demonstrate the trustworthiness of the analysis.

Chapter Four: The Study Design

4.1   Introduction

In the previous chapter, I described my motivation for adopting IPA and how its qualitative, exploratory approach reflected an epistemological stance, which enabled me to "find out what is happening, particularly in little-understood situations…seek new insights…[and] assess phenomena in a new light" (Robson, 2002, p.59). In the current chapter, the design of the study is described in two parts. The first part covers the proposed design of the study up to the point of receiving academic and ethical approval for the study to begin, and in satisfying the transfer of the study from MPhil to PhD and subsequently moving the study from the University of Worcester to the University of Central Lancashire (UCLan). The second part of this chapter begins with the outline of the analytical method recommended by (Smith et al., 2009), followed by a description of my experience of applying the different analytical stages of IPA. This has enabled me to describe the analysis of each participant and the cross-case analysis with the benefit of experience, rather than the protocol set out by (Smith et al., 2009). This is a departure from the conventional way of presenting the research design of a study. Instead, it represents an accurate and transparent account of the difference between the proposed research design and how it was carried out, rather than how it should be carried out in advance of the study.

      This approach was important for two reasons. Firstly, it is a true reflection of what happened and, secondly, it documents how the phenomenological process is applied, rather than merely being a set of practical steps to follow. It is, therefore, not merely an explanation of how the analysis was to be conducted in advance of the start of the study, it is also a reflexive account. Additionally, for the reader and the experienced researcher, the approach facilitates a coherent link between the design of the study and the insight I gained from implementing the design protocols and the practical steps commensurate with the research paradigm discussed in Chapter Three. I begin Part One of this chapter by describing how the participants were recruited to the study.

4.2   Recruitment of participants to the study

4.2.1   Participant risk

Participant risk can be defined as the potential physical or psychological harm, discomfort or stress to human participants that a research project may generate (British Psychological Society: *Code of Human Research Ethics*, 2014). A particular concern of

my Institutional Ethics Review Board (IERB) was whether the costs of asking the mothers about their stressful event would be offset by the benefits of the knowledge gained by conducting the research (Brown, 2014). Consideration was, therefore, given to the measures that I would put in place if, during any of the mothers' interviews, they displayed signs of emotional distress. I therefore consulted a significant number of articles which offered guidance related to the ethics of conducting research on sensitive topics (e.g. Becker-Blease & Freyd, 2006; Collogan et al., 2004; Legerski, & Bunnell, 2010; Newman, & Kaloupek, 2009). Although a minority of participants in all of the studies had confirmed perceptions of psychological distress following trauma-related research, the distress appeared to be mild and transitory. Moreover, individuals who had experienced feelings of distress found their involvement in the research to have been positive and leaving them with no regret.

4.2.2   Purposive sampling

When using interpretative phenomenological analysis (IPA), participants are recruited according to criteria of relevance to the research question. This approach is referred to as 'purposive sampling', in which the group of participants share the experience of a condition, event or situation (Holloway, 2005). This view, taken by Holloway (2005), is also shared by Smith et al., (2009) "participants are selected on the basis that they can grant us access to a particular phenomenon under study. That is, they 'represent' a perspective, rather than a population" (p. 50). Priority was, therefore, given to recruiting mothers to the study, firstly, because of the context in which the study came to the author, as discussed in Chapter One and, secondly, because of anecdotal evidence provided by 'Veronica' that only mothers had assumed responsibility for the care of their injured sons. Additionally, 'purposive sampling' also reflected the views of Smith et al., (2009) stating that:

> by making the groups as uniform as possible according to obvious social factors
>
> or other theoretical factors relevant to the study, one can then examine in detail
>
> psychological variability within the group, by analysing the pattern of
>
> convergence and divergence which arises. (p. 49)

That is not to say that the experiences of fathers of sons who had been traumatically injured were disregarded, rather it emphasises the need for future research

to explore how fathers might experience the traumatic injury of their sons differently from mothers, and the effect this might have on the fathers' mental wellbeing.

4.2.3   The role of gatekeeper

In Chapter One, I described how I met with 'Veronica' after her presentation at the Ruskin University Veterans Conference. At this meeting, 'Veronica' agreed to undertake the role of 'gatekeeper' and, in doing so, was able to "grant or refuse access to the field" (Silverman, 2013a, p. 445). In this context, 'access to the field' referred to mothers who had experienced their son's TCI, and which Van Der Maren (1995) describes as access to "the subjective universe of the focal phenomenon" (p. 113). During the meeting with 'Veronica', I outlined the aim and objectives of the study, the risks associated with asking participants about sensitive and potentially distressing accounts, and also about where each mother would prefer the interviews to be conducted.

With the insight I had gained from extant literature, and the assurances I had received from the participants through the mediation of the 'gatekeeper' that they were able to respond to sensitive questions about their experiences, I applied for ethical approval through the University of Worcester Ethics Committee. In addition, I also followed the principles laid out by the British Psychological Society (BPS) in two publications: the *Code of Ethics and Conduct* (2009) and the *Code of Human Research Ethics* (2014). Furthermore, to support my application, I developed three primary protocols. Firstly, participants were excluded from the research if they were currently receiving therapeutic treatment or counselling, secondly, participants had to be able to meet the inclusion criteria listed in Table 10, and thirdly, in giving their consent to take part, each of the mothers would agree, if necessary, to the support made available to them during and after each interview, as detailed in Table 11.

Table 9: Participant inclusion criteria

1	They have a son who has sustained combat injuries
2	Feel sufficiently confident to discuss their experiences and deal with the distressful emotions which may emerge during or after interviews with the researcher.
4	A willingness to comply with the levels of support outlined in the research information sheet
5	Will not be involved in other research projects during the collection of data

Table 10: Levels of participant support

Level of support	Type of support
Level 1 (during interview)	Chaperone recruited from regional Ripple Pond group
Level 2	The Ripple Pond help-line accessible Monday – Friday 0900–1600 (interviews will be conducted between these hours)
Level 3 (during interview	Husband of participant (where applicable i.e. several husbands are retired and will be within easy reach of the participant's home address)
Level 4 (after interview: daytime hours)	Family GP (when level of distress is persistent and beyond the support of Levels 1 to 3
Level 5 (after interview: out of hours)	The Big White Wall (when level of distress is persistent and beyond the support of Levels 1 to 4

Although each participant was sent an information sheet via the 'gatekeeper', direct access to the participants via email and then by interview with the author was only allowed when ethical permission had been granted by Worcester University Ethics Committee. In addition, in accordance with the BPS *Code of Ethics and Conduct* (2009), all mothers gave their consent to take part based on the detailed information sheet they had received from me via the 'gatekeeper'. Before the start of each interview, participants were reminded that they could freely withdraw or modify their consent at any point in the study, as well as being able to request the destruction of all or part of the data that they contributed. All mothers were assured of their anonymity and gave their permission for anonymous data to be displayed as verbatim extracts in this thesis, and in academic journal publications, non-academic publications and conferences related to the findings of the study.

Although the 'gatekeeper' had received an expression of interest from nine mothers, after applying the inclusion criteria in Table 10, which was included in the participant information sheet, only 6 mothers were considered suitable to take part in the study. This number of participants conformed to the advice of Smith et al. (2009) "as a rough guide, we would suggest that between 3 and 6 participants can be a reasonable sample size for a student project using IPA. Indeed, many studies by experienced IPA researchers now have numbers in this range" (p. 51). A copy of the participant information sheet is at Appendix 2. A copy of the ethical approval is at Appendix 3.

4.3   Data collection and storage of data

Before the collection of data began, I adhered to the rules governing the security of data laid down by The University of Worcester during the initial part of this study. Upon the successful transfer of the study to the University of Central Lancashire (UCLan), I stored the digital recordings and electronic transcripts, including the participants' consent forms in a password-protected electronic file in accordance with the *Research Data Management Policy* (UCLan, 2016). In the event that parts of the research are later published, the anonymised processed data will be kept securely for a maximum of 5 years from the date of publication (BPS Practice Guidelines, 2016). Ethical approval for the study from UCLan is at Appendix 4. Before each interview commenced, participants were reminded of the nature of the study and of the ethical considerations and they were asked to sign a participant consent form (see Appendix 4).

Participants were also reminded of the interview topic and that, if they became distressed during the interview or at some time after the interview, the levels of support listed in Table 11 were available to them. Likewise, in the event of a participant becoming distressed during any interview, the interview would be suspended and only resumed if the participant gave their consent. During each interview, I monitored each mother's response to difficult questions, as well as gauging my own level of empathic response to sensitive areas of discussion during each interview. Moreover, I often paused to check with each mother that they were not unduly upset by the content of the interview, in addition to allocating enough time at the end of each interview to review any difficulties each mother may have experienced. I also used this as an opportunity to remind each mother of the support they had available to them and which they had agreed to prior to me seeking approval from my Institutional Ethics Review Board (IERB) at the University of Worcester.

4.3.1   Sharing of data and confidentiality

Several participants requested access to the findings of the study once it was completed, as they were interested to learn of other mothers who, like them, had similarly experienced their son's TCI and they were curious to see whether they had all shared common experiences. A summary report will be provided highlighting the key similarities and differences between participants, rather than a detailed reflection of each mother's narrative account.

4.3.2 The qualitative interview

In developing the interview protocol, Hill, Thompson, & Williams, (1997) encourage researchers to review the literature to determine what has been done before, so that they can build on previous research. For the current study, there was a complete absence of existing literature which had investigated the impact of a son's TCI on a mother's wellbeing. However, by examining injury and illness in the general population I was able to "focus on what remains to be known and think of new ways to examine old questions" (Hill, 2005, p. 10). The studies identified in Chapter One were, therefore, used to construct the aim of this study as well as help compose the interview schedule. The richness of the data analysis, according to Smith et al. (2009) is reflected in the depth and breadth of the interview with the participant:

> unless one has engaged deeply with the participant and their concerns,
>
> unless one has listened attentively and probed in order to learn more about
>
> their lifeworld, then the data will be too thin for analysis.(p. 58)

At the same time, the researcher must "avoid imposing their own structures and assumptions as far as possible" (Britten, 1995, p. 251). To facilitate this, I referred to the advice given by Smith et al. (2009), which suggests that "for adult, articulate participants, a schedule with between 6 and 10 open questions along with possible prompts, will tend to occupy between 45 and 90 minutes of conversation, depending on the topic" (60). This, in turn, would enable me "to follow the participant in novel and unanticipated directions as the story of their experience unfolds" (Smith & Osborne, 2008, p. 33). Additionally, given there was very little known in relation to the topic of the study I followed the recommendation of Bryman (2008) and Kyale (1996) in terms of the types of questions to use in constructing a semi-structured interview schedule. The interview schedule used for both interviews is in Appendix 6. The different interview schedules used for Interviews One and Two also served as a check list to ensure that the same areas of enquiry were covered with each mother, therefore adding to the rigour and validity of the data collection (e.g. Flick, 2014; Yardley, 2000).

Prior to seeking approval for the study, I had estimated the need for four distinctly different interview schedules, to coincide with the care pathway each son had received during their recovery and rehabilitation, as discussed in Chapter Two. However, it became clear from conducting the first interview with the first two mothers

that the areas of interest considered for inclusion in the second interview schedule had, for the most part, been incorporated in the first interview. Given the considerations discussed in relation to the sample size and how this might inhibit the practicalities of the analysis, I decided to conduct two rather than four interviews, since two interviews would "yield adequate data to allow in depth analysis of similarities and differences between cases" (Smith et al., 2009, p. 63). This also satisfied an important aim of phenomenological research, "to enter, as far as possible, the psychological and social world of the respondent" (Smith & Osborn, 2008, p. 57).

All interviews were conducted in each mother's home, which provided confidentiality and a place of security, as well as the availability of the support outlined in Table 11. Similarly, conducting the interviews in the participant's home demonstrated sensitivity to the ethical considerations regarding participant risk and the protocols implemented to support the participants during the interview should they become distressed. Conducting interviews in each mother's home was also sensitive to how important the interview environment was to each mother's sense of safety and comfort. This, and the use of open-ended questions during each interview, would encourage each mother to talk freely about their experiences and would also allow them to direct their responses to me. Conducting the interview in a public space would have had the potential to not only impede the interviewee in sharing their personal experiences by being in proximity to others, but also ran the risk of background noise compromising the quality of the recorded interview.

4.4 Analysis of data

Although I followed the guidelines laid down by Smith et al. (2009), I was mindful that "researchers conduct the analysis of narrative data in different ways" (p. 80). The stages of analysis recommended by Smith et al. (2009) are summarised in Figure 5.

Figure 5. Stages of analysis adapted from Smith et al. (2009)

This involves taking the themes identified in stage 3 and writing them up one by one. Each theme needs to be described and exemplified with narrative extracts followed by analytic comments from the author. Each theme gives a persuasive account that explains to the reader the important experiential items that have been found during the stages of analysis.

At this stage, the researcher can make notes about his or her observations and reflections about the interview experience or any other thoughts and comments of potential significance. They may focus on content (what is actually being discussed), language use (features such as metaphors, symbols, repetitions, pauses), context, and initial interpretative comments. It is useful to highlight distinctive phrases and emotional responses

Stage 4: Write up of themes

Stage 1: Multiple reading and making exploratory notes

Stage 3: Seeking relationships and clustering themes

Stage 2: Transforming notes into Emergent Themes

This involves looking for connections between emerging themes, grouping them together according to conceptual similarities and providing each cluster with a descriptive label. Themes are compiled for the whole transcript before looking for connections and clusters. Some themes might be discounted if they do not fit well with the emerging structure or because they have a weak evidential base.

The researcher engages in the hermeneutic circle in which parts of the transcript are interpreted in relation to the whole of the transcript. This is achieved by engaging with the exploratory notes in stage 1 rather than the transcript with the aim of transforming notes into emerging themes. This involves a concise phrase or code at a slightly higher level of abstraction which may refer to a more psychological conceptualization but remain grounded in the participant's account.

4.4.1   Stage 1. Transcription

All interviews were transcribed on the basis of 'everything audible', meaning that in addition to the basic conversation, hesitation, interjections, incomplete part words, repetitions, prolonged pauses and laughter were included. However, punctuation was kept to an absolute minimum to prevent an inadvertent change in meaning due to the transcription process. Punctuation was replaced by adopting a system of identifying pauses in the transcript by their different length. This reflected the natural way in which each participant responded to each question. All punctuation was omitted from the transcript except for the use of a question mark, when it was clear that a question was being asked by me or by the participant. Any obvious examples of 'part words' had the remainder of the word added in brackets, and any abbreviations (military or otherwise) used by the participant were replaced with the full word as well as the acronym. In addition, any inaudible portion of transcript was followed by '[inaudible]', rather than a question mark. Any hesitations, interjections or repetitions were also removed to provide a coherent conversational flow for the reader.

A pseudonym was selected to replace each participant's first name to maintain anonymity and the confidentiality of each participant. Additional pseudonyms were

used for the names of family members, friends, military personnel and organisations that might reveal the identity of the participants. These pseudonyms began with the first letter of the mother's study name (e.g. Jennifer: Julian, Jeremy, Jason, Jackie) and of the family names belonging to each participant. This was intended to help make connections and associations between each mother's narratives, as themes within each mother's narrative began to emerge during the initial stages of the analysis. All the interviews were transcribed and anonymised by following this same approach. A sample of Jennifer's first verbatim transcript before analysis is at Appendix 7.

4.4.2 Reflexivity practices during the analysis of data

My decision to write up this current chapter of my thesis after the analysis of all the participants' narratives was based on how I became aware of the need to embed the practice of reflexivity into the stages of analysis after the study had begun. The role of reflexivity is often absent from qualitative studies and the significance of it, therefore, can be underestimated or obscured to the novice researcher. "Reflexivity is often mentioned as being crucial in qualitative research but rarely taken really seriously" (Landridge, 2007, p. 58). As a novice qualitative researcher, I became aware of the contribution made by reflexivity at the point of transcribing Jennifer's first interview and how this contrasted with my immediate perceptions of Jennifer recorded in a reflective diary during my train journey home.

My decision to embed my reflexive practices in my description of how I conducted the stages of the analysis is intended to facilitate a coherent link between my expectation of conducting the practical steps recommended by (Smith et al., 2009) and my personal experience of interpreting each participant's narrative. In doing so, I intend to demonstrate the contribution made by reflexivity and at which point it had the most influence on the study. By maintaining a reflexive diary throughout the collection of the data and up to the point of writing up the study, the second part of this chapter is written to inform the reader of my experience of conducting the stages of analysis with emphasis on my engagement with the hermeneutic cycle in which reflexive action became an essential part of the interpretation of the participants' narratives. In doing so, I am holding myself accountable for the quality of the research and the claims that it makes. According to Seale (1999), "this accountability should be fallibilistic" (p. 6). The term 'fallibilistic' for Seale represents how the study should not attempt to position itself beyond judgement and should provide its audience with material upon which they

can judge it. In the role of researcher this required me to be neither "neutral, or objective, or detached from the knowledge" (Mason, 2002a, p.7). Guided by Seale and by Mason my first reflexive action was to avoid using computer software to assist me in the analysis of the participants narrative.

4.4.3 Computer Assisted Qualitative Data Analysis Software (CAQDAS)

As an undergraduate, I had become aware of a range of CAQDAS programs available to qualitative researchers. Within my institution, several senior lecturers had recommended the use of *NVivo*, "a commonly used software program" (Silverman, 2013, p. 265). However, in assigning this element of the analysis to a software program, I was concerned that I would divorce myself from reflexivity and, in doing so, prohibit my authentic engagement with phenomenology and the phenomenological theorists who underpin the IPA approach. The key benefit of using CAQDAS software is that it will organise narrative transcripts into codes or categories and subsequently sub-themes far more quickly than the manual approach, and additionally, it will enable the researcher to interrogate the various sub-themes and their associated 'meaningful extracts' far more quickly than via a manual approach. Although the time saving feature of using software was appealing, I was unsure how much time I would need to acquire the expertise to use the software, and also, how I would relinquish "the researcher's intuition in which the researcher takes an active role" (Smith & Eatough, 2007, p. 36), by "employing a range of skills" (Smith, 2007, p.4), as discussed in Chapter Three.

4.4.4 Stage 2. Descriptive and exploratory comments

In the first instance, the narrative content of Jennifer's transcript was transferred into a Microsoft Word table format, which was made up of two columns. Within the narrative, I used the Microsoft highlight function to identify line-by-line Jennifer's "descriptions, assumptions, sound bites, acronyms, idiosyncratic figures of speech and emotional responses" (Smith et al., 2009, p. 84). This was recorded by using the Microsoft Review function (see Figure 7). This gave me unlimited space in which to examine the highlighted meaningful extracts and their corresponding significance in detail. I quickly realised that if I had adopted the handwritten approach advocated by Smith et al. (2009), I would have limited the number of words to descriptively and conceptually explore each highlighted meaningful part of Jennifer's extract. This would have prevented me from giving significance to "passages of their narrative that resonate with the

phenomena and in doing so move to a deeper, more detailed, reading of the part" (Smith et al., 2009, p. 104).

During this stage of the analysis, I also began to allocate a code or short phrase to encapsulate a meaningful extract. This gave me a sense of having divided the whole of the narrative into more manageable portions and, in doing so introduced me to the 'matrix of relationships' (Richardson, 1963, p. 291) from which the mothers' phenomena became visible. At the same time this encouraged me to follow the recommendation of Ricoeur (1970) enabling me to explore the real underlying meaning of the phenomena with "a care or concern for the object and a wish to describe and not to reduce it" (p. 28). However, towards the end of this stage of the analysis, I became aware that the allocation of codes or short phrases to capture the essence of a 'meaningful extract' had become redundant. In place of codes, I began to rely upon my familiarity with the meaningful extracts and exploratory comments born from a prolonged engagement with Jennifer's narrative and exploratory and conceptual comments associated with the third stage of the analysis. Moreover, the code or phrase I had used initially had little resemblance to their original meaning. The relationship between meaningful extracts and the exploratory comments recorded in Microsoft Review is represented in Figure 6.

Figure 6. Pictorial view of the link between meaningful extracts and exploratory comments recorded in Microsoft Review

4.4.5   Stage 3: The Hermeneutic circle

The inquisition of the meaningful extracts in each group involved me interrogating the narrative again in order to gain further insight into its nature, meaning and origin (Eatough & Smith, 2008; Smith, 2004). Crucially, this moved the analysis beyond my tentative and speculative interpretation into making prospective links with "varied existing psychological theories, models or approaches" (Brockie & Weardon, 2006, p. 23). This reflected the inductive and iterative procedures of IPA, which are intended to help the researcher develop an initial 'insider's perspective' on the topic or phenomenon.

Taking 'the insider's perspective' is only one part of the analytic process. In addition, the researcher must also provide an interpretative account of what it means for the participant to have experienced their *Erlebnis*. This means that there is a balance of 'emic' and 'etic' positions in IPA. In the former (phenomenological, insider) position, the researcher prioritises the participants' essential view of their account "to produce a reading of the text that fits all important details into a consistent, coherent message, one that fits coherently into the context" (Diesing, 1991, p. 110). This process is referred to as the 'double-hermeneutic', which involves two interpretations. "[T]he first is the participant's meaning-making (interpreting their own experience), the second is the researcher's sense-making (interpreting the participant's account)" (Smith & Osborn, 2003, p. 51).

An additional feature within the hermeneutic cycle was the relationship between understanding the mothers' verbatim transcripts (referred to from this point on as the 'narrative'), and my interpretation of the parts of the narrative in relation to the whole of the narrative. According to Smith et al. (2009), the relationship between 'the part' and 'the whole' exists at a series of levels. These levels are described in Table 12. This stage of the analysis is also iterative and repetitive, and described by Rapport & Wainwight (2006) as "the manner in which interpretation through understanding is achieved by the circular process of continuous re-examination of propositions" (p. 233).

This continuous re-examination and self-critique also encouraged me to 'dwell' with the volume of data and become aware of "[w]hen we stop and linger with something, it secretes its sense and its full significance becomes… amplified" (Wertz, 1985, p. 174). The act of dwelling, according to von Eckartsberg (1998), is the process by which "phenomenology makes room for the phenomenon to reveal itself and speak its story into our understanding" (p. 49). In doing this, I became aware of how

'dwelling' was an additional and essential part of the interpretive and reflexive process, in that it encouraged me to re-examine provisional assumptions and experience "an extreme form of care that savours the situations described in a slow, meditative way and attends to, even magnifies, all the details" (Wertz, 2005, p.172). I also became aware that this approach resonated with how van Manen gives priority to descriptive and interpretive phenomenology in equal measure, as discussed in Chapter Three. This evolved naturally but, unlike van Manen, it did not reflect 'artistic endeavour', but instead reflected my sensitivity to the relationship between 'the part' and 'the whole.'

Table 11. Relationships between 'the part' and 'the whole'

The part	The whole
The single word	The sentence in which the word is embedded
The single extract	The complete text
The particular text	The complete oeuvre
The interview	The research project
The single episode	The complete life

Engaging with Jennifer's meaningful extracts throughout the different revolutions of the hermeneutic cycle, and by applying the 'double-hermeneutic', I became aware of a three-way conversation between Jennifer's representation of herself, through the events she gave significance to, her perceptions of herself and of others, and how she described her emotions evoked by different situations, and my fore-understanding to give interpretation and meaning to Jennifer's narrative. This three-way conversation, illustrated in Figure 7, is indicative of an interpretivist ontology which understands people and the world to be "interrelated and engaged in a dialogic relationship that constructs multiple versions of reality" (Shaw, 2010, p. 234). Seeking this version of reality for Smith et al. (2009) required me to 'look again' and ask if I had:

> experienced anything like this, then we might usefully dwell upon it for a
>
> moment and think about the life events that led us there. If this is beyond our
>
> experience, then we might ask what it tells us about the magnitude of such an
>
> expression for the participant. (p. 89)

This, in turn, echoes the insight of Schleiermacher (1998) whereby "everyone carries a minimum of everyone else within himself" (p. 92). Assessing the magnitude of such an expression was repeated until it "begins to discern configurations of meaning, of parts and wholes and their inter-relationships" (Eckartsberg, 1998, p. 50). These inter-relationships emerged from within the meaningful extracts of the participant and from within me and the activity of reflexivity. The interaction of the double-hermeneutic and reflexive practice is illustrated in Figure 7.

Figure 7. The interaction of the double-hermeneutic and reflexive practice
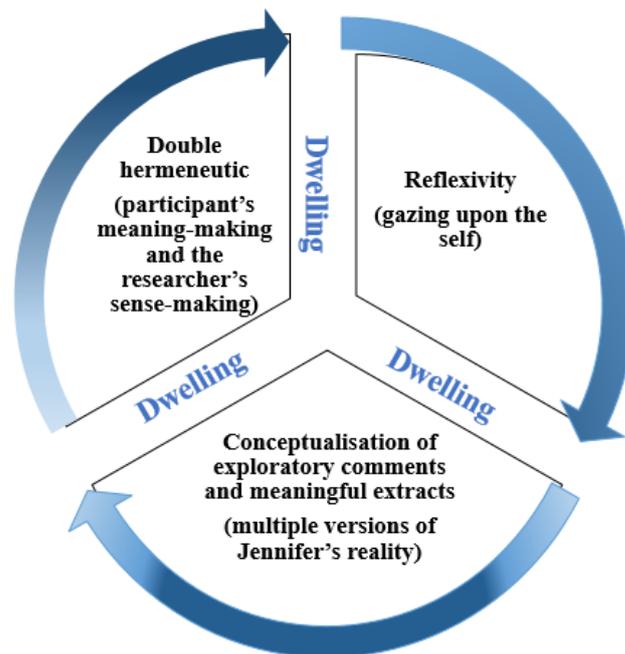
My awareness of this 3-way conversation was profound and brought greater acuity to the views of Woolgar (1988), who suggests that "the relationship between objects in the world and those who live in that world is no longer one of separateness: representation and object are not distinct, they are intimately interconnected" (p. 20). In Figure 8, the blue and yellow coloured text in Column 1 identifies parts or meaningful extracts provisionally identified for inclusion in Jennifer's first theme. Column 2 represents the codes associated with the theme. Column 3 represents the re-writing of exploratory comments recorded in Microsoft Review (concealed from view) and their meaning in relation to the highlighted extracts in Column 1. A sample of Stage 3 can be seen at Appendix 8.

Figure 8. Highlighted meaningful extracts, codes and synthesis of exploratory comments

Narrative	Codes	Exploratory comments and conceptual interpretation
Q: So you received the news by telephone? Yes. Q: Can you describe how that felt? Physically it would be true to say that I felt sick and completely numb…I went onto a sort of autopilot, was very calm. Jackie did say have you got anyone with you here and I said no I'll phone someone and she said I know Josh wants to phone you himself and so I checked out that she was okay and then she said I know Josh wants to phone you so I'll get off the phone now. She sounded calm and that's when I put the phone down and I felt sick and very numb and just sat there I also remember looking up and coming in here and just picking up things randomly and putting them down in odd places, no idea what I was doing,….I don't know what it was it was as if my brain had cracked and I would pick up a cup in the kitchen and leave it in the dining room, pick up an ornament and put it down somewhere else and rushed up stairs and that in fact happened after Josh had rang me. She did tell me that he had an injury that he was alive and all we've been told is that he has a broken arm and some facial injuries. I then had the phone call from Josh who I couldn't understand	Initial shock Disbelief Calmness of daughter in conveying the news. Physical symptoms of shock Moving objects erratically around the house Unable to understand what son had said	Jennifer's discussion with her daughter in law seemed to have been one that discussed the practicalities of who would contact who. Jackie seemed to have been the one who allocated tasks and therefore may have been much more in control of her emotions than Jennifer. Jennifer describes Jackie as being very calm which seemed in stark contrast to how Jennifer responded to the conversation with her son. Jennifer's inability to understand her son caused her to associate this with a level of facial injuries that in fact did not exist. She seemed to have panicked immediately after putting the phone down and between talking to her daughter again. This seems like a contradiction. On the one hand Jennifer recalls being very calm with her daughter in law and on the other hand that she felt like she was jumping around. Jennifer's use of the word calm might be describing a sense of numbness or disbelief and the jumping around might be referring to a heightened state of arousal and anxiety and therefore the precursor to distress. Jennifer's concern that she couldn't be on her own seems to support the above description of how she had responded to the telephone conversation with her son. That she was in a sense of panic or anxiety and felt a sense or need for comfort and reassurance from her close friend. At a conceptual level this calling out for help is explained by social support theory. Jennifer's need to have the company of a friend was perhaps because she was also unclear about how to make sense of her own behaviour and feelings and felt the need to be comforted by someone who she could trust. Jennifer's inability to understand her son caused her to associate this with a level of facial injuries that in fact did not exist. She panicked immediately after putting the phone down and between talking to her daughter again.

4.4.6 Stage 4. Seeking relationships and associations between themes

The provisional interpretation of the themes which emerged during the stages of the analysis can be seen in Figure 9. The table consists of the meaningful extracts identified in Stage 1 and 2 in the left-hand column. The codes that were initially allocated to them and in the right-hand column are a provisional write-up of the cluster of meaningful extracts in Column 1. This fourth stage of analysis was used to compose the write-up of Theme One. A copy of this is at Appendix 9.

Figure 9. Provisional write up of theme one

Meaningful extracts	Conceptual interpretation
"She did tell me that he had an injury that he was alive and all we've been told is that he has a broken arm and some facial injuries." "I felt sick and very numb and just sat there I also remember looking up and coming in here [conservatory] and just picking up things randomly and putting them down in odd places, no idea what I was doing." "……the predominant thing that was going through my mind was that I hadn't understood anything that he had said…there were facial wounds and they were just facial wounds and all around the face and I started to imagine all sorts of things." "……mumbling in the background was a feeling that mum wouldn't like the way I was behaving with a very sort of critical parental voice going on about don't be so wet don't be so pathetic get a grip." "I thought the only way I'm going to be able to do that is to get my friend to come round and help and support me." "And once I'd put that logical thought into my head and I'd phoned my friend in a way it had put a spoke into the spinning out of control feeling."	Jennifer responded to the schedule of questions and those questions which arose within the interview by discussing a number of critical events. For the majority of the interview these events centred around the moment she received the news from her daughter-in-law, her reaction to the news, her reaction after speaking to her son, how she regained her sense of self-control, her self-criticism of how she behaved, her fear of her son's facial injuries and how seeing her son informed her that she had imagined her son's facial injuries to be much worse than they actually were. While the initial level of distress Jennifer describes seems to have been significant it may in fact point to how Jennifer may have a propensity to adopt a narrow choice of options when processing information which has the potential to cause a heightened level of arousal and anxiety. In the context of this sub-theme Jennifer seems to have experienced at a conceptual level 'the stress response' which seems to have lasted for many hours from immediately after the conversation with her son until the next day when she visited him in hospital and was able to acknowledge that his facial injuries were minor cuts and grazes. Creating images of her son's facial injuries caused Jennifer to become distressed about how she would cope with not being able to recognise her son and how this might change their relationship. It is also important to highlight Jennifer's use of words and analogies to describe several key moments in her interview.

A summary of the four stages of the analysis are illustrated in Figure 10.

Figure 10. Summary of the four stages of analysis
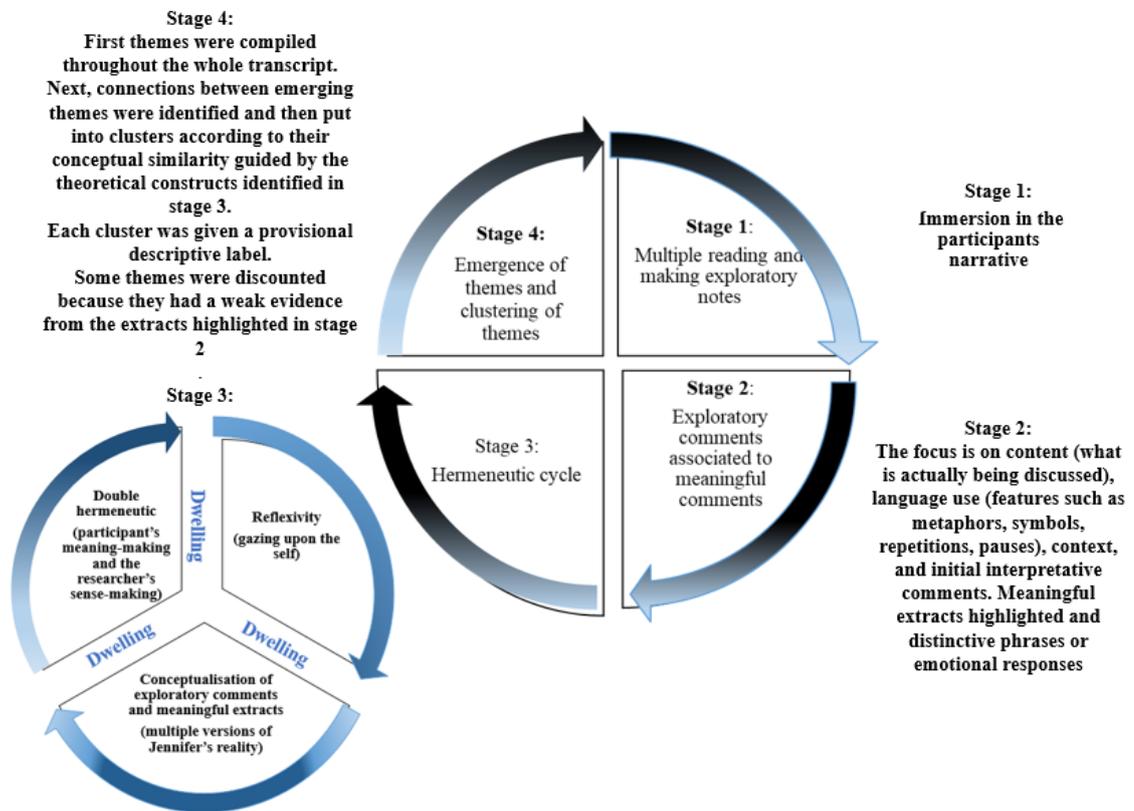
In searching for connections across emergent themes in Jennifer's first transcript, I called upon the four specific ways of identifying patterns between the themes recommended by Smith et al. (2009, p. 94). These patterns are briefly discussed next.

4.4.7 Abstraction

Abstraction involved putting like with like and developing a new name for the cluster of themes. This cluster was then assigned to a superordinate theme. This superordinate theme was later subsumed into the final stage of the analysis, which looked for similarities and difference across all the mothers' narrative accounts.

4.4.8 Contextualisation

Contextualisation was used to look at the connections between emergent themes, by attending to their 'temporal' and 'cultural themes' (Smith et al., 2009). This was related to particular 'critical events' in Jennifer's life before her son's injury and during the

'critical events' that Jennifer encountered during her son's rehabilitation. This enabled me to organise the themes that emerged from Stage 4 of Jennifer's analysis in terms of the temporal moment where they were located. This temporal and cultural perspective was shared by all the mothers.

4.4.9   Numeration

It was also possible to take account of the frequency with which the "themes identified in the analysis were supported by meaningful extracts" throughout Jennifer's narrative (Smith et al, 2009, p.98). This was related to the open-ended questions asked during Jennifer's semi-structured interview and the number of times Jennifer repeatedly referred to events, perceptions and her emotions throughout her interview. This strongly suggested the importance of these themes when the number of extracts or meaningful units for each theme were calculated.

4.4.10   Function

These criteria were also relevant to Jennifer's narrative, when "identifying connections and patterns between themes" (Smith et al., 2009, p.98). In analysing Jennifer's account, several themes emerged which demonstrated how Jennifer had presented an impression of herself which was different from the underlying meaning. Jennifer achieved this by the function of her language, which often called upon analogy intricately intertwined with her deeply held meaningful thoughts about herself. This function of making connections with themes was used with one other participant. All three approaches were used in making connections and associations between the themes that emerged from the final stage of Jennifer's transcript analysis. Except for one other participant, contextualisation and numeration were the primary methods used with the other four participants' narratives.

4.4.11   Stage 5: Writing up an interpretive summary of the participants' narrative

In organising the most relevant and important themes identified in Jennifer's narrative into three superordinate themes, I was in a position to write up an account of my understanding of Jennifer's narratives. I had begun this intuitively during the third stage of the analysis, in which I had refined the comments recorded within the Review function in Stage 2 of the analysis. This now represented a synthesis of the inter-relationships, connections and patterns between exploratory comments contained within the review boxes and the meaningful extracts from the first column of Jennifer's

narrative. This was applied to each of the themes that had emerged during the analysis of the whole of Jennifer's narrative, with each theme representing the output of the circularity of the hermeneutic cycle.

This large volume of comments required reduction, while, at the same time, preserving their overall meaning, which reflects the views of Smith et al. (2009), when they state "the task of managing the data changes as the analyst simultaneously attempts to reduce the volume of detail (the transcript and the initial notes) whilst maintain complexity" (p. 91). I felt it important to use the extracts which made up each of Jennifer's themes in combination with the large volume of exploratory comments compiled during Stages 2 and 3 of the analysis to provide a nuanced account of Jennifer's experiences. This contrasted with the advice of Smith et al. (2009), who view the write-up as "an attempt to produce a concise and pithy statement of what was important in the various comments attached to a piece of transcript" (p. 92).

4.4.12 Stage 6. Similarities and differences across all cases

In conducting a cross-case analysis of all the mothers' combined write-ups, I looked for 'sub-themes' that would "reflect the experiences of the group of participants" and capture "the quality of the participants' shared experience of the phenomenon under investigation" (Willig, 2008, p.61-62) and, at the same time, 'find ways in which the rich and divergent stories' are similar but also different (Smith & Osborn, 2003, p.73). This was attended to by applying the principle of 'reoccurrence' (Smith et al., 2009, p. 106). In this study, I decided that for an emergent or superordinate theme to qualify as recurrent, it must be present in at least "half of the mother's written up accounts" (Smith et al., 2009, p. 107), and I also felt that applying these criteria added to the validity of the findings. Table 13 illustrates the results of identifying recurrent themes across the three superordinate themes identified in the final stage of the analysis.

Table 12. Identification of recurrent themes

Superordinate Themes	Felicity	Lynn	Patricia	Sarah	Mary	Jennifer	Present in over half
The stressful event unfolds	√	√	√	√	√	√	√
The support of others	√	√	√	√	√	√	√
Life after the stressful event	√	√	√	√	√	√	√

The recurrence of themes throughout all the mothers' narrative accounts was strongly influenced by the temporal nature of the phenomena. All the mothers interacted with similar events (discussed in the Results and Discussion Chapters Six to Eight). Although they may have experienced these events in dissimilar ways, the differences served to provide a valuable instrument with which to measure the intensity and divergence of the mother's phenomenon. This was also evident in the dialogue which emerged between my interpretation of each mother's meaningful extracts and psychological constructs found in literature. This dialogue also provided the nuances to the mothers' similarities and differences, offering a triangulation of indicators to help guide me in identifying recurrent themes.

4.5   Evaluation of the stages of analysis

Given the limited consensus amongst qualitative researchers about a specific evaluation method applicable to IPA (Willig, 2008), I was guided by (Smith et al., 2009) who favours the 'four principles' approach of (Yardley 2000; 2008). This involves sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Before the start of the study I attended in part to the principle of sensitivity and context by familiarising myself with literature that had used IPA methodology. This attended to an important pre-requisite for when conducting qualitative study and how it was necessary for me to "have a fairly extensive grounding in the philosophy of the methodological approach adopted and the intellectual history of the categories and distinctions that have been applied to the topic" (Yardley, 2000, p.

120). I have demonstrated this in the previous chapter in describing the relationship between my epistemological stance and IPA methodology and the phenomenological theorists that underpin the IPA approach.

In describing the stages of analysis in the research design I have attended to Yardley's third principle, "the criteria of 'transparency and coherence' relate to the clarity and cogency and hence the rhetorical power or persuasiveness of the description and argumentation" (Yardley, 2000, p. 221). Similarly, Meyrick (2006) employs a 'transparent pathway'(p. 806) or audit trail as a means of demonstrating rigour in the research process. I have reflected both approaches in how firstly, I provide a detailed description of how I conducted the analysis of Jennifer's first interview, which became a standardised approach for the analysis of all the mother's transcripts and secondly, I have supported each stage of analysis with a sample taken from Jennifer's table of analysis and directed the reader to a sample of original copies contained in the appendices. This enables the reader to "retrace all the stages of the analysis, based on a complete set of coded transcripts, together with a description of the development of the codes and interpretation" (Smith et al., p. 243). The principles of commitment and rigour and impact and importance are discussed in Chapter 9, given these 2 principles of evaluation were only possible after the findings of the study came into view.

4.6   Conclusion

The design of this study was presented in two parts. The first part covers the proposed design of the study up to the point of receiving academic and ethical approval for the study to begin. The collection of data began with Jennifer's first interview.

In the second part of the chapter, I provide a detailed account of how the various stages of analysis were conducted. Additionally, in presenting the research design retrospectively I have been able to describe the analysis of each participant and the cross-case analysis with the benefit of experience gained from actualy 'doing' the analysis rather than follow the protocol set out by (Smith et al., 2009) in advance of the analysis. Heidegger's existential phenomenology, and his focus on 'Dasein' (being-in-the-world) also brings to the fore how reflexivity is inseparably linked to the stages of analysis when conducting IPA. This also reflects the views of Heidegger (1962), who argued that we experience new encounters as already interpreted, and how meaning-making is at the core of human experience, as well as our ability to actively make sense of our experiences. In making sense of my experience of conducting IPA research, I

engaged with reflexive practice, which brought together the double-hermeneutic and the constraints and affordances of my fore-understanding to interpret each mother's life world. This was revealed to me during the analysis of the first participant's verbatim transcript and was replicated with all transcripts thereafter.

I have also described how I employed the four specific ways of identifying patterns between the themes that emerged, after the stages of analysis had been applied to each participant's transcript. In addition, I have described how all six cases were examined for "convergences and divergences in the data" (Smith et al., 2009, p. 73). This was achieved by applying re-occurrence of the data (Smith et al., 2009), resulting in the formation of three superordinate themes and eight sub-themes to be presented in the Results and Discussion Chapters Six to Eight.

The stages of analysis I adhered to in applying IPA conform to practical and accessible guidelines to conducting research using the approach outlined by Smith et al. (1999), Smith & Osborn (2003) and Smith et al. (2009). In following these guidelines, I have also reflected the views of Smith (2004), who suggests that "one cannot do good qualitative research by following a cookbook…what determines the quality of the outcome is the personal analytic work done at each stage of the procedure" (p. 40). Within the IPA approach, the dialogue with psychological constructs begins to emerge during the hermeneutic cycle (Smith et al., 2009). These consisted of Attachment Theory, Coping Theory, Social Support Theory, Post Traumatic Growth (PTG) and the 'Myth of Motherhood.' This is discussed in detail in the next chapter.

Chapter Five: The psychological dialogue between the mothers' lived experience and literature

5.1   Introduction

In the previous chapter, I described the research design used to conduct this study. I gave particular attention to the stages of the analysis associated with IPA. I also presented a retrospective account of how I had applied the method of analysis prescribed by Smith et al. (2009) and how reflexive practice had been an integral part of my engagement with the participants' *lifeworlds* during my engagement with the double hermeneutic. This gave me further insight into the importance of the study, how I drew upon my fore-understanding and how my estimation of each participant had changed from my perceptions formed during their first interview and in conducting the transcription of the interview. I also became aware of how, during the second and third stages of the analysis, I had unknowingly assigned detailed descriptions and interpretations to the meaningful extracts identified in each of the participants' narratives, which is indicative of van Manan's 'phenomenological sensitivity.'(1990)

In this chapter, I draw upon the analytical approach of Smith et al. (2009) to demonstrate how there is capacity for linking the individual's experiential view of their lived experience with a psychological dialogue. This psychological dialogue emerged during the third stage of the analysis in which the hermeneutic cycle and reflexive practice combined to provide a provisional interpretation of each mother's narrative. This psychological dialogue was made up of Attachment Theory; Coping Theory; Social Support Theory; post-traumatic growth (PTG); and the 'myth of motherhood.' Although I had initially considered using one of several experiential frameworks with which to provide an additional interpretive lens, I subsequently discounted these on the basis that I chose to be guided by the phenomenological approach espoused by Yalom (1980):

> The proper method of understanding the inner world of another individual is the
>
> "phenomenological" one, to go directly to the phenomena themselves, to
>
> encounter the other without "standardised" instruments and propositions. (p. 25)

The phenomena of the mothers' lived experiences developed from the alignment of the mothers' descriptions of their lived experiences with the psychological dialogue, and simultaneously, with the continuous adjustments I made to the provisional interpretations I gave to each mother's lived world. This approach also reflects the

views of Smith et al. (2009) who acknowledge the coherence between the phenomena and the "extant psychological literature". This approach is also supported by Yalom, who recognises how "knowledge is impossible without some kind of previous conceptual structure" (Yalom, 1980, p. 25).

The coherence between the mothers phenomena and psychological constructs found in the literature enabled me to continuously test and adjust my interpretations, perceptions, and fore-knowledge discussed in the context of the hermeneutic cycle and reflexive practice in Chapter Four. In doing so this enabled me to identify the phenomena of the mothers' 'life worlds.' This gave acuity to the understanding and meaning each mother gave to their motivations, predispositions and responses to stressful events and emotions as described by them and also the dimensions of the mothers' phenomena. In the sections that follow, I orientate the reader to the participants' meaningful extracts and their experiential link to the different psychological constructs which emerged during the stages of analysis discussed in the previous chapter. I begin with an overview of the origin and concepts of Attachment Theory.

5.2   The origin and concepts of Attachment Theory

Attachment Theory originated primarily from research conducted into child development by Bowlby (1969; 1973; 1980), who proposed that children have a strong propensity to form an emotional bond with their parents or caregivers. This bond, or the attachment relationship, provides children with a sense of security, as children learn that they can look to the parent for comfort, protection or soothing when distressed, frightened or feeling threatened. A primary concept of Attachment Theory was the 'secure base' derived from the early attachment studies conducted by Ainsworth (1979), Ainsworth & Bell (1970), Ainsworth, Blehar, Waters & Wall (1978) and Bowlby (1969). Infants and young children who have become securely attached to their parents have been exposed to high levels of sensitive, protective and caring parenting, and use their caregiver as a secure base during times of exploration. According to Ainsworth (1979) "the presence of an attachment figure, particularly one who is believed to be accessible and responsive, leaves the baby open to stimulation that may activate exploration" (p. 935).

In contrast, infants and young children who regularly strive to maintain proximity with their absent caregiver are given fewer opportunities to engage in safe exploration. Reliable, consistent, reassuring responses from the caregiver will lead to a

'secure' pattern of attachment behaviour in the infant. Unreliable, inconsistent or neglectful response from the attachment figure will lead to 'insecurely' attached infants, exhibiting anxious and/or avoidant behavioural styles (Ainsworth et al., 1978; Cassidy, 1999, Mikulincer et al., 2011).

Children continue to rely upon a secure base as they progress through maturation and simultaneously gather important experiences that influence their social and emotional functioning (Ainsworth, 1979; Ainsworth & Bell, 1970; Ainsworth et al., 1978; Bowlby, 1969, 1973). In later years, however, as securely attached adolescents' transit into early adulthood, they develop a sense of autonomy and independence, and become less reliant on their secure base figure (Coble, Gantt & Mallinckrodt, 1996; Feeney & Thrush, 2010).

Historically, attachment researchers have assumed that one of the primary determinants of attachment organization is the proposition that maternal insight (Ainsworth, 1969) and maternal sensitivity (Ainsworth et al., 1978) determine the quality of the attachment relationship (e.g. Demers, Bernier, Tarabulsy & Provost, 2010; Koren-Karie, Oppenheim, Dolev, Sher & Etzion-Carasso, 2002; Meins, Fernyhough, Fradley & Tuckey, 2001). Maternal sensitivity is defined as the mother's ability to be aware of and interpret the infant's behavioural cues and the extent to which the mother or primary caregiver is available and responsive to the vicarious needs of the child in a timely and appropriate manner (Ainsworth et al., 1978; Feeney & Thrush, 2010; Mikulincer & Shaver, 2007). Moreover, this is a primary mechanism through which maternal attachment representations shape the quality of the infant attachment (Cassidy, 1994; Main, Kaplan & Cassidy, 1985) and is critical to the child's language, cognition and social-emotional development (Belsky & Fearon, 2002).

In contrast, mothers of infants with an insecure attachment are less sensitive in their response, because of a difficulty in reading the infant's behaviour, misattributing the intentions of their behaviour and/or an inability to see past their own perspective and reflect that of the infant. In a sample of 129 mother-infant dyads, Koren-Karie et al. (2002) found that mothers who were classified as positively insightful displayed significantly more sensitive behaviour than mothers who did not demonstrate a propensity for positive insight.

Maternal sensitivity is also fundamental in the development of the infant's mental internal working models (IWMs). The development of IWMs is essential in generating the infant's value of self and of significant others within his or her immediate relationships (Bowlby, 1969/1982). The infant also uses these IWMs to

guide and interpret their behaviour across a wide variety of interpersonal contexts (Bowlby, 1973; Bretherton, 1985; Main et al., 1985). In addition, more recent research has established how the functioning of these IWMs, can be revised and updated, based on new interpersonal experiences. This within-person variability is possible since people possess multiple models of self and of others, (Baldwin, Keelan, Fehr, Ehns & Koh-Rangarajoo, 1996; Klohnen, Weller, Luo & Choe, 2005; Mikulincer & Shaver, 2007). However, recent research conducted by Fraley, Roisman, Booth-LaForce, Owen & Holland (2013) and Gillath, Shaver, Baek & Chun (2008) has shown that attachment style is strongly influenced by interpersonal experiences in the family of origin, by peer relationships, by relationship-specific dynamics and by potential genetic antecedents. The characteristics that differentiate the different styles of attachment are key to understanding Attachment Theory. These characteristics are discussed next.

5.3   Attachment styles

Three attachment styles were proposed originally by Ainsworth et al., (1978). These styles consisted of 'secure', 'avoidant', and 'anxious–ambivalent'. Almost a decade later, Hazan & Shaver (1987) developed brief, paragraph-long descriptions of the three styles of attachment. This three-category measure was widely adopted by researchers in social, clinical and personality psychology, partly because of its brevity, its face validity and its ease of administration (Fraley, Hudson, Heffernan & Segal, 2015). In 1990, Bartholomew challenged researchers to reconsider the three-category model, instead proposing a four-category measure of attachment 'secure', 'fearful', 'dismissing' and 'preoccupied' based on how people hold separate representational models of themselves (model of self) and their social world (model of others).

A self-report measure, the Relationships Questionnaire (Bartholomew & Horowitz, 1991) was also developed comprising four paragraphs which each described the attachment types, and then instructed the participants to select the paragraph that best characterized their approach to close relationships. Although the attachment patterns suggested by Hazan & Shaver (1987), Bartholomew & Horowitz (1991) and Griffin & Bartholomew (1994b) became widely used, several researchers questioned their accuracy and suggested alternative measures of attachment styles. These alternative measures were proposed with the aim of replacing the four paragraphs used by Bartholomew and colleagues with short descriptions and a rating for each (e.g. Collins & Read, 1990; Simpson, 1990). In contrast, Feeney & Kirkpatrick (1996) used this combination of item and rating to scale people along various dimensions, and to

assign people to categories with greater fidelity. The emergence of Attachment Theory, during the stages of analysis described in Chapter Three, reflect the three attachment styles proposed originally by Ainsworth et al. (1978). For this reason, the alternative measures of attachment styles proposed by Bartholemew & Horrowitz (1991) were discarded. 'Secure attachment', 'avoidance attachment' and 'anxious attachment' are discussed next.

5.3.1   Secure attachment

Securely attached adults view themselves positively (Bartholomew & Horowitz, 1991), expect closeness and caring from others, adaptively regulate affect (Mikulincer & Shaver, 2007), and can reflect on their own and others' mental states (Slade, 2005). People who are relatively secure in their attachment to others are more likely than those who are insecure to experience satisfaction and to report high levels of commitment in their marital and dating relationships (e.g. Frei & Shaver, 2002; Tucker & Anders, 1999). In addition, their relationships are characterized by less conflict (e.g. Campbell, Simpson, Boldry & Kashy, 2005; Simpson, Rholes & Phillips, 1996) and they tend to be more resistant to dissolution and divorce (Davila & Bradbury, 2001; Kirkpatrick & Davis, 1994). Likewise, those who are more secure in their attachment are less likely than others to report depressive symptoms (e.g. Carnelley, Pietromonaco & Jaffe, 1994; Hankin, Kassel & Abela, 2005), are more likely to report higher levels of self-esteem (e.g. Bartholomew & Horowitz, 1991), and they tend to cope more effectively in response to stressful events (e.g. Berant, Mikulincer & Shaver, 2008).

5.3.2   Avoidant attachment

There is ample evidence that avoidant people's tendency to deactivate their attachment system affects the ways in which they appraise threats and cope with stressors. They tend to deal with stress on their own (a strategy that Bowlby (1973) called compulsive self-reliance) and refrain from appraising events as threatening and from expressing distress, anxiety or despair, even if they are forced to experience these negative emotions (Mikulincer & Shaver, 2007a). This self-reliance results in cognitive and behavioural distancing strategies, such as diverting attention from threat-related cues and by suppressing threat-related thoughts (Birnbaum, Orr, Mikulincer & Florian, 1997; Fraley & Shaver, 1997; Mikulincer et al., 1993; Mikulincer & Florian, 1995,1998). Attachment avoidance is also associated with the degree to which an individual distrusts intimacy and dependence, strives to maintain emotional distance from attachment figures, and how they subsequently rely upon de-activating strategies to minimize

distress (Ein-Dor, Doron, Solomon, Mikulincer & Shaver, 2010). In general, avoidant individuals tend to have low expectations of others, perceive others to be less trustworthy and often see their treatment by others as unfair (Ronen & Mikulincer, 2009).

According to Mikulincer & Shaver (2007a), avoidant, de-activating strategies are a reaction to past experiences with unavailable or disapproving attachment figures. From these experiences, a person learns to expect better outcomes if feelings of vulnerability or neediness are hidden or suppressed. Their uncomfortableness with closeness is also associated with maladaptive coping strategies and influenced by their inability to reflect on their own and others' mental states (Slade, 2005).

5.3.3 Anxious attachment

Anxious individuals tend to hyperactivate the attachment system initiated by appraising threats as extreme and their own coping resources as deficient, to ruminate on disturbing thoughts, and to report high levels of distress during and after stressful events (Alexander, Feeney, Hohaus & Noller, 2001; Birnbaum, Orr, Mikulincer & Florian, 1997; Mikulincer & Florian, 1995; 1998). In addition, anxious individuals perceive signs of threat and exaggerate the potential for negative outcomes in what other people consider to be non-threatening (e.g. Cassidy & Kobak, 1988; Shaver & Mikulincer, 2002). Research has also established how anxious individuals seek closer contact with others and express their intense needs and worries in response to perceived threats (Feeney & Noller, 1990; Mikulincer, Orbach & Iavnieli, 1998). Similar to avoidant attachment, individuals with anxious attachment experience difficulty reflecting on their own and others' mental states, due to their preoccupation with attachment relationships (Slade, 2005).

5.4 Attachment styles and their association with types of coping

5.4.1 Coping strategies

The identification of coping strategies have been developed from the Theory of Psychological Stress and Coping proposed by Lazarus and colleagues over a number of years (e.g. Folkman, Lazarus, Gruen & DeLongis, 1986; Lazarus, 1966, 1981; Lazarus & Cohen, 1977; Lazarus, Kanner & Folkman, 1980b; Lazarus & Folkman, 1984a, 1984b). Coping is defined as "the person's constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Lazarus & Folkman 1984b, p. 141).

Coping Theory identifies cognitive appraisal and coping as two distinctly different processes. Cognitive appraisal is the process through which the person evaluates whether a particular encounter with the environment is relevant to his or her well-being, and if so, in what ways. The second process has two widely recognized major functions: regulating stressful emotions (emotion-focused coping) and altering the relationship between the person and the environmental or external causes of their distress (problem-focused coping). Both processes act in sequence and, in doing so, become critical mediators of the stressful event and long-term outcomes for the individual's wellbeing. Regulating stressful emotions has generally been divided into three distinctly different strategies. Firstly, there is emotion-oriented coping, involving efforts to regulate negative emotions that emerge when confronted with a stressor. Secondly, coping which is problem-focused, which involves active steps to alter the person-environment transaction or altering or managing the source of the stress (Folkman & Lazarus, 1984a). Thirdly, there is avoidance-oriented coping, involving efforts to avoid coming into contact with, or thinking about, a stressor (Endler & Parker, 1990). A fourth coping strategy was later added by Roger, Jarvis & Najarian (1993). This coping strategy is described as detachment coping, which is characterised by the individual's ability to remain objective in terms of emotions associated with stressful situations, along with the ability to keep things in perspective.

Although individuals tend to have habitual or preferred coping strategies (Moos & Holahan, 2003), coping strategies are modifiable (D'Eramo Melkus et al., 2010; Kroese, Adriaanse, Vinkers, van de Schoot & de Ridder, 2014). In addition, coping strategies that are adaptive at one point in time may be used less frequently or may have different effects if adopted at different points in the stressful encounter (Carver & Scheier, 1994; Maes, Leventhal & de Ridder, 1996). Research in recent years has established a strong association between coping strategies and attachment styles, especially in stressful situations in which the attachment behavioural system is activated under conditions of stress or threat (e.g. Berant, Mikulincer & Shaver, 2008).

Associations between attachment insecurities and various forms of psychopathology have also been identified (Mikulincer & Florian, 1998; Mikulincer & Shaver, 2007a). Attachment Theory posits that, attachment-related needs, mental representations and behavioural tendencies are automatically activated when a person is exposed to natural or human-caused traumatic events, impelling a search for external or internalized attachment figures who can provide a degree of protection and support (Mikulincer, Shaver & Horesh, 2006). When an individual perceives a sense of threat,

attachment security can sometimes allow a person to feel relatively secure and protected, and decrease the possibility of the onset of stress, as well as the development of PTSD (Mikulincer, et al., 2006). In contrast, a traumatized person may fail to find internal representations of security providers or external sources of support and comfort, increasing the individual's vulnerability to PTSD (Mikulincer et al., 2006). Various social-cognition models of PTSD have been proposed. Nietlisbach & Maercker (2009), for example, suggest a reciprocal, interactive, concept of social cognition should be integrated into models of trauma processing. Likewise, the model of PTSD proposed by Sharp, Fonagy & Allen (2012) outlines how social bonds and social cognition may contribute to the development of PTSD after a traumatic event. Within their model, social cognition (comprising of various social factors, including social support, trust and social acknowledgement) is proposed to mediate the relationship between trauma and PTSD symptoms. Social cognition is associated with early caregiving and attachment behaviour. Adults with insecure attachment patterns are therefore more likely to develop PTSD symptoms (Sharp et al., 2012).

A study conducted by Mikulincer & Florian (1995) examined the coping responses of Israeli soldiers during their basic military training. Soldiers who reported a secure attachment style called upon an emotion-orientated approach to coping, while soldiers with an avoidant attachment style implemented distancing techniques from their attachment figures. Similar activation of the attachment system was found in earlier studies within the civilian population (Mikulincer, Florian & Weller, 1993).

5.4.2   Avoidant attachment and coping

Avoidant people's tendency to de-activate their attachment system affects the ways in which they appraise threats and cope with stressors (Mikulincer & Shaver, 2007a). Avoidant individuals tend to rely on maladaptive coping strategies in which they divert attention away from threat-related cues and threat-related thoughts (Mikulincer & Florian, 1995, 1998; Mikulincer et al., 1993). This is regarded by Bowlby (1973) as a maladaptive coping strategy, which is conceptualised as compulsive self-reliance. According to Mikulincer & Shaver (2007a), compulsive self-reliance involves the de-activation of the attachment system in times of distress. Although, dealing with stress by avoidance or distancing oneself from the stressful situation may be effective in dealing with short-term threats, when the stressful event is long-term, avoidance coping strategies often result in negative outcomes (Kirchner, Forns & Mohíno, 2008; Suls & Fletcher, 1985).

A recent study conducted by Berry & Kingswell (2012) investigated associations between adult attachment and coping strategies for exam-related stress. The findings suggested that students who were more avoidant in their attachment relationships were less likely to report using helpful problem-focused and emotion-focused strategies to cope with their exams. In contrast, students who were more anxious in their attachment relationships reported using more dysfunctional coping strategies. These types of coping strategies were associated with surface level approaches to study, which have been linked to poorer outcomes. Other dysfunctional strategies included denial and disengagement strategies, which led to the avoidance of the reality of the stressor. This was associated with a likelihood that the student would be hindered in applying problem-focused efforts to carry out the level of study required.

5.4.3   Anxious attachment and coping

Research conducted by Mikulincer & Shaver (2003) suggests that proximity seeking for anxiously attached individuals might be a viable coping option to them, if they can make their needs clear to those from whom they are seeking support. When anxiety increases, individuals will engage in more emotion-focused coping which takes place relatively early in the stressful event. However, individuals often exaggerate both the severity of their stressors and their own helplessness, in a bid to elicit others' support. This may, over time, test the patience and the ability of others to comfort and console them and, instead, might evoke an unfavourable view of the person seeking support

(Alexander et al., 2001; Berant et al., 2008; Mikulincer & Florian, 1995; Mikulincer et al., 1993). In addition, anxious individual's perception of an unfavourable view of others is explained by the interpersonal experiences and the IWMs of attachment anxiety and its association with unstable self-esteem (Butler, Hokanson & Flynn, 1994; Kernis, Brown & Brody, 2000; Tennen & Affleck, 1993).

Later research conducted by Srivastava & Beer (2005) demonstrates that high attachment anxiety, but not attachment avoidance, heightens the relationship between social feedback and self-evaluations. That is, the self-evaluations of anxiously attached individuals seem to be especially affected by peer evaluations. Past research that focused exclusively on the individual's level of self-esteem indicated a link between low self-esteem and insecure attachment (Bylsma, Cozzarelli & Sumer, 1997; Cassidy, 1988; Feeney & Noller, 1990). Later research by Foster, Kernis & Goldman (2007) reinforces the view that the security of an individual's feelings of worth has important implications for interpersonal functioning. Moreover, this points to the duality of self-worth and attachment style, in that, insecurity in one will be reflected in the other.

These findings also support a review conducted by Mikulincer & Shaver (2005) which points to how the defensiveness and self-aggrandizing tendencies associated with unstable self-esteem (Kernis, 2003) are absent in people with secure attachment representations. In this context, attachment security acts as a resource that minimizes the need for defensive strategies in situations that may otherwise call for it (e.g. after receiving negative interpersonal feedback). Furthermore, secure attachment is an important indicator of stable self-worth.

Although attachment orientations are fairly stable over time, they can be modified by important experiences that affect a person's beliefs about the value of seeking help from attachment figures and the likelihood of finding safety, protection and comfort (Davila & Cobb, 2004; Mikulincer & Shaver, 2007b). According to Bowlby (1982), working models of self and others are largely accurate reflections of actual interactions with significant others and, therefore, can be revised and updated based on new interpersonal experiences. This within-person variability is possible because people possess multiple models of self and other (Baldwin et al., 1996; Klohnen et al., 2005; Pierce & Lydon, 2001). At higher levels of mental organization, working models include abstract rules or beliefs about relationships, and at lower levels they include information about specific interpersonal experiences (Overall, Fletcher & Friesen, 2003; Overall & Sibley, 2010).

Fluctuations in anxiety and avoidance may result from the activation of particular models of self and made more accessible by specific interpersonal transactions and states of mind. In studies examining day-to-it day variability in attachment, Davila & Sargent (2003) and Zhang (2009) found that perceptions of interpersonal loss on a given day were associated with greater attachment insecurity on that day. Other studies have linked various vulnerability factors with greater variability in attachment patterns. For example, people who had adverse early experiences with parental figures (Davila, Burge & Hammen, 1997), or had current depressive symptoms (Zhang & Labouvie-Vief, 2004), were more variable in attachment security.

5.5   Attachment and Social Support

Research conducted by Cassidy & Kobak (1988) and Mikulincer & Shaver (2003a; 2007b) provides evidence of how seeking social support is a coping response related to either hyperactivation or de-activation of the attachment system, referred to earlier as anxious and avoidant attachment style respectively. A history of secure and responsive attachment figures during childhood and the initiation, development and maintenance of interpersonal relationships and the functions they serve can promote the belief that people will be available if needed during adulthood (Uchino, 2009). This provides feelings of security and belonging during times of stress (Florian, Mikulincer & Bucholtz, 1995).

Unlike individuals with secure attachment, anxious and avoidant individuals do not call upon the secure base or secure haven proposed by Bowlby (1969;1982), preferring instead to adopt an emotional or avoidance coping strategy in preference to seeking the help of others (Folkman & Lazarus, 1988; Folkman et al., 1986; Mikulincer & Florian, 1995). Consequently, insecure individuals, both anxious and avoidant, are unable to rely upon attachment from others and, as a consequence, distress is intensified, and defensive strategies other than confident proximity seeking are developed. This has serious repercussions for avoidant attachment types in that they are more likely to make demands on or withdraw from a close relationship, either as a way of protesting the other's perceived unresponsiveness or because they fear being rejected. This generally leads to relational conflict and intense emotions that can make it difficult for anxious or avoidant attachment individuals to communicate constructively (Mikulincer & Shraver, 2007a).

Secure individuals may also decide not to seek the support of others to help cope with their distress. However, this coping strategy is adaptive and serves to strengthen

the individual's perception of their coping competency. This competency originates during childhood and is developed from a child's interaction with a variety of different situations and contexts in which the secure base created by their mother or primary caregiver is key to influencing the child's IWM. This in turn creates a template for the implementation of a range of different adaptive coping strategies in adulthood. These include taking action, by planning or prioritising tasks, to resolve the cause of the stressor (Laszarus & Folkman, 1993; Mikulincer & Florian, 1995; Mikulincer & Shraver, 2007a).

5.6   Types of social support

Three types of social support have been identified by Cohen (2004) as "instrumental, informational, and emotional"(p. 67). Instrumental support is described as ''material aid'', such as financial assistance. Informational support involves providing information with the intention to help the recipient cope with a stressful situation. Emotional support relates to an individual's belief that they are important to, or cared for, by significant others and has been identified as one of the strongest correlates in terms of psychological well-being (Ingersoll-Dayton, Morgan & Antonucci, 1997; Kawachi & Berkman, 2001). Indicators of emotional support include feeling cared for, being understood and being listened to (Lincoln, 2000).

Seeking emotional support is primarily aimed at evoking empathy and companionship from one's social network to assist in the management of emotional stressors and the maintenance of emotional equilibrium (Greenglass, Schwarzer, Jakubiec, Fiksenbaum & Taubert, 1999). Emotional support has also been linked to healthy functioning (Schwartz, Lindley & Buboltz, 2007) and positive emotions, which contribute to psychological and physical well-being and the use of effective coping strategies. These coping strategies are often effective in reducing psychologically aversive states, such as depression (Sherman, Skrzypek, Bell, Tatum & Paskett, 2011), panic (Maulik, Eaton & Bradshaw, 2011) and despair (Thoits, 1995).

A study conducted by Fernandes, Cruz, Moreira, Santos & Silva (2014) compared the benefits of different types of social support in women undergoing breast cancer treatment. Emotional, instrumental and informational support were particularly helpful at the beginning of their treatment. However, while family members and friends were a consistent source of emotional support, spouses tended only to contribute instrumental support at the beginning of the women's treatment.

5.6.1   Received and perceived social support

Research conducted by Collins & Feeney (2004), Feeney & Thrush (2010), Florian, Mikulincer & Bucholtz (1995), Kafetsios & Sideridis (2006) and Schmidt et al. (2012) has established how attachment styles can directly influence the availability and effectiveness of perceived and received social support. Moreover, the perceived availability of others' emotional support, when needed, is associated with a secure attachment style (Feeney, 2004; Feeney & Thrush, 2010; Grossmann, Grossmann & Zimmermann, 1999). The findings support earlier research which associated received and perceived social support with the reduction of negative effects when individuals were exposed to physical and emotional trauma (Lawrence & Fauerbach, 2003). More recently, research conducted by Moak & Agrawal (2010) with HIV patients established an association between increasing perceived social support and the reduced likelihood of depression, anxiety disorders, social phobia and alcohol dependence.

Likewise, these findings are also reflected in later research conducted by Moreira, Fernandes, Gomes, Silva & Santos (2013) who found social support to be effective in reducing symptoms of depression and anxiety related to the treatment of breast cancer. In addition, this also reflects the much earlier research of Ognibene & Collins (1998), who observed that securely attached adults tend to seek more social support as a way of coping following a stressful event, while insecurely attached adults engage in avoidant or distancing coping strategies. Securely attached individuals seek out the emotional support of others, based on their sense of confidence in themselves to effectively manage the cause of their distress, and their sense of trust and confidence in those from whom they seek social support (Thoits, 2011; Uchino, Bowen, Carlisle & Birmingham, 2012).

Similarly, these findings are supported by earlier research conducted by Rees & Freeman (2007) who suggested that received social support is a transactional process that reduces the negative effect of stress. This supports the later research carried out by Kawachi & Berkman (2001) and Thoits et al., (2011) who found factors related to social support (e.g. sense of control, confidence in oneself, reassurance of worth, sense of support, social guidance) facilitate an individual's ability to deal with stressors, encourages greater self-efficacy and, in doing so, lowers the risk of depressive symptoms. However, although the relationship between a lack of social support and depression is well established, further research is needed to gain a greater understanding about the causal mechanisms between these two constructs (Uchino et al., 2012).

Research into social support in the context of attachment style and its association with particular coping strategies was conducted by Gomez-Hernandez, Max, Kosier, Paradiso & Robinson (1997) and Mikulincer et al. (2006). Their findings support the view that a traumatized person with an insecure attachment may fail to find internal representations of security providers or external sources of support and comfort from attachment figures. Consequently, this may interfere with the individual's ability to cope effectively with the source of their distress and predispose the person to develop PTSD. In addition, Wu & Yang (2012) found highly avoidant individuals to be less likely to seek out social support in times of distress, and therefore, the nature of their coping (i.e. low or high emotion focused) did not affect their psychological functioning.

The findings of these studies are important in the context of evidence that suggests social support can be an effective buffer against general psychological distress (Turner-Cobb et al., 2002), as well as for PTSD symptoms (Martinez, Israelski, Walker & Koopman, 2004). The positive impact on health status from the social support provided by friends is highlighted by research which has shown that poor social support, often operationalised as quality of friendships, poses a risk for mortality (Giles, Glonek, Luszcz & Andrews, 2005; Kroenke, Kubzansky, Schernhammer, Holmes & Kawachi, 2006). In the context of these findings, insecure attachment poses a barrier in calling upon or seeking the support of meaningful interpersonal connections or networks that can influence the quality of life and the enhancement of physical health and mental wellbeing.

Research conducted by Hobfoll & London (1986) suggests that depression can be intensified by greater amounts of social support and that sharing crises with friends and neighbours may be associated with less anxiety. The studies of Mikulincer & Florian (1997) provide support to this claim by highlighting how social support is associated with anxiety, depending upon the nature of the stressor, the timing and type of support, the identity of the supportive figure and the personal characteristics of the recipients. However, anxious individuals balance their desire for support with their fear of rejection. In doing so, efforts to solicit closeness may, at times, be countered by their withdrawal (Overall & Sibley, 2009). Consequently, past research findings are inconsistent. Some suggest that, higher attachment anxiety is associated with more support seeking (e.g. Shaver, Schachner & Mikulincer, 2005). Others suggest that there appears to be no link (Mikulincer & Florian, 1995, 1998; Ognibene & Collins, 1998), whereas others, suggest that higher anxiety is related to less support seeking (DeFronzo, Panzarella & Butler, 2001; Florian et al., 1995; Mikulincer et al., 1993).

Despite conflicting research, social support overll is a valuable social commodity, which is beneficial during stressful encounters. However, the type of support and when it is accessed during times of stress is experienced differently, depending upon an individual's attachment style and coping strategy. Nevertheless, individuals who have access to social support during times of stress, whether perceived or received, are better equipped in most instances than those who have not. Attachment and post-traumatic growth (PTG) and various social-cognition models of PTSD have been proposed. Nietlisbach & Maercker (2009) suggesting that a reciprocal, interactive concept of social cognition should be integrated into the models of trauma processing. The PTSD model proposed by Sharp, Fonagy & Allen (2012) outlines how social bonds and social cognition may contribute to the development of PTSD after a traumatic event. Within their model, social cognition (comprising various social factors, including social support, trust and social acknowledgement) is proposed to mediate the relationship between trauma and PTSD symptoms. Social cognition is associated with early caregiving and attachment behaviour. Adults with insecure attachment patterns have compromised mentalising of trauma and, therefore, are more likely to develop PTSD symptoms (Sharp et al., 2012).

5.7   Attachment and Post-traumatic Growth (PTG)

Prior research suggests that optimists are more likely to perceive benefits or report positive life changes following stressful life events (e.g. Tedeschi & Calhoun, 1996; 2004) and to use more effective coping strategies (Carver, Scheier & Weintraub, 1989), as well as experiencing greater psychological and physical well-being (Scheier & Carver, 1992; Scheier, Carver & Bridges, 1994). These studies support later research which have shown how traumatic events can result in beneficial changes (e.g. Helgeson, Reynolds & Tomich, 2006; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). These beneficial changes have been conceptualised in the literature as positive re-interpretation (Cheshire, Barlow & Powell, 2010), positive illusions (Taylor & Brown, 1988) and benefit finding (Tennen & Affleck, 1998). Although these terms are similar in that they all refer to how, after a stressful or traumatic event, individuals are able to bounce back, Tedeschi & Calhoun (2004) suggest that PTG is not the same as 'bouncing back' or "simply a return to baseline – "it is an experience of improvement that for some persons is deeply profound" (Tedeschi & Calhoun, 2004, p. 2).

Five areas of possible improvement or growth after trauma have been proposed by Tedeschi & Calhoun (1996): new possibilities, relating to others, personal strength,

spiritual change, and appreciation of life. Research conducted by Linley, Joseph, Cooper, Harris & Meyer (2003) suggests that PTG may also occur in people not directly exposed to trauma. This positive change does not occur as a result of the trauma itself, but rather as a result of the struggle to deal with the trauma and its psychological consequences (Tedeschi & McNally, 2011). I adopted the term PTG, as described by Tedeschi & Calhoun (1996), as it more accurately reflects how four of the mothers talked about the changes they perceived in themselves, which they attributed to the experience of caring for their sons.

A model of PTG introduced by Schaefer & Moos, 1998) investigated factors that may influence PTG. They organized the predictors of growth into four clusters including: a) environmental system; b) personal characteristics of the individual; c) event related factors; and, d) coping response. Both the environmental system and the personal characteristics of the individual refer to pre-trauma characteristics. Environmental system factors include life stressors, such as social coping resources or chronic physical illness. Personal characteristics refer to the relatively stable personality traits, such as self-efficacy or coping resources. Event related factors refer specifically to the nature of the traumatic event, such as the duration of the event or the intensity of the event, that, in turn, affect the recovery process. Finally, coping response is highly influenced by the type of attachment style and its associated coping strategy, and as discussed earlier, follows the traumatic event.

Attachment styles may also be predictors of PTG through a common association with adaptive coping strategies and received social support. These findings are reflected in studies which have examined the association between attachment style and the development of PTSD in Israeli undergraduates (Mikulincer, Shaver & Horse, 2006a) and political prisoners (Salo, Qouta & Punamaki, 2005). This adds support to how securely attached individuals are more likely to resolve traumatic experiences and to experience positive changes (Tedeschi & Calhoun, 1996; 2004). Studies have also demonstrated the importance of assessing the amount of growth following a traumatic event with individual characteristics, such self-efficacy (Abraido-Lanza, Guier & Colon, 1998), self-esteem (Tedeschi & Calhoun, 1996) and optimism (Updegraff, Taylor, Kemeny and Wyatt, 2002).

Despite the strong relationship between secure attachment and PTG, the evidence is not consistent. In a study by Dekel et al. (2007), attachment anxiety and attachment avoidance were positively associated with PTG. This supports earlier research by Dieperink, Leskela, Thuras & Engdahl (2001) and Fraley, Fazzari, Bonanno

& Dekel (2006), who provide evidence of a positive relationship between attachment anxiety and attachment avoidance with post-traumatic stress (PTS). In subsequent studies, attachment anxiety was a unique predictor of PTS and trauma-related psychological problems (Besser & Neria, 2010; 2012). In a study conducted by Ghafoori, Heirholzer, Howsepian & Boardman (2008), anxiety and avoidance were 'collapsed' into a general category of insecure attachment, which was positively associated with PTS. However, in a later study conducted by Benoit, Bouthillier, Moss, Rousseau & Brunet (2010), secure attachment was associated with reduced PTS severity three months after the traumatic event. In a subsequent study by Arikan & Karanci, 2012), only attachment anxiety was positively associated with PTG.

The variation in these studies is confounding. However, a possible explanation is provided by a much earlier study conducted by Helgeson et al. (1986), who claim that PTG may be a coping strategy for PTS, rather than an outcome. This proposition is supported by related research conducted by Dekel et al. (2007). In their study, wives who were identified as either anxious or avoidant attachment types, but who had not experienced the traumatic event themselves, reported a positive association with PTG. Research which has investigated the relationship between attachment, PTS and PTG suggests that individuals who are securely attached or are able to apply adaptive coping strategies that aim to resolve the cause of the stress associated with a traumatic event, are able to adapt positively and gain clarity and meaning from their experiences (Mikulincer et al., 2006; Turunen, Haravuori, Punamäki, Suomalainen & Marttunen, 2014).

5.8   Attachment and the myth of motherhood

Feminist scholarship has been instrumental in promoting the conceptualization and research about mothering and motherhood, and how it influences women's lives and their family members (Adams, 1995; Ross, 1995). Additional impetus has been given by the personal and theoretical insight of Adrienne Rich (1977), Audre Lorde (1984), Dorothy Dinnerstein (1976) and Jessica Benjamin (1988). The inclusion of studies examining racial and ethnic issues and the challenges and life outcomes of the working class have also increased the depth and breadth of studies about motherhood (Bassin & Kaplan, 1994; Glenn, Chang & Forcey, 1994). Gains have also been made by examining the conceptual and empirical work on care and caring (see Fisher & Tronto, 1990; Sevenhuijsen, 1998; Tronto, 1989, 1996; Ungerson, 1990; Waerness, 1996).

The term 'mother' can be ambiguous and is often used to refer to both a woman who gives birth and to one who actually cares for and raises a child, typically, though not always, the same person (Card, 1996; Leonard, 1996). This view of the mother's role in a family was first introduced in to the literature more than fifty years ago by Parsons & Bales (1955), who were resolute in their claim that fathers were expected to fulfil largely instrumental functions, such as providing income and disciplining children, whereas mothers were expected to fulfil largely expressive functions, such as caregiving.

Caregiving encapsulates the attachment relationship in the research conducted in child development by Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1980), in which children learn that they can look to the parent for comfort, protection or soothing when distressed, frightened or feeling threatened. Definitions of mothering hold in common a key theme, "a socially constructed set of activities and relationships involved in nurturing and caring for people…the main vehicle through which people first form their identities and learn their place in society" (Glenn, Chang & Force, 1994, p. 357).

The origin of these socially constructed views of caring were promoted by the views of Winnicott and Bowlby nearly three decades earlier, and who advised mothers that their proper place was the home, where she was to spend her time caring for her infant. This influenced a shift in the material published in books and women's magazine in the early 1990s. The observations of Kaplan (1990;1992) found that popular culture images of mothers in the 1980s present women as either career-oriented or as mothers, but seldom as both. The views of Kaplan resonated strongly with the earlier views of Adrienne Rich (1977) in *Of a Woman Born*, in which she presented a political and economic view of how the ideology of motherhood is used by society to define or limit women's role in society. Through this process, the ideology of mothering promoted society's views of patriarchal structures. Mothers aligned themselves with this ideology which provided legitimacy to this economically and culturally defined interpretation of the role of mother. Rich (1977) contested that "the institution of motherhood is not identical with bearing and caring for children" (p. 42). However, society's widely accepted view that the two are inextricably linked only served to normalise women's experiences and, in doing so, reinforced patriarchal structures and power hierarchies. Chodorow took a slightly different view in proposing that the social function of reproduction defines social relations. Starting from the assumption that "women's mothering is one of the few universal and enduring elements of the sexual division of labour" (Chodorow, 1978, p. 3), and going on to propose that "women's mothering as

an organisation of parenting is embedded in and fundamental to the social organisation of gender" (34).

Over the last thirty years, Chodorow's challenge to the accepted naturalness of women's roles as carers has helped to uncover the function of social, political and economic institutions in constructing the norms associated with mothering. Ultimately, her analysis has helped feminist scholars to raise important questions about the interaction between the public and the private sphere, as well as the social construction of gender norms (Guerrina, 2010). Both Chodorow (1978) and Guerrina (2010) have been industrious in presenting a powerful challenge to the 'traditional' constructions of women's mothering and the role it plays in maintaining gender power structures. Moreover, they raised awareness of how social norms serve to constrain our understanding of mothering and their primary role as carers.

Despite the gains made in challenging the traditional view of mothering and how it serves to constrain women's equality within the home and the workplace, the experience of being a woman worker with very young children is becoming more common. In the UK, for instance, almost half of women with a child under 12 months are now working, with employment growing faster among mothers with higher levels of qualification (Harrop & Moss, 1995). This, places present day mothers in the UK in a double bind. On the one hand, mothers are encouraged to view mothering and their caring role as a 'labour of love'. On the other hand, mothers seek employment to help meet the needs of their family. In other words, their reasons are: purely financial reasons.

> We still need to pay the mortgage and we need to pay the bills. We'd just about survive on what my husband brings in, but it would be nice to have you know little treats, like to be able to go on holiday, you know to have days out and stuff, as a family group. (Thomson, Kehily, Hadfield & Sharpe 2000, p. 12)

This financial imperative for mothers in UK society gives support to the views of Coontz (1992) who, several decades earlier, viewed the 'traditional family' of a wage-earner father and a stay-at-home mother as an historical and cultural aberration and not the exclusive responsibility of 'motherhood'. This view reflects the dilemma of modern-day mothers who are also employed in the UK:

There's so much research to say that children should be at home with mum and in a play situation and there's also so much pressure particularly in a town like this that mum's got to go back to work as fast as they can and the child is only stimulated if they're in a day nursery. (Thomson et al., 2008, p. 13)

For some mothers, their motivation to return to work is based on how their second salary enables them to meet the financial needs and aspirations of the family. For middle-class mothers, their motivation to return to work is influenced by how their career provides them with personal fulfilment and reflects similar aspirations as their spouse. Nevertheless, mothers are still viewed as the main caregivers and "tend to take longer leaves than their husbands and are viewed by society and their family as responsible for infant care" (Grych & Clark, 1999, p. 894). It is possible that middle-class mothers who do not need immediate employment for livelihood, must have a high investment in their career to return to work immediately after the birth of a child.

Scandinavian countries have, for many years, shown how the introduction of a paid paternity leave system can slowly change public opinion on fathering and how employers' attitudes towards paternity leave can be changed (Brandth & Kvande, 2002; Hass, 1997). Men can become preoccupied with their role as breadwinners during the transition to parenthood and become anxious as to their capacity to provide for the new family (Cohen, 1987). In recent years, research has reported how fathers have been increasingly reporting the family as a central source of well-being and express a growing desire for involvement in child-rearing (Levine & Pittinsky, 1997). However, the burden of providing for the new family may place higher stress on men in the workplace in terms of retaining their status and opportunities once they have returned to work.

The socially constructed view of motherhood and the role of mothers is reinforced by the current government's subtle use of attachment theory to raise awareness in young mothers of how imperative it is for them to establish a secure relationship during the early years of their child's development. The government's strategy for easing the demands made of parents was to launch two initiatives. Firstly, there is the provision of the National Health Visiting Service (NHVS), made up of specialist community public health nurses, who provide expert advice, support and interventions, to families with children (NHVS, 2014). Secondly, there is the Government's Healthy Child Programme, which was launched in May 2016, which

focuses on care, and brings together research evidence about how to deliver good health, wellbeing and resilience for every child from twenty-eight weeks of pregnancy through to the age of five (Public Health England, 2016). The key phrases used in the Government's website literature relate strongly to Attachment Theory, as illustrated in Figure 11.

Figure 11. Giving every child the best start in life (Public Health England, 2016)

This is not the first time that Attachment Theory has been used by the government of the day to influence the views of society and, more importantly, the attitudes towards motherhood. In her book, Riley (1983) reminds us how Bowlby's theory of 'maternal deprivation' warned mothers how their child "could be damaged if for any reason it was removed from its mother's care at least for the first three years of its life" (p. 191). Although there is no direct reference made to 'maternal deprivation', the language used on the Public Health website is explicit in stating the positive outcomes for an infant who is cared for by parents, who jointly provide a secure, loving and supportive environment. In response to the Government's Public Health initiative, Meins (2017) argues that rather than relying upon Attachment Theory, "the government's focus should be on equipping parents with evidence-based information on babies and how best to interact and play with their children as they grow and develop" (p. 22). In making this claim, Meins is, in fact, supporting the definition of maternal sensitivity and maternal instinct, which underpins a mother's secure attachment with her

child (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1980) and its importance in a child's future mental health (Bowlby, 1974).

Despite the opposition of Meins to the Government's public health strategy, the position taken by both Meins and the Government only serves to reinforce society's view of motherhood as the primary carer within the family. It also has potential for mothers who have a financial imperative to work after the birth of their child (Thomson, Kehily, Hadfield & Sharpe, 2008) to view the Government's offer of support as pernicious, as with the more emphatic views of Schlessinger (2000), whose book *Parenthood by Proxy: Don't Have Them If You Won't Raise Them* accused employed mothers of neglecting their children and urged mothers to recognise that as employed mothers they had difficulty in meeting children's basic needs of adequate food, clothing, protection, supervision and security, and how caregiving for a mother often coincides with marital conflict, work–family conflict and feelings of constrained personal freedom (Nomaguchi, 2012; Thomas et al., 2008).

In attacking both Attachment Theory and the Government's offer of help, Meins (2017) suggests that Attachment Theory, with its bias towards 'motherhood', should be replaced by mother and father jointly contributing to the development of their child. However, the unresolved anomalies of shared maternity leave make this unviable, given the unaffordability of child care for mothers who are in low paid employment (Thomson et al., 2008), This serves to perpetuate the ideology of patriarchy (Chodorow, 1978; Hays, 1996; Mauschart, 1999; McMahon, 1995; Rich, 1976), and the socially constructed view that mothers have primacy for the care of their young children.

Gender equality in the workplace and shared maternity leave, together place modern day parents under enormous pressure to meet their financial needs, fulfil their career ambitions and, at the same time, create a healthy environment for their child to develop. The socially constructed view of mothers as the primary carer of their infant is beginning to change. However, the Government's public health initiative, and the language it calls upon to describe the services that it provides to parents, is based on research conducted during the past fifty years, which has strengthened the efficacy of how secure and insecure attachment has the potential to affect child development and, subsequently, adulthood. Implementing the ideals of shared parental care requires a shift in society's historical view of motherhood, and how employers overcome gender prejudices in the workplace for mothers and fathers who elect to take statutory maternity leave. In addition, there are the issues of the cost of child care, as well as how to remove a mother's sense of guilt about returning to work (Feldman, Sussman &

Zigler, 2004; Thomson, Kehily, Hadfield & Sharpe, 2008). The relationship between the 'myth of motherhood' and the mothers' meaningful extracts are summarised in Chapter Eight.

5.9   Conclusion

The psychological constructs that emerged during the analytical stages of this study conform to the view of Eisenhart (1991) in that it was "constructed by using an established, coherent explanation of certain phenomena and relationships" (p. 51).These psychological constructs were interlinked throughout the three superordinate themes, which also reflect the wide-ranging studies that have investigated the strong association between Attachment Theory, Coping Theory, Social Support Theory, PTG and the 'myth of motherhood'.

The psychological dialogue which emerged during the stages of analysis was important on three levels. Firstly, it reflects the outcome of adopting reflexivity during the stages of IPA analysis; secondly, it provided insight to each mother's motivation for adopting a range of coping strategies, including when and how they accessed emotional support; thirdly, the psychological dialogue helped to raise the interpretation of the mothers narrative to a conceptual level which served to distinguish the differences and the similarities between the six mothers and their experiences before, during and after the stressful event of their sons' TCIs. Lastly, the association between attachment and the 'myth of motherhood' provided an important lens with which to view an additional level of interpretation to the absence of support experienced by several of the mothers and which is a key finding of this study. In the next three chapters, I present the results and discussion of the study.

Chapter Six "The stressful event unfolds."

6.1   Introduction

In the previous chapter, I described the dialogue between my interpretation of the participants lifeworld and psychological constructs found in the literature. In chapters 6 to 8 that follow, I have presented to the findings and discussion of the study together. In assigning a chapter to each of the 3 superordinate themes the reader is presented with "an understanding of the participant's point of view, and a psychological focus on personal meaning-making texts" (Smith and Osborne, 2003, p.79).

The themes presented in the next three chapters represent the mothers' shared experiences and is an integral part of the IPA approach. The idiographic nature of IPA is also represented by how certain themes for all the mothers were 'lived' more strongly with different outcomes for each of the mothers. This was made possible by the dialogue between the mothers' phenomena and the psychological constructs found in the literature. This also made it possible to present the complex findings by adopting a simultaneous flow of my interpretation of each mother's storey represented by their meaningful extracts, and the link with the psychological constructs discussed in Chapter Five.The outcome of this analytic and evaluative processes was the emergence of three superordinate themes 'The stressful event unfolds", "The support of others", and "Life after the stressful event" and eight sub-themes illustrated graphically in Figure 12.

An important feature of adopting IPA is to convey the participants storey as it was told during the interview (Smith et al. 2009). In talking about their life experiences all of the mothers stepped into the past to talk about the meaning they had given to their perceptions of the stressful event and returned to the present to talk about how they understand the perceptions they recalled in the present day. For this reason, there are occasions when the participants storey presented with their meaningful extracts varies from past to present and back to past tense. This was central to enabling me to "understand the content and complexity of those meanings" (Smith, 2008, p. 66).

Figure 12: The three superordinate themes and eight sub-themes

SUPERORDINATE THEME 1	A heart sinking moment
The stressful event unfolds	Your relationship with your son is for life
	Strategies for coping
SUPERORDINATE THEME 2	Family and friends
The support of others	A safe haven
	Mother's support to son
SUPERORDINATE THEME 2	Dark days
Life after the stressful event	Gaining a sense of purpose

Figure 13 represents superordinate theme one and its three sub-themes: 'The stressful event unfolds' consisting of three sub-themes, 'It was a heart sinking moment', 'Your relationship with your son is for life' and 'Strategies for coping.'

Figure 13: Superordinate theme one 'The stressful event unfolds'

SUPERORDINATE THEME 1	A heart sinking moment
The stressful event unfolds	Your relationship with your son is for life
	Strategies for coping
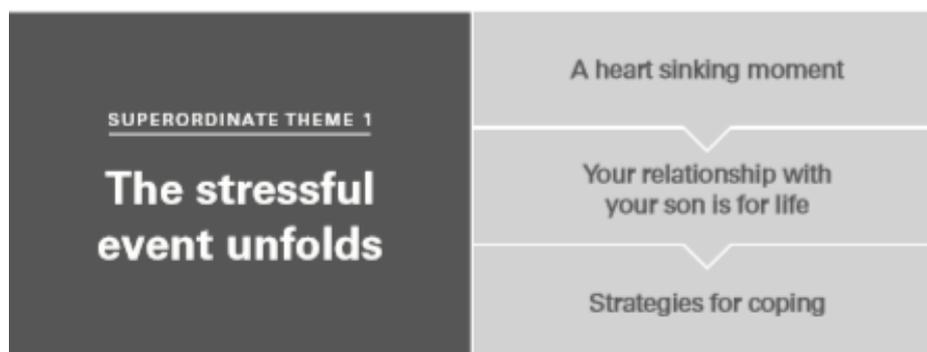
This first chapter is allocated to superordinate theme which explores each mother's perceptions of how they learned of their son's Traumatic Combat Injury (TCI),

their relationship with their son before and after their TCI and the different types of coping strategy they called upon as their stressful event unfolded. Table 14 provides participant demographic information relevant to the study. A table of family members and their pseudonyms are listed in Appendix 10.

Table 13: Participant demographic information

Participant's Psydonymn	Participants age	Nature of son's TCI	Duration of son's rehabilitation	Sons Age	Length of service in armed forces	Branch within armed forces
Jennifer	62	Single lower leg	3 years	35	Army	Infantry
Felicity	64	Single lower leg	12 months	35	Army	Infantry
Sarah	58	Chest cavity	3-5 years	30	Royal Navy	Infantry
Lynn	59	Single lower leg	12 months	30	Army	Infantry
Mary	63	Double lower leg	3-5 years	35	Army	Royal Army Medical Corp
Patricia	60	Chronic brain injury	3 years	29	Army	Infantry

6.2   Sub-theme one: 'it was a heart sinking moment'

6.2.1   Felicity

Felicity describes how her son telephoned her to tell her of his TCI "he was bright and cheerful on the phone and he said absolutely nothing to worry about… I have lost my leg but I am fine and you will be contacted by someone from the Regiment during the day and I will be flown into Selly Oak" (Felicity1: p.4, line 113-114). Felicity gives an early indication in her interview of how she was able to cope with the distress of her son's TCI "I think we genuinely have had an advantage over the majority of the general public ……we have been lucky, we walked through the wards and knew what we were going to see and what it was going to look like" (Felicity1: p.3, line 86-87).

6.2.2 Lynn

Lynn initially understood the visit of someone from the military to mean her son had been killed in action, which was reinforced by Lynn being asked by one of her colleagues to wait in a room normally assigned to parents with a gravely ill child "I said I've lost him haven't I and she said no, no, no, no and from that point there was like such a relief" (Lynn1: p.10, line 305). Lynn describes how the visiting officer described her son's TCI to her "he took my hands and he said, at this point I was teary but I wasn't like crying, and he said and he looked at me, he looked up to me and he said but he's alive and he's been talking" (Lynn1: p.10, line 314-315). Lynn gives an indication of how she was able to mitigate the distress she experienced when she recalls how she began to plan in preparation for visiting her son in hospital " in my mind I can see myself sitting in that car being driven down to Birmingham and going, right, what have I got to do, I'll have to do this, I'll have to do that" (Lynn1: p.4, line 99-100).

6.2.3 Patricia

Patricia learned of her son's combat injury from her visiting officer (VO) at 2 o'clock in the morning. Despite the uncertainty of her son's TCI and whether he would survive, "We know he's been badly injured we don't know how he's been injured and we don't know if he's alive" (Patricia1: p. 8, line 223), Patricia, like Lynn and Sarah, mollified her immediate distress by planning and organising herself so she could inform family members and prepare for her journey to Selly Oak "I thought I'll have to tell Peter and he's out in Afghanistan so that was a bit funny at the time but the immediate priority was just sort of like right, what do we do now, so I'm already thinking what's happening where I'm going" (Patricia1: p. 8, line 231-232).

6.2.4 Sarah

Sarah learned of her son's TCI from a Royal Navy visiting officer who was accompanied by a padre. Sarah was told that her son would probably not survive his injuries "don't expect anything because it's unlikely he will survive his injuries are very severe" (Sarah1: p.5, line 162). The blunt way in which the extent and seriousness of her son's injuries were described to her induced an immediate physical response "utterly shocked having to rush to the loo with diarrhoea" (Sarah1: p.6, line 173). Almost immediately Sarah implemented a coping strategy to help ameliorate her distress "my role was to ensure that the dogs were okay, so I tried to contact their owners or make plans for them because they were away on holiday" (Sarah1: p.6, line 187). This disclosure gives insight to the types of coping strategy Sarah might call upon when she

encounters stressors and how despite receiving the devastating news that her son might not survive his injuries she was sufficiently self-aware to realise that she would need to make alternative arrangements for the dogs she was kennelling so that at some point she could travel to Selly Oak to visit her son.The dynamics of Sarah's strategies for coping are discussed further in sub-theme three.

6.2.5   Mary

Mary was informed of her son's TCI before her son's wife Melony because her son Martin had only recently become married and had not updated his NOK form with the MoD "he started to tell me what had happened and bearing in mind my father had an above knee amputation and he started off by saying Martin had lost his leg below the right knee and I thought okay that's no bother and then he said above knee as well and then he said he had an injury to his right arm" (Mary1: p.6, line 178-180). Mary discloses how she was reassured further after receiving a telephone call from Martin's commanding officer "Martin was declared fit to fly that afternoon, because he's a medic we had a call from his Lieutenant Colonel to say he had done the thumbs up and was vaguely aware" (Mary1: p.7, line 230-231). This enabled Mary to interpret Martin's gesture of giving 'the thumbs up' to mean that he had suffered no trauma to his head and that he would survive his injuries.

6.2.6   Jennifer

Jennifer initially learned of her son's TCI from her daughter-in-law Jacky who was designated NOK "She did tell me that he had an injury that he was alive and all we've been told is that he has a broken arm and some facial injuries" (Jennifer 1: p. 6, line 168-169). Jennifer recalls how she felt immediately after her conversation with Jacky "I felt sick and very numb and just sat there, I also remember looking up and coming in here [conservatory] and just picking up things randomly and putting them down in odd places, no idea what I was doing (Jennifer 1: p. 6, line 164-165). Jennifer, then had a brief conversation with her son Josh after he had received emergency care for his wounds in Camp Bastion. However, Jennifer imagined her son's injuries to be far more serious than what they actually were "I thought maybe that he had the whole of his mouth blasted away……what am I going to have to cope with, my imagination run riot when he phoned" (Jennifer1: p. line).

6.3   Sub-theme two: 'your relationship with your son is for life'

6.3.1   Felicity

Felicity is explicit in disclosing the closeness of her relationship with Fredrick "I have a strong relationship with Fredrick and is special because I ride and it was something that sport wise that I could do with Fredrick that… I don't play cricket… I don't play rugby but the riding was something that we did together" (Felicity1: p.1, line 31-32). The shared activity of horse riding particularly up to the point Fredrick would have necessitated Felicity's close attention, care and supervision indicative of maternal sensitivity, defined as the mother's ability to be aware of and interpret the infant's behavioural cues and respond to the infant in a timely and appropriate manner (Ainsworth et al., 1978; De Wolfe & van Ijzendoorn, 1997) and her maternal instruction associated with secure attachment and the development of Fredrick's cognitive and social skills (Groh et al., 2014; van Ijzendorn Dijkstra & Bus, 2005).

Felicity's maternal sensitivity and maternal instruction continued throughout Fredrick's development and up to Fredrick becoming an adult and leaving home to begin studying towards a degree in horticulture "so there would have been lots of contact throughout the week and Fredrick would come here to ride in the morning before lectures (Felicity1: p. 2, line 49-50). Although Fredrick had gained independence from his mother, Felicity was still able to apply a degree of authority "he would have to come back to help out in the stables so although he had left home if he wanted to pursue that particular hobby then he had to put the work in as well" (Felicity1: p.2, line 50-51).

Felicity also talks about how Fredrick made friends easily in the community he grew up in "he is a very easy going happy go lucky social kid round here I would think you could say he's a real team player quite an all-round sportsman, quite a leader" (Felicity1: p. line). Felicity emphasises Fredrick's ability to socialise with others again when she talks about the number of different friends who visited Fredrick during his recovery in SO "he's had friends from around here he's got school friends and so there were many visitors and they had travelled from London all these youngsters sitting around his bed" (Felicity1: p. 7, line 233-234). Fredrick's ability to establish and maintain close relationships is based on his sense of self as worthy of love and care and others availability (Cassidy, 1988a; Sroufe, Egeland, Carlson, & Collins, 2005a) and grew from the secure attachment he had with his mother when he was a child and throughout his development (Belsky & Fearon 2002; O'Connor & McCartney 2007). However, the frequency and number of friends who visited Fredrick during his two

weeks in hospital caused Felicity a degree of frustration "sometimes Fredrick would ask us to wait while he was with friends we understood but also we were driving to the hospital every day and we only had a week off from work (Felicity1: p. 7, line 235-236)

Felicity's frustration at not being able to spend time with Fredrick was the beginning of Felicity's awareness that her relationship with Fredrick was about to change. This perception was reinforced when Fredrick returned home after discharge from Selly Oak "that was when I found out what a mother could and couldn't say, it wasn't cool to have your mother say I don't think that is a terribly good idea, you know, it isn't cool to have your mother or father drop you off…..you can't be dropped off at the pub by your mother" (Felicity1: p.11, line 400). This change in Felicity's perception was not the result of an intimate disclosure between herself and Fredrick, rather it is the change Felicity was able to observe in him as a result of the challenges Fredrick had encountered during his deployment to Afghanistan "you have this hugely fine line to tread because they are not your little boy, they are adult men, who have been in the most awful circumstances where they have witnessed the most incredibly things that we just can't imagine" (Felicity1: p.3, line 75-76).

Felicity's acknowledgement of how Fredrick's military experiences had influenced his development beyond the secure environment she had created during his childhood reflects a quotation from (Bowlby, 1973, p. 412) which refers to the developmental pathway of an individual ''... turns at each and every stage of the journey on an interaction between the organism as it has developed up to that moment and the environment in which it then finds itself''. In Bowlby's view both history and present circumstances are important as well as established patterns of adaptation, transformed by new experiences while, at the same time, new experiences are framed by, interpreted within, and in part created by a prior history of adaptation. Fredrick's development coincides with Felicity's awareness of how Fredrick had adapted to the influences of his environment both as a child and more recently as an adult serving in the armed forces "preferably, the parents learn to see their child as an autonomous individual and no longer as a child who needs close attention, care and supervision" Aquilino, (2006, p. 33).

6.3.2   Lynn

The relationship between Lynn and her son Lance is characterised by the consent Lynn gave to allow Lance to join the Army before his 18th birthday "we've always had a good relationship and I don't want to ruin that, so yes, I made that decision and I happily

signed the papers" (Lynn1: p.7, line 190-191). In giving her consent, Lynn reflects the affectionate and reciprocal relationship between her and Lance indicative of secure attachment (Mikulincer, Shaver, & Pereg, 2003). Attachment theory emphasizes the propensity for human beings to make and maintain powerful affectional bonds with significant others. In couples, a secure attachment bond is an active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security. These bonds are based on a "profound psychological and physiological interdependence" and, therefore, have an impact on psychological well-being (Hazan & Zeifman, 1999, p. 351) and the harmony and cooperation central to her attachment security with Lance (Ainsworth et al., 1978). Similar to Felicity, Lynn was also able to recognise the changes in their relationship boundries "the day that he decided he'd been to court for riding a mini-motor with no insurance or a licence and he got 6 points on a licence he didn't even have yet, and we came out of court and he said "mam, let's go to the recruiting office before I get into any more trouble" (Lynn1: p.6, line 166-167).

Lance's awareness of the constraints imposed upon him by his environment compared to the opportunities afforded to him by a life in the army, reflects the views of (Arnett, 2000, 2005; Sussman & Arnett, 2014) in how emerging adulthood is the developmental period in which individuals are likely to be exploring their identity, undergoing transitions, focusing on the self, and feeling a sense of both possibility and instability. Moreover, Lance's decision to join the Army and his transition into adulthood is symbolic of a son's pursuit of autonomy and independecne from his mother (Steinberg 2002). From a mother's perspective, Lynn discloses how she was accepting of the inevitability of Lance's decision to join the army "I knew he was doing what he wanted and it was good, it was a really good thing you know, he says himself you know he wouldn't change it" (Lynn1: p.8, line 233-234) reflecting the perceptions of a patient referred to by Welldon, (1992, p. 53) "I feel so relieved that a boy was born, I now know that he will be able to distance himself from me….becoming independent will be an easier task for him than if I had had a girl."

Although, Lynn's disclosures reflects how she had experienced a degree of distress in accepting Lance's decision to join the army, she welcomed the opportunity to be reacquainted with her role as mother and the close attention, care and supervision indicative of the recirporcal relationship between maternal sensitivy and secure attachment (De Wolfe & van Izendoorn, 1997) "so visiting in the afternoon and evening and ultimately going down the canteen for meals with him and being there

through his frustrations and his highpoints and his low points" (Lynn: p. line). In responding to Lance's needs during his recovery in hospital Lynn reflects the views of Main, Kaplan, & Cassidy (1985, p. 65), "parents' attachment working models shape their caregiving behaviour and affect their ability and willingness to provide a safe haven and secure base for their child."

The resumption of Lynn's caregiving reflects the intergenerational transmission of attachment and its reciprocal relationship with maternal sensitivity (Kelly, Slade, & Grienenberger, 2005; Sette, Coppola & Cassibba, 2015) "getting him what he needed you know, he relied on me to fetch him what he needed, just sort of that kind of thing really because he relied on me and he said it and he didn't know what he would have done if I hadn't been there is what he said" Lynn 1: (p. line). However, Lynn talks about her role as distinctly different from other family members "I think generally a mother is the one who does all the caring especially if it's a very young child she does all the caring, fathers in my experience react less well to not being in control" (Lynn: p.4, line 121-122). This is reflected in the views of Tarlow, (1996, p 56) "caring is part of the world of women" and of Glenn, (1994, p. 3) "historically mothering and gender in the West are deeply constitutive of each other, intricately and intimately entwined."

In talking about the care and support Lynn gave to Lance during his recovery in hospital, Lynn perceived a sense of 'felt-security' indicative of how individuals seek proximity to attachment figures in times of need as a way of protecting themselves from threats and alleviating distress (Sroufe & Waters, 1977) "well, there was I think an overwhelming sense of relief that he was there and I was able to touch him and give him a kiss and talk to him" (Lynn 1: p.15, line 468-469).

6.3.3   Patricia

In her first interview Patricia describes the relationship she had with Paul as a teenager "he was quite difficult to talk to it's difficult to say in words" (Patricia1: p.4, line 108) and indicated strongly that a tension existed between them shortly before Paul left home to join the army "I think at times he just shuffled around at home and he didn't have a purpose and he just wanted to go…maybe it was to get away from us to get away from family I don't know" (Patricia1: p. 4, line 109). However, despite the tension that existed before Paul joined the army Patricia discloses how their relationship then and now is the same "we were close but yes…I think we still are but it's difficult isn't it?" (Patricia2: p.23, line 743). The difficulty Patricia refers to but is unwilling to talk about, is characteristic of the long-term impact of TBI which goes beyond the patient and

extends to the family and the burden placed on the primary caregiver (Cavallo & Kay, 2005; Landau & Hissett, 2008; Lefebvre et al., 2008).

Patricia emphasises this further in the distinction she makes between the relationship she has with her two younger children compared to her relationship with Paul "I'm close with my two youngest but in different ways and they are adults now, I've not had that opportunity with Paul" (Patricia2: p.24, line 783). Patricia emphasises this further when she talks about the progress Paul has made during the past ten years "and he's doing more he's walking a lot more not by himself it's assisted walking but he's actually getting up and walking and he's talking more" (Patricia2: p. 11, line 359-360). In doing so Patricia displays the same maternal sensitivity and maternal insight she experienced as a young mother in how caring for Paul as an adult she interprets Paul's behavioural cues and responds to him in a timely and appropriate manner (Ainsworth et al., 1978; De Wolfe & van Ijzendoorn, 1997).

This is emphasised further by the improvement Patricia looks for in Paul's recovery "when you're asking him to talk, he'll say hello, how are you, goodbye, yes and no, but you can see him thinking about that, so he takes a while to talk" (Patricia2: p. 11, line 362). This close attention to Paul's needs also reflects the views of Leonard, (1991, p. 129) "in the practice of mothering, the child has a real claim on the mother. This claim is emotional and physical as well as moral. This claim is not experienced as limiting, rather it provides meaning, purpose and identity." Patricia's commitment and sense of purpose is palpable when she talks about how she recently encouraged Paul to begin deep muscle stimulation therapy to help in the maintenance of his recovery "I've gone back today and I said, I think that would be a really good thing for you to try, give it a whirl what have you got to lose" (Patricia2: p. 22, line 690), emphasising the close engagement she has with the different interventions available to Paul, her maternal sensitivity and Patricia's dispositional coping strategy discussed in the next sub-theme.

6.3.4   Sarah

Sarah is explicit about the quality of her relationship with Steven "definitely loving and we definitely had arguments because I think we are very alike" (Sarah1: p.3, line 81). She is specific about how they both worry "he is also a worrier and I guess I am too" (Sarah1: p.3, line 87). Sarah provides a description of her perception of Steven worrying and how she supported him when he attended his Royal Marines selection course "we just talked about…. it doesn't reflect all the phone calls to say well I'm coming home this weekend but I've heard my mate's family are coming up and I think he has a cold

and we may not make it this week and we've got a thirty miler to do and can you go round the shops and make sure we've got everything we might need in case I get this cold" (Sarah1: p.3, line 87-89). Later, Sarah also talks about how during Steven's adolescence nearly six years before his Royal Marines selection course, they were able to discuss Steven's experimentation with social drugs "I remember we had this talk about drugs and we weren't going to do it and how were you going to take this forward because you didn't want me to tell you off or reprimand you in any shape or form so there was a lot of very direct conversations" (Sarah1: p.4, line 103-104).

In talking about the support Sarah gave to Steven and how she put herself in his shoes she demonstrates her maternal sensitivity and her maternal insight reflecting the secure attachment with Steven (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002). In addition, Sarah's recollection of the conversation with Steven and addressing him as if he was in the room is significant on 2 levels; firstly, by addressing Steven in the first-person Sarah demonstrates how the memory of this conversation and the significance of the event continues to resonate in the present day and that it is associated with matters that are unresolved or which Sarah would like to review with Steven in the present day; secondly, the ability for Sarah and Steven to discuss important or distressing matters in the past is indicative of reciprocal emotional disclosure and how individuals who self-disclose their feelings and thoughts to one another is also characteristic of secure attachment (Mikulincer & Nachshon, 1991). This view is supported by later research conducted by (Graham, Huang, Clark, & Helgeson, 2008) who make the claim that sharing negative emotions can improve the discloser's trust in others as well as eliciting social support, alternative perspectives and advice from listeners, characteristic of the difficult conversations Sarah was able to have with Steven when he was younger.

In her second interview Sarah talks about the lack of emotional disclosure between them during Steven's rehabilitation "I trod on eggshells…for the first 3 years we hardly spoke about anything at all, he didn't want to talk about it and I didn't want him to reject me" (Sarah2: p.8, line 243-244). Sarah is unwilling to talk about the reasons which may have prevented Steven from disclosing his emotions, however, Steven's lack of disclosure reflects the behaviour observed in a study of Vietnam era veterans diagnosed with PTSD. In this study veterans recorded significantly lower levels of disclosure and emotional expression to their partners than those veterans without PTSD (Carroll, Rueger, Foy, & Donahoe, 1985). More recently, veterans in a health care setting were more willing to disclose traumatic events only to medical

providers, rather than support figures (Leibowitz, Jeffreys, Copeland, & Noël, 2008). Steven's continued reluctance to talk about his TCI imposes a degree of personal distress upon Sarah which is discussed further in superordinate theme two and three.

6.3.5   Mary

Mary is hesitant about discussing her relationship with Martin when he was a child, preferring instead to generalise about the way in which she structured her time with Martin and his twin brother during their childhood years "we were always together playing I don't know what we did, I would go out, I joined the NCT before they were born so there were groups to meet up with afterwards" (Mary1: p.2, line 50-51).

Moreover, throughout Mary's first interview, her responses were conspicuously vague and lacked the iridescence of Sarah and Patricia's disclosures and sits in opposition with how attachment security is associated with later mother–child dialogues that are more emotionally open (Laible & Thompson, 2000), and richer in detail (Fivush & Vasudeva, 2002). This is reflected by Mary when she talks about an event recounted to her by her son which had little relevance to the nature of Mary's relationship with Martin "one time he was charged with getting, they had a big pool and a small pool and for some reason the children, presumably it was a class but there was quite a few there were changing rooms and for some reason he had to get them around to the other changing rooms, so he got them all out at the end of the session and said left wheel, march and so he's always had that sort of leadership" (Mary1: p. 2, line 60-63).

 Mary's recollection reflects research in which mother-child dyads may be more emotionally constrained and uncomfortable and who reconstruct past events that are incoherent and lacking in relevance (Oppenheim, Koren-Karie, Dolev, & Yirmiya, 2009). Additionally, it is reflective of attachment avoidance defined by independence, distance from others, and discomfort with closeness (Mikulincer & Shaver, 2003).

Mary's insecure relationship with Martin is also observed in how Mary talks about the comfort and reassurance she sought when Martin was operationally deployed for the first time in 1999 "oh I was quite anxious when he went despite his reassurances that he was part of the peace keeping force" (Mary1: p. line 135-136) and how, unlike Sarah and Steven, Mary and Martin were unable to disclose personal information with each other "I don't think he had any problems, but he would not have told me if he had" (Mary1: p.4, line 133). Mary reinforces the lack of closeness in her relationship with Martin when she makes the claim that Martin was aware of her concern about his deployment "oh I think he knew they have got to go he's got his orders he has to go"

(Mary1: p,5, line 138) and which enables Mary to be accepting of their inability to disclose emotional information with each other "so you don't want to overlay any unnecessary stress they have enough of their own" (Mary1: p.5, line 138) as well as present a virtuous impression to the author "I don't think he would have noticed anything but no it wouldn't have been, there's no point, there would have been no point" (Mary1: p.5, Line 139-140) indicative of how avoidant attached individuals have a positive sense of self and a negative sense of the attachment figure (Mikulincer & Shaver, 2007a).

Mary's acceptance of the lack of disclosure between her and Martin is also an indication of how avoidant persons are unwilling to make intimate self-disclosures (Ainsworth et al., 1978) or to reciprocate others' disclosures (Mikulincer & Nachshon, 1991) and sits in opposition to the reciprocal emotional disclosure observed between Sarah and Steven. Moreover, the inability for Mary and Martin to disclose their feelings and thoughts to one another has existed from the period in which Mary recalls her son's first deployment in 1999 to the present day "you just keep your concerns to yourself other than keep your head down" (Mary1: p.5, line 140).

Later in her first interview Mary provides a further example of the difficulty Mary and Martin have in disclosing their feelings and thoughts to one another when she talks about a misunderstanding between her and Martin during his recovery in hospital "once the other visitors had gone Martin shouted at me that I should really listen to him I tried more than once to explain but he wouldn't let me do so" (Mary1: p.16, line 552-553). The inability for Mary and Martin to reciprocally self-disclose and resolve their misunderstanding emphasises further the insecure attachment between them. Moreover, this motivated Mary to return home and visit her GP "I was so upset about this that I had an appointment with a GP on the Friday and was given more time off work" (Mary1: p.16, line 557). The advice Mary was given by her GP is also a measure of the lack of self-disclosure between Mary and Martin "It was suggested that I write to Martin to explain but he rang that Friday afternoon" (Mary1: p.16, line 557).

Despite their telephone conversation Mary and Martin were unable to reconcile their differences, signifying the start of a deterioration in their relationship "it really does hurt to this day that he didn't even think that I was only interested in his well-being" (Mary1: p.16, line 560-561) and which emphasises further Mary's avoidant attachment style and how she perceives her relationship with her son to be untrustworthy and his treatment towards her as unfair (Ronen & Mikulincer, 2009). This is discussed further in the next sub-theme.

6.3.6   Jennifer

In talking about her daughter-in-law Jacky, Jennifer acknowledges the value she placed on their relationship "being able to be with her and share him meant a lot to me, it meant his presence was not so far away, I knew she had been talking to him, I knew she had had letters from him and then Joseph was born and there was a part of Josh there in Joseph" (Jennifer1: p. 3, line 96-97). However, rather than specify the emotional support Jacky provided, Jennifer focuses on how Jacky facilitated Jennifer's perceived physical contact with Josh as well as the perceived intimacy, and 'oneness' indicative of the hyperactivating strategy associated with an anxious attachment style (Mikulincer & Shaver, 2003). This same sense of 'oneness' is observed in Jennifer when she visits Josh for the first time in hospital "I just wanted to scoop him up and to touch him and just to be there with him" (Jennifer1: p. 8, line 314). Jennifer acts out her maternal sensitivity towards Josh by instead responding to the distress of her grandson "I had to pick him up I had to focus on him and give him everything to help him come in and in a way, it helped me then to see Josh" (Jennifer1: p.8 line 290-291). In doing so, Jennifer achieved the proximity, support, and comfort indicative of the hyperactivating strategy associated with anxious attachment (Mikulincer & Shaver, 2007a) and in the same way she had in the past when she had visited Jacky and her grandson.

Unlike the sons of the other mothers, Josh's injuries were initially minor in that the force of the blast he encountered had caused some damage and bruising to both of his heels and which Jennifer believed Josh would quickly recover from "they weren't going to touch his feet he had had major surgery but having had the surgery it was healing up and yes it would take a long time before he could move it again but it was healing up" (Jennifer1: p.9, line 332-333). After a period of rest Josh received a surgical procedure to protect the heel of his damaged foot "it wasn't amputation at that point it was erm they were going to do a muscle flap" (Jennifer2: p.16, line 522). As a result of the surgery the heel became infected resulting in numerous visits to hospital over an 18-month period "from April 2010 through to December 2011 he was constantly going in for either wash-outs to try and clear the infection or having a little bit more taken off" (Jennifer2: p.20, line 635-636). In March 2012 Jennifer received a telephone call from Josh on the day she was sitting her final exam for her counselling qualification and which coincided with Josh attending a meeting with his consultant to discuss the infection in his foot "I said how did you get on and he said oh we've made the decision to have an amputation, he said I just can't cope with the pain anymore mum" (Jennifer2: p. 18, line 567-568).

Rather than express any empathetic concern for the pain and distress her son had experienced during the previous 18 months and more significantly the decision to elect for surgical amputation, Jennifer gives priority to how the conversation with her son presented a threat to herself "for me it was the beginning of a nightmare really this was what he'd avoided on 21 May 2009 and now it was coming round to hit me" (Jennifer2: p.21, line 773-674). Jennifer's response is similar to how she responded initially to learning of her sons injuries discussed in the first sub-theme and a further indication of her anxious attachment (Alexander, Feeney, Hohaus, & Noller, 2001; Birnbaum, Orr, Mikulincer, & Florian, 1997; Mikulincer & Florian, 1995, 1998). Jennifer's response is also indicative of how individuals find it difficult to cope with distressing emotions when they perceive little or no physical or emotional support, described by Atkinson, (1997) as "a theory of trauma" (p. 3). Jennifer's perceived lack of emotional support is discussed further in the next superordinate theme.

Jennifer talks about her 'trauma' in describing how she became upset with Josh for not discussing his decision to elect for surgical amputation "I was angry at him for ruining my celebration........ I hate the fact that he's put me into this position where I've got to change I've got to adjust" (Jennifer2: p.22, line 725). In accusing Josh of denying her the opportunity to celebrate Jennifer indicates how she conceals her need to be recognised for her achievement. Additionally, in stating her need to change, Jennifer provides context and meaning to when in her first interview she talked about her critical self-view "I should be able to take care of everyone I should be here for Jacky and Josh and everyone and all the rest of my family" (Jennifer1: p. 4, line 127) and her mother's disparaging view of her "I also think that is probably what my mother would have expected me to have done, she would have done that she wouldn't have cracked" (Jennifer1: p. 4, line 129-130). Jennifer's need for recognition and her mothers disparaging view reflect the strong relationship between Jennifer's insecure attachment style and the depletion of her self-esteem (Hankin, Kassel, & Abela, 2005; Lee & Hankin, 2009).

6.4   Sub-theme three: 'strategies for coping'

6.4.1   Felicity

Unlike several of the other mothers who explicitly talked about their various strategies for coping with stressors generally in their lives, Felicity preferred to focus on Fredrick's strategies for coping with the stressors he experienced during his recovery and rehabilitation "Fredrick's answer is that, actually it doesn't help to share the pain, it

doesn't make him feel any better and in fact it makes the other person feel worse, so we just get on with it" (Felicity1: p.12, line 421-422).

Fredrick's ability to overcome his pain during his initial recovery at home is a reflection of the physical and mental stamina he developed during his military service (Crowley et al. 2015; Lieberman et al., 2014; Williams, Brown, Bray, Anderson Goodell, Olmsted, & Adler, 2016) and According to (Bowers, Weaver, & Morgan, 1996) and how the unit cohesion experienced during his military service helped to moderate his experience of stress enabling him to function effectively under considerable stress. The unit cohesion Fredrick experienced manifested itself in the regular face-to-face interactions during work, training or preparation for operational deployment, which together contributed to the development of his wellbeing and social functioning (Ahronson & Cameron, 2007; Iqbal, 2014). Fredrick's wellbeing and social functioning were observed by Felicity in the number of colleagues and friends who visited Fredrick throughout his period of recovery in hospital, discussed in the previous sub-theme. Additionally, Fredrick's positive self-regard and self-confidence in his ability to cope with his TCI (Mikulincer & Shaver, 2003; 2007a) is observed in retrospect by Felicity "Fredrick truly has lead the way through all of this and in the whole six months of his rehabilitation he didn't once look back" Felicity 1: (p.12, line 417-418) and is a further reflection of Fredrick's secure attachment with his mother (Mikulincer & Florian, 1995) and the psychological benefits of the emotional bonds formed with his military colleagues.

Felicity also reflects Fredrick's physical and mental stamina as well as her positive self-regard and self-confidence (Mikulincer & Shaver, 2003; 2007a) when she talks briefly about how she coped with a period of ill health, lasting several months prior to her second interview "so I had quite a lot of ill health and I think I probably became, but I'm quite a self-reliant sort of person anyway I think, you know, I dealt with what I had to do" (Felicity2: p. 14, line 502-503). Moreover, Felicity's coping strategies originated from her childhood and the cohesion within her fellow pupils "if you're dropped into a boarding school aged ten, mum's not going to come and sort out that you've lost your toothbrush and my father was a busy vet, so he was on duty every other weekend, so you learn to sort out things a bit" (Felicity2: p.17, line 611-612) and her secure attachment " I had a very happy secure childhood" (Felcity2: p. 18, line 629).

In addition to self-reliance, secure attachment also has a strong association with an adaptive coping strategy (Mikulincer & Shaver, 2003), such as problem focused coping, characterised by clear behavioural attempts to directly manage the cause of

distress (Lazarus, Kanner, & Folkman, 1980b). Felicity's limited disclosure about her coping strategies is indicative of Felicity's tendency to divert attention from herself and her self-effacing demeanour. However, by talking about Fredrick's coping strategy Felicity reveals her mental and physical stamina, her adaptive coping strategies and the intergenerational transmission of attachment (Sette, Coppola & Cassibba, 2015; Van Ijzendorn, 1992). Moreover, Felicity reflects how her own environment, like that of Fredrick's, is influenced by how the individual adjusts to the affordances and the constraints of their environment (Bowlby, 1973, p. 412) "I've just been incredibly privileged really, I loved my nursing in London, then got married and we've got three little boys, a GP wife in the country, lovely home (Felicity2: p, 18, line 629-630) as well as the underlying constructs of Bowlby's secure base theory (Bowlby, 1958, 1969) in that Felicity's primary attachment figures provided Felicity and her family members with a "haven of safety in retreat" (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002, p. 4) "and probably perfect for what we were just about to walk into" (Felicity1: p. 3, line 94). Felicity's relationship with her family members is discussed further in the next superordinate theme.

6.4.2   Lynn

Although I ask Lynn to describe her strategies for coping with stress Lynn prefers to talk generally about the stressors in her life "you kind of become a coper in life, I grew up with a mother who was a paranoid schizophrenic, so I have been a bit of a coper through my life and had some of my own health issues at various times" (Lynn1: p. 2, line 59-60). Lynn's response gives insight to how she has at some point intentionally reflected on the stressors she has encountered in her life and how she has become aware of the benefits associated with the coping strategies she has used "so you become a coper, whether it's just a shutting out or an actual thinking through and coping I'm not sure" (Lynn1: p. 3, line 61-62). Lynn makes an important distinction in pointing out the different types of coping strategy she has used; firstly, 'shutting out' is indicative of an emotion-orientated approach and secondly, 'actual thinking through' is representative of a problem-orientated approach (Lazarus & Folkman, 1984; Lazarus et al., 1980b). Calling upon both approaches for coping with stressors is indicative of securely attached people who typically activate both (Seiffge-Krenke, 2006). Later Lynn becomes eager to talk about two specific stressful events, comprising of her husband's gambling which resulted in Lynn declaring herself bankrupt to clear her husband's debts and their separation and learning of hers son's TCI and caring for him during his

recovery in hospital "I've had two main periods, one with my husband's habits until I learnt to cope with that and then one after Lance was injured" (Lynn1: p.3, line 61-62). The event Lynn refers to as 'then one after Lance was injured' is reference to two cardiac arrests (CRs) Lynn responded to on her ward which coincided with the start of her son's rehabilitation programme. Lynn's reluctance to talk about these 2 CRs is unclear and is not discussed by Lynn until her second interview discussed in superordinate theme two and three. However, Lynn's unwillingness to talk about these stressful events gives insight to the impact both events had on her wellbeing and how it had been more difficult to cope with the stress associated with her husband's gambling and their marital break-up and her son's TCI.

In caring for Lance during his recovery in hospital, discussed in the previous sub-theme, Lynn demonstrates a problem-orientated approach "getting him what he needed you know, he relied upon me to fetch him what he needed" (Lynn1: p. 9, line 265) and an emotion-orientated approach "he didn't know what he would have done if I hadn't been there is what he said" (Lynn1: p.9, line 266) and which further reflects the secure attachment between Lynn and Lance discussed in sub-theme one, in that both Lynn and Lance were confident that each other would be attentive, responsive, and available for each other to mitigate their distress (Mikulincer & Shaver, 2003).

Additionally, in caring for Lance during his recovery in hospital and in travelling to Headley Court after responding to 2 CRs, Lynn demonstrates how she "suppressed involvement in competing activities" by removing herself from her place of work and normal daily responsibilities "in order to concentrate more fully on the challenge or threat at hand" Carver, Scheier, & Weintraub, (1989, p. 269) indicative of a problem-orientated approach to coping (Laszarus & Folkman, 1980;1984).

6.4.3 Patricia

During her first interview Patricia was explicit in disclosing how she employs a range of strategies to cope with stressors she encounters "I read a lot and I don't relax very well I'm not one to sit and do nothing, so I like to be doing…so I think I focus on these things so that you don't focus on that unless you've really got to" (Patricia1: p.3, line 75-76). This is indicative of dispositional coping (Laszarus & Folkman, 1984) in that Patricia engages with an activity which will distract her from the cause of her distress. However later in her first interview Patricia talks about how she was eager to gain as much information and clarity as possible about the extent of Paul's TBI and his prognosis for recovery "I had lots and lots of discussions with the consultant and that,

which was unusual because people didn't normally do that, I wanted to see the x-rays I wanted to see all of that, so I could get some sort of understanding of what was going on and what the prognosis was" (Patricia1: p.18, line 589-592). In seeking information Patricia demonstrates how she chose a different coping strategy, representative of problem-orientated coping, to gain evidence and facts to enable her to gain a greater understanding of her son's TBI and which also mitigated her distress, moreover, it provides insight to how Patricia trusts the understanding and insight she gained from adopting this coping approach.

This also reflects Patricia's maternal sensitivity discussed in the previous sub-theme, and how securely attached individuals are more likely to seek new information to make judgments compared to people with avoidant or anxious attachment styles (Mikulincer, & Florian, 1995). Moreover, this coping approach is indicative of an adaptive approach to coping with distress (Laszarus & Folkman, 1984) also associated with a secure attachment style (Mikulincer & Shaver, 2003) and together strongly associated with the maintenance of wellbeing rather than the maladaptive distracting strategy Jennifer uses by turning away from her stress rather than looking into it to resolve her distress.

However, despite the adaptive coping strategies Patricia has implemented in the past and continues to call upon in the present day, she is candid about the level of distress she sometimes experiences "which isn't to say that I don't have those moments those days and I still have them now, of overwhelming despair and upset" Patricia1: p. line). Despite Patricia's disclosure she is dismissive of how her experiences of distress have in anyway incapacitated her or that she has felt a decline in her wellbeing "I think I had a bit of stress and depression if I am picky a bit, but life goes on, life has got to go on, I had to work, I had to be up there for Paul, meet others" (Patricia1: p.22, line 703-704). Moreover, Patricia uses language which emphasises the positive view she has of herself "and I'm not saying that those who are finding it difficult are wrong, it just isn't me" (Patricia1: p. 24, line 763-764) and how she attributes this view of herself to her physical robustness "a strong constitution, a strong backbone" (Patricia1: p.24, line 766) rather than the outcome of the different coping strategies she employs.

Patricia personifies this self-perception when she talks about how she overcame a setback in Paul's planned care just a few days before her second interview. For almost 12 months, Patricia had negotiated for Paul to move to a care home which would reduce the time it was taking Patricia to make the return journey to visit Paul from six hours to under two hours. This move also had the added benefit of increasing the frequency of

visits Patricia and other family members would be able to make, as well as give Paul easy access to friends who are still serving in his Regiment. In talking about how she and Paul responded to their disappointment "we've had that moment of solidarity, we hate the world, we hate them, or we don't like them and all this that and the other, what are we going to do about it, well okay, so he was joking again he's going to have his hair cut" (Patricia2: p. 20, line 629-630), Patricia portrays the strong relationship between secure attachment, maternal sensitivity and her adaptive coping. In talking about how she managed and mitigated Paul's distress, Patricia reflects the view of Chodorow & Contratto, (1982) "mothers' are viewed as having unlimited resources for mothering work, capacity to understand and support her children, and a willingness to prioritize her children's needs over any of her own" (p. 76).

In her second interview Patricia also talks specifically about the dispositional coping strategy she uses to mitigate her own feelings of distress "put some loud music on, I put Heaven Radio on, 'I am woman I am strong' belt that out, everybody knows if I'm playing that then it's probably wise to go away" (Patricia2: p.28, line 881-882). Patricia's reference to a song sung by Helen Reading 'I am women I am strong' is a mantra for Patricia and serves to reinforce her resolve as well as strengthen her positive and robust view of herself when she experiences periods of distress "for me that's my outlet if you like and I don't think that's necessarily a bad thing it's got to go somewhere" (Patricia2: p.28, line 890-891).

In relying upon her own resources such as engaging with Paul's consultant, reading, listening to her music or going for a run Patricia understands her coping strategy to be an autonomous function that originates from within herself, "I think it's quite difficult for me to call it a strategy, I understand why you're saying that and when you look on the outside you think, oh yes that's probably what it is, but it's just something I do" (Patricia2: p.29, line 911-912). This is indicative of dispositional coping (Carver & Scheier, 1994; Cerea, Bottesia, Grisham, Vienoc, & Ghisia, 2017), reflecting how Patricia instinctively adjusts her coping strategy to deal with the range of negative emotions she encounters and in doing so maintain her wellbeing as effectively as possible "and yes it does get rid of them, it does and it makes me feel better because I've externalised it, it's gone" (Patricia2: p.29, line 912-913). In the next sub-theme Patricia talks about the support she received from family and friends and how this also enabled her to mitigate her feelings of distress.

6.4.4   Sarah

Sarah is explicit in stating how her coping strategy was influened by her mother's response to stressors "my mother did show her feelings and I think it was because …in my own mind for god sake mother smarten your act up is that awful and because I said that I had already had cut myself off from being allowed to show emotions because I didn't approve of my mother showing emotions" (Sarah1: p. 10, line 285-287). Sarah discloses how she was motivated to use this same coping strategy to protect her own children from any feelings of distress she encountered "with the children if they get upset then they see me upset, my opinion is that it would not be helpful to them so therefore I wouldn't because I would imagine they would think of me in the way I thought about my mother not having that" (Sarah1: p. 10, line 298-300). Sarah's coping strategy for managing her mother's distressing emotions resonates strongly with the suppression of attachment-related thoughts (Fraley & Shaver, 1997; Mikulincer & Horesh, 1999). This strategy for coping was identified by (Bowlby, 1969/1982) as "compulsive self-reliance," associated with an avoidant attachment style, characterised by how people manage their distress by dismissing the importance of seeking relationship support, maintaining distance from others, and inhibiting emotional display (Kobak & Sceery, 1988; Main, Kaplan, & Cassidy, 1985; Mikulincer et al. 2011).

However, an avoidant attachment style is in conflict with Sarah's secure relationship with Steven discussed in the previous sub-theme. Rather, Sarah's self-reliance is a more accurate reflection of how Sarah was able to turn inwards to cope with stressful events because her family members were unavailable not because they were unwilling to be supportive (Bowlby, 1977). In being able to turn inwards Sarah was confident that she could remain objective in how she responded to stressors in her life. This objectivity is indicative of rational and detachment coping strategies (Palmer & Rodger, 2009; Roger, Jarvis, & Najarian, 1993), demonstrated by Sarah when she talked about how she prioritised the care of her dogs while also dealing with the distress of learning about her son's TCI discussed in sub-theme 2.

Despite turning inwards as a child to ameliorate the distress of her mother's upsetting emotions and how this created a dissonance between Sarah and her mother, Sarah talks about how the relationship with her mother had not prevented Sarah from later in her adult life creating a secure base and happy life during her adulthood "so my life was lovely really you know I was doing everything I loved, yes I missed Shaun but found ways of dealing with that and the dogs certainly helped, so I had seven dogs at any one time so I had a rule that I would only walk two dogs at a time which was three

or four walks a day so my life was charmed I would say quite honestly" (Sarah1: p. 1, line 12-13). The insight Sarah gives to her 'charmed life' represents the strong link between her attachment style and her adaptive coping strategy for dealing with distressing emotions (Roger et al., 1993) on three levels; firstly it reflects how the IWM associated with attachment as a child can be modified when surrounded by other adults who create the characteristics associated with secure attachment (Mikulincer, Hirschberger, Nachmias, & Gillath, 2001); secondly, Sarah's self-reliance as an adult is strengthened by her ability to call upon her rationality, her coping strategy of detachment and her 'charmed life'. Together this created Sarah's secure base prior to her son's TCI and which was successful in enabling her to suppress the negative emotions and distress encountered in her life and when she learned of her son's TCI; thirdly, Sarah's perception of a 'secure base' (Bowlby, 1988) and her self-reliance minimises her need to seek social support. This is discussed further in the next superordinate theme.

6.4.5   Mary

Mary's lack of self-disclosure with Martin discussed in the previous sub-theme, provided a strong indication of Mary's attachment avoidance (Mickulincer & Shaver, 2003) which has been strongly associated with relationship dissatisfaction (Shaver et al., 2005a). This is also reflected in Mary's relationship with Martin's wife Melony "we just knew that we had to sort of let her be the one that got all the information without really thinking that she didn't have the wherewithal within her necessarily to think about the fact that we were deliberately standing back" (Mary2: p.1, line 17-18).

This is an important admission by Mary in that it reflects the behaviour of avoidantly attached individuals pre-emptively disengage their attention "from distressing experiences before negative affect has been encoded and experienced" (Diamond, Hicks, & Otter-Henderson, 2006). This is often represented by incongruence between what individuals report and what they experience, moreover this response is "triggered automatically and run to completion without conscious effort or monitoring" (Gyurak, Gross, & Etkin, 2011, p. 409) and demonstrated further when Mary talks about how she was able to cope with the images she encountered when she visited Martin in hospital "I had seen people with their legs removed before and presumably she had not" (Mary1: p.8, line 267-268). Mary quickly adds "which I have only subsequently thought about…. but that for me was a given" (Mary1: p. 8, line 269) indicating further how 'cut-off' Mary was from her emotions and how she has only

recently become aware of the distress Melony had experienced in seeing her husband's injuries and the level of emotional support she gave to her daughter-in-law. This is discussed further in superordinate theme three.

Mary's inability or unwillingness to recall stressful events in her life epitomised by how she experienced little distress upon learning of her son's TCI discussed in sub-theme one, her inability to self-disclose, and her lack of emotional support to Melony, collectively provide insight to the repressive coping strategy associated with avoidant attachment style (Mickulincer & Shaver, 2003). Previous research has shown that avoidant attachment style and repressive coping has a strong association with poor emotional and physical well-being (e.g., Mikulincer, Florian & Weller, 1993). Mary talks about how she sought support from friends to help protect her wellbeing in the next superordinate theme.

6.4.6   Jennifer

In her first interview Jennifer is unwilling to talk explicitly about her strategies for coping, preferring instead to focus on describing the distress she experienced. In talking about her son's decision to elect for surgical amputation, Jennifer unknowingly provides insight into how her insecure relationship with Josh and her hyperactivating strategies for dealing with distress depleted her self-esteem in the role of mother. It is not until her second interview that Jennifer talks about the stressful events she has experienced earlier in her life and how she was prescribed anti-depressants to mitigate her levels of anxiety "I was diagnosed with cancer back in 1987 and my marriage fell apart" (Jennifer2: p. 14, line 438) and the consequences on her physical and mental wellbeing "the way I handled it I became anorexic, my marriage fell apart, and I was given anti-depressants" (Jennifer2: p.14, line 440). Beginning in 2011 Jennifer experienced several concurrent stressful events and was prescribed anti-depressants again "The second time around was when, after Josh was injured, mum had died, dad had died, and I went to the GP because I wasn't coping too well" (Jennifer2: p. 14, line 441-442). Jennifer marks these events in time and a measure of the debilitating effect they have had on her wellbeing when she states "that was 2011, and then they did give me some anti-depressants about a year ago because I had cancer again and they said I needed it, so I took them for about three months and then I said I don't need this, I just need to talk to some-body" (Jennifer2: p. 14, Line 444-445).

In talking about her previous stressful events and being subscribed anti-depressants, Jennifer provides a history and context to the catastrophic way in which she responded to learning of Josh's injuries " having had the previous 6 years at that sort of worry level, as one of the son's had said, mum if you didn't have something to worry about you would find something"(Jennifer1: p. 1, line 11) and how attachment insecurity is associated with depressive symptomology (e.g., Bifulco, Moran, Baines, Bunn, & Standford, 2002; Roberts, Gotlib, & Kassel, 1996; Scharfe, 2007).

Additionally, how according to (Mikulincer, Shaver, & Solomon, 2015) persistent and pervasive trauma can heighten attachment insecurities, especially among individuals who entered a period of trauma with already existing attachment-related doubts and insecurities.

Although Jennifer is willing to disclose the level of stress she had experienced in the past, Jennifer is unwilling to talk about how she has coped with previous stressful encounters or how she controls her levels of distress, other than the anti-depressants prescribed by her GP. The only indication Jennifer gives in how she copes with stress is

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when she talked about how she responded to the distress of learning of her son's TCI discussed in sub-theme one "once I'd put that logical thought into my head and I'd phoned my friend in a way it had put a spoke into the spinning out of control feeling and I'd taken control of myself" (Jennifer1: p.5, line 167). Although Jennifer's coping strategy is associated with seeking emotional support, in calling her friend Jennifer discloses how she felt unable to call upon the support of family members often associated with positive psychological outcomes (Holahan, Moos & Shafer, 1996; Pierce, Sarason, Sarason, Joseph & Henderson, 1996). In the next superordinate theme, Jennifer provides insight into her motivation for seeking support from her friend, talks more freely about her motivation for not seeking the emotional support of her family members, and the defences she constructed to protect her poor self-esteem discussed in sub-theme two.

6.5   Summary of Superordinate theme one

This chapter has looked at how each mother learned of their son's TCI, the mother's perception of their relationship with their son and how each of the mother's coped with prior stressful life events. Each mother learned of their son's TCI in slightly different ways depending on whether their son was married or single and the nature and extent of their son's TCI. Additionally, each mother gives insight into the different way in which they responded to learning of their son's TCI and their initial strategy for coping with the distress they experienced. Felicity, Lynn and Mary called upon their prior experience as nurses to mitigate their feelings of distress, while Sarah and Patricia gave priority to practical tasks before travelling to SO. In contrast, Jennifer amplified the intensity of her distress by imagining her son to have been injured for more seriously than he had said and her concern that his injuries would change her relationship with her son.

Individual differences in attachment anxiety and avoidance reflect both a person's sense of attachment security and the ways in which he or she deals with stress and distress (Mikulincer & Shaver, 2003; 2007a). From a theoretical perspective Felicity, Patricia Lynn and Sarah displayed a secure attachment style and adaptive strategies for coping with their distress and how these fluctuated over time as their stressful encounter unfolded. This reflects research which has established a strong association between attachment security and adaptive coping strategies (Lazarus & Folkman, 1984; Milkuncer & Shaver, 2003). In contrast, Mary and Jennifer were observed to have a maladaptive strategy for coping with distress consistent with their

respective insecure attachment style. Mary avoided any social contact with her son and daughter-in-law despite the proximity of where they lived and attributed this to her son's fractious behaviour towards her. Jennifer also avoided contact with her son by taking care of her grandson and confiding her profound distress and worries to her close friend rather than family members.

In the next chapter the superordinate theme 'receiving and giving support' each mother talks about the different types of social support they received from family and friends after learning of their son's TCI, the support they received from AWS during their son's period of recovery in SO and the support each mother gave to their son after discharge and during their rehabilitation programme.

Chapter Seven: "The Support of Others."

7.1   Introduction

This superordinate theme and its three sub-themes, summarised in figure 14, examines each mother's perception of the support they perceived and received initially during their son's initial period of recovery in hospital; the support each mother received during their visits to see their son in hospital; and in the third sub-theme the support four of the mothers gave to their sons after their son's discharge from hospital and their return home.

Figure 14: Superordinate theme 2 'The support of others'
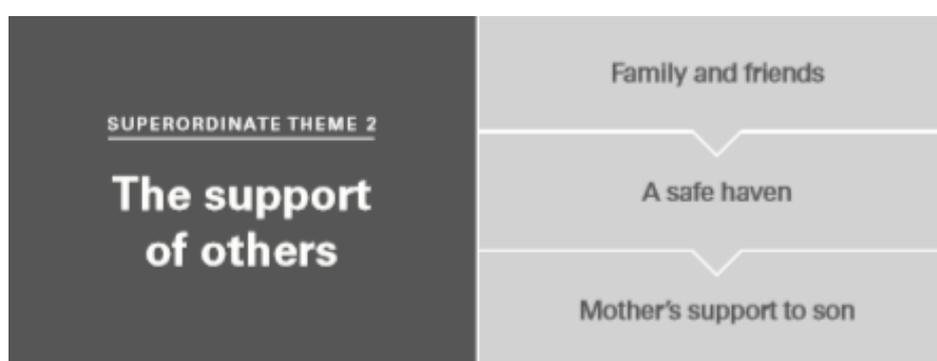
7.2   Sub-theme one: 'family and friends'

7.2.1   Felicity

Felicity talks about how she perceived the need to provide companionship and emotional support to all of her family "as a mother you want to protect, care for and nurture your family, I knew my mother would be devastated I knew that his brothers would be devastated and again as a parent I felt that I was then in the role of protecting them and that became more and more apparent" (Felicity1: p.5, line 173-174) reflecting the views of (Laschinger & Havens 1997; Laschinger, Heather, Finegan, Shamian, & Wilk, 2001) in how people of all ages tend to seek proximity to their attachment figures in times of need. Felicity makes it clear that she does not underestimate how much this contributed to how she and her family members adapted to the challenges they encountered "I think we are very lucky we are quite a strong close family unit" Felicity 1: (p, 1, line 31-32).

Felicity also emphasises the benefit of the support she received from her youngest son "Flynn was an amazing support and a great listener" (Felicity1: p. line) discussed in the previous superordinate theme and also her husband "I think we ended up Floyd and I sort of you know obviously comforting each other" (Felicity1: p. line).

The close interpersonal relationships between Felicity's immediate and extended family members served to protect Felicity in providing the safe haven created by secure attachment figures (Mikluencer & Shaver, 2003) during childhood and across life span. In addition to the priority Felicity gave to her family members she also provided support to her large network of friends "we came back and the phone rang constantly, people through the house all of the time and we ended up in the role of comforting everybody else" (Felicity1: p.9, line 301-302). This represents a measure of Felicity's empathic concern for others who might be distressed but how it was not reciprocal in that Felicity was unable to draw upon the resources of her friends, such as their empathy and companionship to assist her in coping with the distress of her son's TCI (Reinhardt, Boerner, & Horowitz, 2006; Greenglass, Schwarzer, Jakubiec, Fiksenbaum, & Taubert, 1999).

7.2.2   Lynn

Although Lynn talks about the initial emotional support she received from work colleagues the day she learned of her son's TCI discussed in superordinate theme one, Lynn also talks affectionately about the initial support she received from Family "I remember when he was injured my mother-in-law, because where we used to live, there was a lot of his family, it's very much a family street and there was a lot of his family in that street and my mother-in-law was across the road" (Lynn1: p.8, line 224-225). Moreover, how her family members were eager to provide companionship and emotional support in the same way Patricia talked about her family in superordinate theme 1, "Family member after family member walked in with me standing at the door, all giving me a hug as they came and that was when me mother-in-law said at least we've still got him" (Lynn1: p.11, line 361-362). The similarity between Lynn's experience and Patricia's experience of family support after learning of their sons TCI, emphasises further, how the proximity of family and friends was in itself a strategy for coping (Ali & Khalil 1991).

Despite the close proximity of family members Lynn preferred the companionship and emotional support of her close friend who was also her work colleague "my friend stayed that night when everybody else had gone you know….she, like slept on my sofa basically and got me organised in the morning" (Lynn1: p.12, line 398). Lynn emphasises the benefit to her of the instrumental and emotional support she received from her close friend "if you're on your own and you've got to cope then you do, but if there is somebody to take the strain you can let them, I wouldn't have been

thinking like that at the time but I did and she just said look you'll need this you'll need that take your tablets take you know" (Lynn 1: (p .13, Line 403-404). Lynn talks more explicitly about the support of her friend when she visited Lynn at Selly Oak "It provided normality really, because you would talk about anything and everything, you weren't necessarily talking about Lance we were going shopping in Birmingham and you know so it was just a bit of normality a bit of humanity" (Lynn1: p.14 line 386-387).

The meaning Lynn gives to normality is not to the act of shopping itself or that Lynn's shopping is a dispositional coping strategy activated automatically by Lynn whenever she is distressed (Carver & Scheier, 1994: Cerea, Bottesi, Grisham, Vienoc, Ghisi, 2017), rather, in this context Lynn's friend created a sense of normality in the companionship and social interaction she provided, a facet of instrumental social support (Litman, 2006; Semmer, Jacobshagen, Perrot, Beehr, & Boos, 2008), and situational coping (Carver & Scheier, 1994; Cerea et al., 2017). The support given by Lynn's close friend during the activity of shopping, reflect two strategies for coping with distress; firstly, seeking out social support (Litman, 2006) and secondly, the suppression of competing activities (Folkman et al., 1986). Both are considered to be adaptive coping strategies and enabled Lynn to gain respite from the distress of her son's TCI . In the next sub-theme Lynn describes the emotional support Lance received from the other injured service personnel and the military staff who were caring for them. She also talks about the support she received from AWS and the other mothers she was accommodated with at Norton House during her son's recovery.

7.2.3   Patricia

Patricia discloses how her extended family travelled from all over the country to be with her during the surgery Paul underwent immediately upon arriving at SO "I'm sat out there waiting and then gradually all the family have come up… my sister's come obviously his dad and his step mother and his brother and his friends it was quite a reunion really as we're waiting, as this 2-hour operation became a 10-hour operation" (Patricia1: p.14, line 443-444). Patricia is explicit about the importance of the companionship and emotional support she received from her family "Yes for me it did it was good because there were…..it was everybody in that sense" (Patricia1: (p. 15 line 489) reflecting the claims of (Dunkel-Schetter & Bennett, 1990; Wethington & Kessler, 1986) and how received support can lead to a reduction in the impact of the stressor "it was comforting I think and of course we'd got Paula there Paul's girlfriend and

included her so yes it was comforting" (Patricia1: p.16, line 502). The proximity of family members and the perception of support was for Patricia in itself an additional coping resource which she could call upon if necessary (Ali & Khalil 1991; Melrose & Brown, 2015; Reinhardt et al., 2006) "if the worst came to the worst we'd all be there" (Patricia1: p. 16, line 503). In the next sub-theme Patricia talks about the social support she received from AWS during her stay at SO.

7.2.4   Sarah

Sarah's response to questions about the level of support she received after learning of her son's TCI begins with Sarah talking about how she rejected the support of her parents-in-law "my father in law was appalled that I didn't want them up here I don't like them particularly they would only be coming up as a duty and I didn't want them full stop" (Sarah1: p.7, line 199-200). Sarah provides insight to how little support she has received from her parents-in-law in talking about the lack of support she has received generally "you know all my life I have or my married life I have been a merchant navy wife and you get on with things you know there is no support out there for you it's you and you alone" (Sarah1: p.7, line 203-204).

Sarah contrasts the relationship with her parents-in-law with the relationship she had with her father "my Dad was lovely he was a difficult man to live with as well but the lovely part of him was that he was gregarious, he was friendly he was out-going and he loved women" (Sarah1: p.8, line 229-231). Sarah is enthusiastic to talk more about her father "a very silly thing but to get you to understand what my Dad was like, it is probably quite personal but please don't be shocked by it, I used to get really difficult periods especially when I was a teenager and he would be sent off to go and buy sanitary towels and whatever and he would come back with arms laden, not bothered in the slightest" (Sarah1: p.8, line 266-267). Sarah's voice softened as she described her father's affection for her, reflecting how this provides her with a sense of safety. It also reinforces the disdain Sarah has for how her mother responded to distressing events, discussed in the previous sub-theme, and referred to again to contrast the different relationship she had with her mother compared to her father "there was no-lee way for her at all that annoyed me so I thought that was a weakness I think in my mother I'm ashamed to say that now but and because I very much was a daddy's girl" (Sarah1, p.10, line 291-292). Sarah's willingness to talk without prompt from me about the affectionate relationship she had with her father, gives a measure of her sense of loss. Additionally, how despite the difficult relationship with her mother, discussed in

superordinate theme one, the origin of Sarah's secure attachment to her son is based in the experiences she had with her father during her infancy, childhood and adolescence (Bowlby, 1980) - reflecting the intergenerational transmission of attachment (Verhage et al. 2016).

7.2.5   Mary

Mary talks about the support she received for the first time, when she was at SO and had just seen her son Martin for the first time "I was then on the computer emailing a lot of people and told various people so the news went around the world to New Zealand France Scotland you name it." (Mary1:p. 14, line 481-482). However. during the first few weeks of her son's recovery in hospital Mary called upon a friend who then relayed Mary's updates on Martin's progress to her network of friends "when I was at SO I used to telephone her and then she would disseminate to various people" (Mary1: p. 14, line 490-491). In this context, Mary's regular updates through her close friend created in Mary a sense of perceived social support (Greenglass, Schwarzer, Jakubiec, Fiksenbaum, & Taubert 1999) and by sharing her distress with her social network via the internet created a positive effect (Gable, Reis, Impett, & Asher, 2004; Ko & Chen; 2009).

Mary's motivation for seeking the perceived emotional support of others is at odds to Mary's lack of empathy and emotional support she made available to Martin's wife and the lack of support she herself sought from Melony. Meaning is given to this contradiction when in Mary's second interview she talks about the support she received from someone who she suggests is neither a friend or a family member "I mean there's something separate isn't there about talking to somebody who doesn't know of you or about you or your family" (Mary2: p.30, line 935). In talking to someone outside of her family Mary gives herself permission to be critical of family members "you can say things about members of your family or whatever that you can't actually necessarily say to friends" (Mary2: p.30, line 936). This reflects Mary's avoidant attachment in how individuals have a positive sense of self and a negative sense of others in order to moderate their distress in relationships with attachment figures (Mikulincer et al., 2011; Slade, 2005).

Mary then talks about the emotional support she received from friends and how it was sometimes helpful and sometimes unhelpful "some were more understanding and supportive than others but then that's just the way it is, some say things you don't like but which may be truthful so you have to take that on board as well (Mary2: p.30, line

949-950). Despite Mary's suggestion that she had a network of friends to call upon she gives significance to one particular person who is primarily a work colleague but who Mary also regards as a friend "this friend she's always…we worked together for a long time and she's always very…down to earth's not the right word but solid in her ability to take stuff" (Mary2: p. 20, line 956-957). Mary found this particular friend's support to be beneficial to her wellbeing "Yes it was just good to share…I mean it didn't hurt her in as much as yes she knows Martin but it wasn't…not her problem but you know it wasn't affecting her so she was able to be…as you would in that sort of situation just able to comfort me I suppose" (Mary2: p.30, line 959-960).

In relying upon this particular friend Mary gives insight to the small number of individuals Mary was able to seek social support from during her son's rehabilitation (Mikulincer & Erev, 1991) and her low expectations of others (Ronen & Mikulincer, 2009). Together these dispositions reflect the mechanisms of avoidant attachment (Mikulincer et al., 2011) and Mary's inability to resolve the conflict which existed between her and Martin discussed in superordinate theme one.

7.2.6   Jennifer

In her first interview Jennifer talked briefly about the support she received from her daughter-in-law Jacky "I think we were very supportive of each other all the way through, although I tried to be the dominant supporter, if that makes sense, I think actually it was quite an equal partnership" (Jennifer1: p. 4 line). 124-125 Jennifer is asked to describe what she meant by dominant "I should be able to take care of everyone. I should be here for her and Josh and everyone and all the rest of my family" (Jennifer1: p. 4 line 126). Jennifer is asked specifically why she felt a responsibility to look after everyone "because you feel a sense of being mother and that you are the elder and the wiser member of the family" (Jennifer1: p. 4 line 128). Jennifer's perception of her hierarchical role is based on how her mother responded to stressful events "I also think it was an element of that is probably what my mother would have expected me to have done, she would have done that, she wouldn't have cracked" (Jennifer1: p. 4 line 129).

Despite Jennifer's admission that she had not fulfilled the caring role of mother to her family members, Jennifer talks about how she had in the past emphasised the importance of family members supporting each other during stressful events "I have always said to the boys you must keep the relationship with your girlfriend, wife because I know and you know that we're here for each other at all times" (Jennifer1: p.

3 line 89-90). This creates a contradiction between Jennifer's admission that she had fallen short of how she was expected to support her family members and how she had made it clear to all of her sons' that their wives should take priority over their relationship with her. This is reflected in how Jennifer gave priority to seeking the support of her friend upon learning of her son's TCI discussed in superordinate theme one and reinforced in Jennifer's second interview when she talks about the social-support she received from family members.

In contrast to Lynn, Patricia and Felicity, Jennifer's experience of seeking social support only served to further deplete Jennifer's self-esteem discussed in superordinate theme one "I had phone calls from family or friends, I was always getting comments like, but you must be so grateful that he's alive, or, oh you shouldn't feel like that, or, you should do this or you should do the other thing which I didn't find helpful" (Jennifer2: p. line.). The unfavourable and judgemental views of Jennifer's family members imbued a negative rather than a positive view of herself, (Wei, Ku, Russell, Mallinckrodt, & Liao, (2008; Wei, Liao, Ku, & Shaffer, (2011). This caused Jennifer to question whether she was loved by her family members and whether they perceived her to be competent in the role of mother (Feeney & Noller, 1991; Shaver & Mikuliner, 2010). Consequently, Jennifer's self-esteem became depleted and she withdrew from seeking the support of her family "I stopped having people to talk to because I didn't want those responses, so I would choose very carefully what I said" (Jennifer2: p. line). Jennifer's withdrawal also reflects her avoidant coping strategy and the claims of (Blain, Thompson, & Whiffen, 1993; Collins & Read, 1990; Mikulincer & Nachshon, 1991; Priel & Shamai, 1995) in how insecure individuals (both anxious and avoidant), have lower numbers of individuals they can count on for support and tend to be less satisfied with the support they receive from others. This was also reflected in Mary's disclosures about the support she received.

Additionally, Jennifer's depleted self-esteem was also fuelled by her perception that family members had an unfavourable view of her in how she had previously coped with stressors in her life. This was amplified by the internal struggle Jennifer experienced between not wanting to be emotionally detached from her son but neither did she feel that her son's emotional support would be returned, indicative of anxious attachment (Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010). Jennifer's fear that she would be rejected by her son and the lack of support from other family members motivated her to turn to her supervisor for support "I think I spoke to the same counselling colleague who bailed me out the night she had the shock in the first place,

so she knew what was going on" (Jennifer2: p. line). The support given by Jennifer's supervisor was profound in bolstering Jennifer's self-esteem and limiting Jennifer's hyperactivating strategies for coping with distress. This is supported by recent research which has shown how a sense of security provided by a psychotherapist improves a client's mental health. In a study conducted by (Zuroff & Blatt, 2006) a client's positive appraisals of his or her therapist's sensitivity and supportiveness predicted relief from depression and maintenance of therapeutic benefits over an 18-month period.

7.3   Sub-theme two: 'A safe-haven'

7.3.1   Felicity

Although Felicity acknowledges how the companionship of his friends was beneficial to his wellbeing "they have army friends he's had friends from around here he's got school friends and so there were many visitors and they had travelled from London all these youngsters sitting around his bed you could hardly walk in and say hey you lot. please can we have some time with Fredrick (Felicity1: p.7, line 233-235), Felicity herself, perceived this to be detrimental to the recovery of the WIS on the ward "it was quite hard to sit back and think medically this shouldn't be happening…that there was too much noise and then there were too many VIPs visiting" (Felicity1: p.7, line 239-240). Despite this Felicity acknowledges the diligence of nursing staff in managing Fredrick's pain "there was a very good pain nursing sister who did manage it except for one night when someone refused to top up but that can happen" (Felicity1: p.8, line 277-278). Additionally, Felicity recognises how medical staff were under immense pressure "It was packed, every bed was taken with either amputees', burns, shrapnel, not many burns mainly shrapnel amputees and a lot of patients with plaster of Paris ……so many wheelchairs" (Felicity1: p.8, line 285-286).

Felicity's observation of the emotional support Fredrick received was an intentional element of the care provided by AWS and NHS staff, because of its contribution to the physical and psychological recovery of service personnel discussed in chapter two "If you visit Selly Oak, the ward can be somewhat busy, shall we say, because usually round the bed you will find five, six, seven, eight or nine people. There will be a point that their friends, commanding officers, Colonel Commandants of various sorts will be there visiting" (House of Commons 2010).

7.3.2   Lynn

Lynn describes how she perceived it to be important that her son Lance was surrounded by other military patients "they were soldiers you were talking to they were military and

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that was good because they understood, they may not have understood what it felt like to be injured or have an injured relative but then they understood the military and how it worked and I don't know that was just comforting to be surrounded by military people who knew what was going on" (Lynn1: p.15, line 492-493).

The level of support Lynn perceived Lance to have received during his recovery at SO and the level of support she received reflects the measures implemented by DMS in alliance with the NHS which contributed to the 'military bubble' discussed in chapter 2. A measure of how much Lynn valued the emotional support Lance and herself received is expressed by Lynn when she talks about the anxiety she felt prior to Lance's discharge from SO "It was just a fear that the real world would hit him like a ton of bricks and that he wasn't obviously in Selly Oak he was surrounded by the military you know there are military nurses and doctors that deal with you you're surrounded by soldiers injured soldiers army drivers you know"(Lynn1: p. 19, line 606-607). In talking about her concerns for Lance after his discharge from hospital, Lynn gives further context to how Lance during his period of recovery in SO, like Fredrick, benefited from the same cohesion amongst the other injured service personnel and the military staff caring for them in hospital as the unit cohesion they had experienced prior to their TCI discussed in superordinate theme one.

Lynn also acknowledges the availability of military transport "and then the army was there to pick us up and run us to the hospital and things and they'd run you wherever you wanted to go really the army drivers" (Lynn1: p. line) and how families were also allowed access to the hospital catering facilities at no expense "they gave you meal vouchers to get meals at the hospital if you wanted" (Lynn1: p. 8, line 250-251). Lynn and Patricia's expressions of how they felt supported by the military bubble and the other mothers accommodated in Norton House, is reflective of felt-security (Sroufe & Fleeson, 1986) and importantly how their secure attachment style facilitated attachment bonds with other people (Rholes & Simpson, 2004).

Lynn was accommodated in both types of accommodation and is explicit about how beneficial this was "those five weeks were enlightening into how the army works and I mean the first week that he was in intensive care I shared a flat in the hospital grounds and then the next four weeks I had a room in Norton House from SAAFA and that was very good being with other families some of whom had much worse injuries than Lance, that's very supportive and such a great idea and it's like a haven that you come to" (Lynn1: p. 8, line 248-251). Moreover, Lynn discloses how as well as providing accommodation and a place to eat communally, it also facilitated the

provision of instrumental and emotional support through various activities "and we had various things laid on at Norton House like army chefs would come and demonstrate and cook for you so it was a sort of you weren't wrapped in cotton-wool but it was the best it could be for the situation you were in" (Lynn1: p.8, line 252-253).

Lynn's reference to the activities organised by the welfare staff is profound in that the activity itself might at first glance seem a distraction from the distress which might have reasonably preoccupied the mothers, however, the activity facilitated an important mechanism in attachment theory in that it created a secure place in which each of the mothers could explore and importantly, share and discuss their emotions with each other (Thompson, 2009; Thompson, Laible, & Ontai, 2003). Additionally, the instrumental support provided by drivers and the activities Lynn took part in reflect how they provided emotional meaning to the supportive act (Semmer et al. 2008). In the next sub-theme Lynn talks about the support and care she gave to Lance during his period of recovery in SO.

7.3.3   Patricia

Patricia and Lynn's experience of the support they received from AWS reflects the instrumental and emotional support provided by the 'military bubble' discussed in chapter 2 but which has received very little acknowledgement within the research environment. Patricia expresses how the instrumental support she received was as important as the emotional support she received during the period of time Paul spent in Selly Oak "the one thing which was really, really fantastic is that going to Selly Oak and the DMS just take over, and they give you stuff, and they tell you, there you go, there's a bag of tea, coffee, sugar, milk" (Patricia1: p. 12, line 381-382).

7.3.4   Sarah

Sarah's reflection leaves no doubt that she perceived herself to have received little emotional support during her 3 weeks at SO "absolutely not absolutely not, not at all no, someone might have come around, you okay but that was it" (Sarah1: p. 16, line 500-501). Sarah's perception is a measure of her self-reliance and of her propensity to look inwards and rely upon her own personal coping resources and which constructed and sustained her 'charmed life' discussed in superordinate theme one. However, Sarah gives further insight to her self-reliance and how this strategy for coping became depleted later during her 'stressful encounter' "I didn't think about my feelings at all and my feelings didn't really come to the fore until he started his rehab at Headley Court" (Sarah1: p.16, line 502). However, Sarah's suppressive coping strategy and

perceived lack of support from AWS and medical staff may have been augmented by the infancy of the relationship between AWS and NHS medical staff and exacerbated by the number of injured servicemen they were caring for referred to in Chapter Two by Felicity in superordinate theme one.

Sarah's perception of the absence of information and support from medical staff reflects the views of Coyne, Wortman, & Lehman, (1988) and Dakof & Taylor, (1990) who suggest that the perception of support by individuals can be unfavourable when support attempts are ambiguous either because support providers are unskilled at providing effective support, because they misunderstand the type of support that is needed by the recipient. Additionally, how nursing staff used words expressing negative information and pessimism and an underestimation of her son's suffering (Liu, Mok, & Wong, 2005). This is highlighted by Sarah when she is asked whether she was given regular updates about her son's progress after his surgery "Never never, they would say doing really well its early days, so what does early days signify to you, it signifies, oh is there still doubt or am I misreading it" (Sarah1: p.12, line 391-392). Sarah's response is reasonable on two levels; firstly, it reflects the demands made upon medical staff in being sensitive to the need for information from family members and providing emotional support; secondly, it provides insight into how Sarah has subsequently reflected on how the medical staff supported her and the level of distress she experienced between learning of her son's TCI and the first 24 hours she spent during his initial recovery in SO not knowing whether her son would survive his injuries "I've been through something that I have never been through in the last 36 hours with this feeling that he is going to die" (Sarah1: p.12, line 393-394). It is also a measure of how at that point in her life Sarah relied upon her self-reliance and rational and detachment coping strategies (Roger et al., 1993), discussed in superordinate theme one, compared to how she responds to stressors in her life in the present day. This is discussed further in the next superordinate theme.

7.3.5   Mary

Although Mary, her husband and second son were not classified as NOK they were still provided accommodation at no cost to themselves "Malcom, Melvin and I were in a hotel about twenty minutes away I had no idea where it was in relation to the hospital and the army lady took us up there (Mary1: p.10, line 330). Mary also acknowledges how the VO assigned to her son's wife Melony, was also extended to her and her husband at any time of the day "she was on the end of a mobile and would drop

everything to give us a lift to and from the hospital" (Mary1: p.10, line 332). Other than Mary talking about the accommodation and transport made available to her and her husband, Mary gives no indication of whether she benefitted from the emotional support provided by AWS and which other mothers made particular mention of without prompt from me during their interviews reflecting the views of Thompson (2011) discussed in Chapter Two. Neither does Mary talk about the level of care given by medical staff to her son.

The absence of any observations made by Mary and the lack of empathy and support she gave to her daughter-in-law discussed in superordinate theme one is a further indication of how avoidant individuals often interpret demands for self-disclosure and emotional intimacy as unwanted interpersonal intrusions and which motivated Mary to maintain independence and emotional distance from her son and daughter in law as well as her husband and friends (Mikulincer & Shaver, 2007a).

7.3.6   Jennifer

Like Mary, Jennifer did not have NOK status and was offered separate accommodation to her daughter-in-law "when we arrived in SO and she was offered accommodation for herself and her children and I wasn't, she turned around and said no, I want to stay with my mother-in-law" Jennifer1: (p.4 line 124-125). Fortunately, Jennifer and Jacky were offered accommodation by a friend which enabled Jennifer to remain with her daughter-in-law and in close proximity to SO. However, Jennifer's experience is at variance to the claims made by Lieutenant-General Baxter 'the family are an integral part, that they are looked after. There are flats at SO where people can stay very close to the hospital just to enable that whole piece where the family can be together during what is a very difficult time for them' House of Commons, 2010). A possible reason for this discrepancy between Jennifer's experience and the policy advocated by DMS was the result of the high number of casualties in the summer of 2009 in relation to the accommodation available for family members other than NOK. It also brings into question the definition of 'family' and whether the term 'family' is solely NOK and dependents or whether it includes extended family such as parents and siblings.

Like Mary, Jennifer was also dislocated from the instrumental and emotional support Patricia and Lynn talked about during their time spent in SO. However, Jennifer like Mary doesn't talk about the level of care they observed or any interaction with AWS or the level of support their daughters-in-law received. The absence of perceived or received emotional support from AWS or hospital staff, stems from Jennifer's

attachment style and coping strategy discussed in superordinate theme one. This is characterised by how she gives priority to her own feelings of distress and her need for comfort rather than perceive a need for comfort in others who were experiencing distress at the same time.

7.4   Sub theme three: 'the power of mums'

7.4.1   Felicity

Although Felicity does not talk explicitly about the caring role she assumed when Fredrick was discharged from SO, unlike, the other mothers, Felicity talks about how her son's determination to adapt to his amputation not only highlighted his autonomy but also how this had changed their relationship boundaries discussed in superordinate theme 1. Felicity's recognition of the change in their relationship was facilitated by the wilful behaviour of Fredrick during his initial recovery "like driving a car with one leg and like riding a bicycle, riding a horse, going to the pub or getting very drunk, handing around your artificial leg as a champagne bucket" (Felicity1: p. 3, line 78-79) Moreover, in being cognisant of Fredrick's wilful behaviour observed in him when he was a teenager, Felicity demonstrates her maternal insightfulness (Ainsworth 1969; Quitmann et al., 2012) "and they have to go through that almost, it's almost a teenage transition" (Felicity1: p.3, line 79-80). This influenced Felicity's caregiving behaviour (Oppenheim & Karen-Karie, 2002) by delegating her caregiving to her younger son "Flynn was an amazing support to me, Fredrick found it easier to be out and about with Flynn rather than his mother…Flynn was very patient and escorted him all over the place" (Felicity1: p. 11, line 405-406).

In talking about the role Flynn adopted Felicity demonstrates her willingness to display her distress to elicit Flynn's supportive responses because of her strong sense of trust in his ability to deal effectively with threats (Shaver & Hazan,1993). This trust reflects her secure attachment to Flynn, but also how it served to augment Felicity's coping competence, prevent potential for conflict between Felicity and Fredrick, and facilitate Felicity's mothering instinct "Incorporated within the term 'mothering' is the intensity and emotional closeness of the idealized mother-child relationship" Phoenix, Woollett, & Lloyd, (1991, p.6). Flynn also provided Felicity with a sense of 'felt-security' (Sroufe & Waters, 1977; Waters, & Cummings, 2000) "and for me this meant that I knew Fredrick was in safe hands so could relax" (Felicity1: p. 11, line 406) enabling her to moderate her maternal sensitivity in relation to Fredrick's autonomy as an adult and his care needs during his initial recovery.

In doing so, Felicity provides additional context to when she talked about her 'special relationship with Fredrick' in superordinate theme one. The nutrients for this special relationship were provided by the maternal sensitivity Felicity exercised in their shared activity of horse riding and which contributed to their secure attachment then, (Ainsworth et al., 1978) and which was evident throughout Fredrick's recovery and rehabilitation. This closeness between Felicity and all her children is discussed further in superordinate theme three.

7.4.2   Lynn

Lynn also refers to her expressive function "I'd been forced but not unwillingly if you know what I mean, I'd been put into the situation of him being there for the five weeks being there with him in Birmingham and he said he didn't know what he would have done without me bringing him stuff and talking to him and telling him off at times, so back into that kind of parenting role" (Lynn2: p. 19, line 621-622). In caring for Lance during his recovery in hospital, Lynn unconditionally resumes her mothering role and in doing so reflects the views of McMahon, (1995, p. 56) "Mothering is a primary identity for adult women, and women's gender identity is reinforced by mothering." Moreover, Lynn unwittingly reinforces the views of the military and medical staff in SO who spoke about 'the power of mums' and its underlying socially constructed meaning which Sarah was introduced to.

Lynn also demonstrates her reflective functioning in observing how Lance no longer signalled his need for the close care and support asked of Lynn during his recovery in hospital "when we got home and it was winter and it was miserable and he had all his mates around and he was going out, being taken out" (Lynn2: p. 20, line 624) and in doing so reflects the views of Leonard, (1996, p. 129) "the mother does not view her child as an autonomous equal deserving of care by virtue of his or her rights, rather, the child's helplessness and need and relationship to her solicit her care." Lance's socialisation with his network of friends reflects how as a child he had sought a dynamic balance between attachment and exploration (Bowlby, 1981) and how Lynn in the role of mother had sought a balance between her need to protect and nurture her son and her need to pursue other goals. In the next superordinate theme Lynn talks about how she sought the emotional support of Lance during the early part of his rehabilitation at Headley Court, which further supports the secure attachment between Lynn and Lance.

7.4.3 Patricia

Patricia's caregiving experience in contrast to the other mothers has been intensely challenging during the eight years her son has been receiving full time care funded by the NHS and continued to be challenging up to the point of her second interview in 2016. Despite not having direct responsibility for Paul's day-to-day care Patricia has assumed responsibility for accessing and more recently procuring the most appropriate interventions to assist in Paul's physiological and cognitive recovery and his aspiration to live as independent a life as possible "and then the idea is to move onto your own flat which is still contained but your own front door kitchen bedroom and it's how you do your washing, how you sort out your food and all of this and plan your day " (Patricia2: p. 14, line 439-441). Patricia's understanding of how she has cared for Paul during the past 9 years and how she continues to care for him is embedded in how she has at the same time also had to care for her two younger children.

Patricia discloses her sense of caring and her close relationship with Paul and how mothers want the best for their children when she describes how she compares the trajectory of her younger son's life with that of Paul's "Phillip's going for his twenty first, Petula's going with her boy-friend again to Malta on holiday Paul hasn't been on holiday should have gone on holiday and has he really experienced everything that life could have thrown at you in that sense probably not in the accepted way" (Patricia1: p.25, line 791-793). Patricia's perception of 'the accepted way' reveals how she continues to provide parental support to Paul, reflecting the views of in how mothers form plans for their children and hope their children will "grow up, establish themselves as functioning adults" Hagestad (1986, p. 685).

Parental support has traditionally been defined in developmental psychology literature as parents' warmth, acceptance, responsiveness and involvement towards their offspring (Jessor, Donovan, & Costa, 1991; Miranda, Affuso, Esposito, & Bacchini, 2016; Scabini, Lanz, & Marta, 1999) and which Patricia hopes Paul perceives in her "Paul doesn't want to see a blubbering crying screaming upset mum he wants somebody that he can hopefully…you might have to ask him that…somebody that I hope that he can turn to and look up to and say she was there for me" (Patricia2: p.23, line 726-727) . Patricia's idealised view of herself reflects the two primary determinants of attachment organization - maternal insight (Ainsworth, 1969) and maternal sensitivity (Ainsworth et al., 1978) which together have determined Patricia's close relationship with Paul (e.g., Demers, Bernier, Tarabulsy, & Provost, 2010) and the level of care she has given to Paul during the past nine years.

In talking about the care Paul has received during the past nine years, Patricia highlights how Felicity and Lynn adjusted to their son's adulthood and the change in their relationship boundaries by accepting how their sons' experiences as an adult and from their military service had broadened their insight. Patricia however, laments how different Paul's transition to adulthood had been by comparing him with his younger sibling "It got quite tough for a while when Phillip got to be the same age because you're thinking this is what Paul should have been doing" (Patricia2: p.25, line 785-786). Patricia's visualisation of the life she expected Paul to have is reflected in the views of (Aldous, 1978) and how mothers of children who were not seen as being on schedule in becoming independent adults experienced strain and a sense of personal failure "I did think that as Paul was growing, was 19, 20, he should be coming home getting drunk going out with girls you know all this that and the other and doing what we all did" (Patricia2; p. 25, line 785-786).

In talking about Paul, Patricia reflects her mothering in the past and her mothering in the present and the future and how it has influenced her life (Adams, 1995; Ross, 1995) "Yes there's sadness really, it's sad because it's like he needs to go on holiday it's not an effort now that I've finished work, it'll be a bit easier" (Patricia2: p.25, line 793 . In looking forward to her retirement Patricia gives insight to her caregiving and her caregiving strategies (Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993) and her unlimited resources for mothering work, her capacity to understand and support Paul and her willingness to prioritise Paul's needs over any of her own (Chodorow & Contratto, 1989). Moreover, how societies socially constructed views of mothering has a reciprocal meaning with how secure attachment between mothers and their children and their caregiving remain constant throughout life span (Ainsworth, 1970; Bowlby, 1969/1982; Gordon, Benner, & Noddings, 1996). Even though 'motherhood' is today recognized as socially constructed roles rather than essential identities, Patricia's experience of firstly raising her son and then caring for him reinforces many of society's naturalized conceptions of these roles.

7.4.4   Sarah

Sarah distinctly recalls a phrase she repeatedly heard on her son's ward during her time at SO "I kept hearing the same sentence, ah the power of mums there's nothing better than a mum" (Sarah2: p.10, line 303). Sarah was ambivalent about these phrases at the time she heard them but has since reflected on how these phrases inferred that she had innate attributes or personal qualities so "we seemed to have an incredible power that

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we didn't know about" (Sarah2: p.10, line 314) which would enable her to cope with the demands that were imposed upon her by her son's continued recovery at home before commencing his rehabilitation at Headley Court.

Sarah is emphatic about the origin of her incredible power "as we're growing up" (Sarah2: p.11, line 312) and implicitly refers to the social beliefs about the role of mothers and the mythology which underscores societies views and beliefs about motherhood reinforced by theorists and researchers who have categorised the different roles of mothers and fathers in the family system (e.g., Craig, 2006; Parke, 2002, 2004). Sarah was very aware of these different roles categorized more than 50 years ago by Parsons & Bales (1955) who advocated fathers would be expected to fulfill largely instrumental functions, such as providing income and disciplining children, whereas mothers would be responsible for expressive functions, such as caregiving, companionship, and sharing leisure activities. Sarah talks about this when she perceived herself to have returned to the expressive function associated with the role of mothers after her son's discharge from hospital "you know we've done our bit, here you are you can deal with it now mum, it's all yours" (Sarah2: p.11, line 330). Sarah's view also reflects how the medical care her son received during his recovery was all embracing, reflecting Lynn's perception of the medial care her son received and at the same time an indication of how Sarah perceived herself to be detached from instrumental and emotional support.

7.4.5   Mary

Mary is explicit about how she made the conscious decision to absolve any responsibility for providing care to her son or indeed care to her daughter in law. This is in opposition to research which has established that despite the change in parent-child relationships when children become adults, parents continue to provide affection, support, and nurturance to their adult children (Fingerman, Hay, Kamp, Dush, Cichy, & Hosterman, 2007; Zarit & Eggebeen, 2002). Indeed, parents provide more support to their adult children than the reverse throughout much of adulthood including financial, instrumental, and emotional support (McGarry & Schoeni, 1997; Zarit & Eggebeen, 2002). However, Mary relinquishes support to Martin in deference to Melony and her role of wife to Martin "you know you're replaced as the first woman in his life sort of thing to somebody who you want there but has replaced you in a way in a different way" (Mary2: p. 42, line 1331-1333) reflecting the views of (George & Solomon, 1996) and how difficult it is for children to develop and maintain secure and functional

attachment strategies with their mothers' when their mothers' behaviour is guided by insecure caregiving strategies.

The similarity between Mary and Martin's representations of their relationship strongly indicates the history of insecure attachment between Mary and Martin discussed in superordinate theme 1, and the previous sub-theme. It also emphasises Mary's lack of empathy towards the emotional needs of Melony during an intensely distressing period in Martin's recovery in SO and contravenes the interactive behaviour representative of a mother's maternal sensitivity and a primary determinant of attachment quality (De Wolff, & van IJzendoorn, 1997). The lack of support Mary gave to Martin or Melony is given greater context in superordinate theme 3.

7.4.6   Jennifer

Throughout Jennifer's two interviews the sequence of events she talks about is sometimes disorderly and contradictory suggestive of Jennifer's tendency to conceal or omit perceptions or perspectives which might attract an unfavourable view of her. Jennifer's motivation for this is to protect her self-esteem and validate her responses to situations she talks about. This is revealed when Jennifer in her second interview Jennifer talks about the support she gave to Josh and Jacky during the eighteen months prior to Josh's surgery "He didn't so much but Jacky would sometimes phone me and tell me we've been to see the surgeon and well, they told me…probably the only time they really told me anything was on 19 March" (Jennifer2: p.4, line 69-70). In raising this point Jennifer conveys the limited amount of contact and communication she had with Josh and Jacky. However, Jennifer quickly counters the accusation she directed towards Josh and Jacky "I would love to have had more but it's not my place to…I mean I wasn't his next of kin, he had his wife and it wasn't…I couldn't pry for more" (Jennifer2: p. 4, line 75). This contradicts Jennifer's earlier disclosure in interview one when she talked about the boundaries she had set when Josh and Jacky married "I wanted Jacky to be aware she was caring for Josh and I had to take a back role because I wanted to make sure that I didn't get in the way of their relationship" (Jennifer1: p.10, line 392).

Jennifer displays a similar contradiction when she talks about her decision to avoid visiting Josh in hospital after his elective surgery "Jacky said to me, did I want to be there with Josh when he came round, I said I couldn't, I couldn't do that, I'll look after Joseph but I couldn't be there" (Jennifer2: p.20, line 660-661). This has similarity to how Jennifer responded to visiting her son in hospital discussed in superordinate

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theme one and how she took care of her grandson to avoid remaining on the hospital ward. Together, these two isolated but related events reflect Jennifer's difficulty in displaying maternal sensitivity indicative of soothing and responding to an infant's cues (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; Brown, Mangelsdorf, & Neff, 2012). Additionally. Jennifer's decision to avoid visiting Josh in hospital reflects her fear of intimacy and her unawareness of how in keeping her distance from Josh she was neglecting and at the same time damaging her relationship with Josh (Gaines & Henderson, 2002; Scharfe &d Bartholomew, 1995). However, Jennifer validates her lack of support by suggesting that she had sacrificed her own needs by putting her son's needs before her own "I didn't want to show my emotions when I thought he might need me to be supporting of him, I didn't think it was appropriate, when he's just had major surgery like that, that he's got to support me (Jennifer2: p.21, line. 667-668). This contradicts Jennifer's explicit disclosure in her first interview when she emphasised how she had spoken to all her sons about the importance of mutual support "I know and you know that we're here for each other at all times" (Jennifer1: p.3, line 90). This is later contradicted by Jennifer when she talks about the lack of support she gave to her sons and how they understandably had an unfavourable view of her ability to cope with stress discussed in superordinate theme one. In her second interview Jennifer once again sacrifices her own needs when she gives deference to Josh's marriage to Jacky mentioned briefly in superordinate theme one "your relationship with your wife is the most important" (Jennifer1: p.4, line 149) and in her second interview when she once again gives deference to Melony "we took him out to supper one night when he was there, we didn't really go and visit him, and so she was much more familiar with the limbless and what it's all like" (Jennifer2: p.21, line 670-671).

Jennifer's series of contradictory and elaborate disclosures across both of her interviews are intentionally convoluted and intended to defend her feelings of worthlessness and depleted self-esteem in the role of mother (Milkulincer & Shaver, 2007a; Mikulincer et al., 2006), reflecting further how Jennifer's anxious attachment to her son went beyond Jennifer's coping resources (Mikuliner & Florian, 1995;1998) and her limited capacity to act as an external source of emotional support for her son, one of the central tasks that parents perform for their children (Paley, Lester, & Mogil, 2013). Together, Jennifer's ineffective coping strategy and history of highly emotional reactivity reflects how regardless of the needs of her son and her daughter in law, Jennifer was unable to 'relax, enjoy and appreciate the feeling of being loved' or seek

proximity and protection from her attachment to her son Mikulincer & Shaver. (2007a, p. 141).

7.5   Summary of Superordinate theme two

The variation between each mother's perception of the support they received from AWS during their son's period of recovery in Selly Oak has highlighted the importance of providing instrumental and emotional support to family members at a time when they are experiencing a high level of distress from the shock and uncertainty of the nature and extent of their son's TCI, prognosis and treatment. Absent from all the mothers' narratives was any perception of support from NHS nursing staff. A possible explanation for this is the number of WIS being cared for in 2009 discussed in Chapter Two and how the collaboration of military and NHS medical staff care was still evolving. The support Sarah, Lynn, Patricia and to a lesser extent Felicity received from AWS reflects the earlier views of Lieutenant General Baxter (House of Commons, 2010) discussed in Chapter Two.

     In contrast, the perception of support experienced by Mary and Jennifer was influenced by the presence of their daughter-in-law and the location of their accommodation, which, was geographically dislocated from the accommodation and supportive environment provided by NH and only available to NOK. The inability for Mary and Jennifer to recall expressions of perceived and received instrumental and emotional support during their sons' recovery in SO is consistent with their insecure attachment styles and in how Mary and Jennifer talked about how their lack of direct support during their son's rehabilitation was based on deffering responsibility of care to their daughter-in-law and her role as wife.

     The absence of MH support for the mothers also originated from the stereotypical connotation associated with 'societies' discourse' and 'cultural myths' related to motherhood. This assumption is strongly rooted in the experience gained by the mothers in their earlier role in the stages of their sons development from child to adulthood. It was assumed that the attributes, skills and personal coping resources acquired during their experience of motherhood would transfer to meeting the care needs of their injured sons during their initial recovery at home and during their periods of respite away from HC during their rehabilitation. For two of the mothers, their perceived role as caregiver was reinforced by how their sons elected to inform them of their TCI while being treated by medical staff at BH. This was reinforced later by the role adopted by the visiting officer, who acted as liaison between the mothers and SO

military and medical staff. The deference given by other family members to the mothers' role as caregiver also reinforced the mother's perceptions that caring for their son was their responsibiliity. This also reacquainted these four mothers Felicity, Lynn, Patricia and Sarah talked about the care they gave to their son. Assuming responsibility for the care of their sons reacquainted these mothers with the responsibilities, knowledge and skills they had learned as young mothers "in the everyday, repetitive and contingent acts which are their own ends as . . . found in the final product, the child, grown to productive adult, capable of both work and love" Leonard, (1996, p. 127). In caring for their sons these mothers had called upon the maternal sensitivity and insight they had demonstrated as young mothers to help their sons to "grow up, and establish themselves as functioning adults" (Hagestad, 1986, p. 685) and how the attachment between mothers and their children and their caregiving remain constant throughout life span (Ainsworth, 1978; Bowlby (1969/1982). Despite this strong attachment Felicity, Sarah, Lynn and Patricia in slightly different ways from each other recognise how their sons have become autonomous individuals with "minds of their own" (Fonagy et al., 1991).

Chapter Eight: "Life after the stressful event."

8.1   Introduction

This third superordinate theme consists of 2 sub-themes summarised in figure 15 and begins with each mothers account of how their mental wellbeing was affected during their son's recovery and rehabilitation followed by each mother's current perception of how the experience of their son's TCI changed their self-perception.

Figure15: Superordinate theme 3 'Life after the stressful event'

SUPERORDINATE THEME 2

Life after the stressful event

Dark days

Gaining a sense of purpose
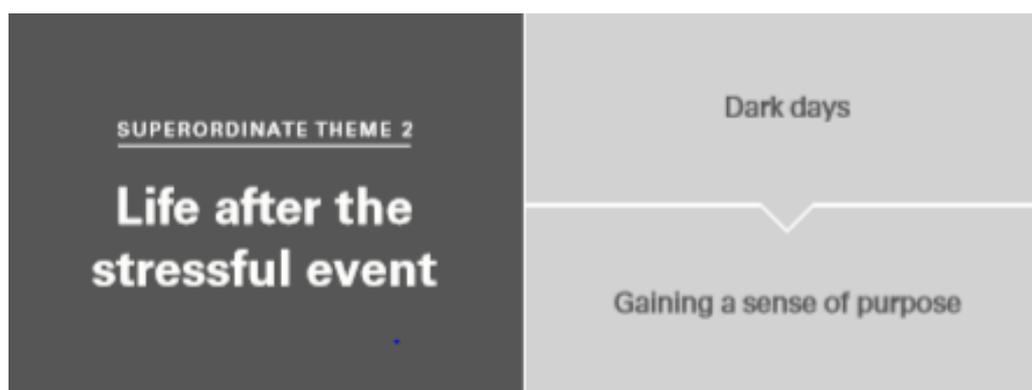
8.2   Sub-theme one 'Dark days'

8.2.1   Felicity

In neither her first or her second interview Felicity gave no indication that she had experienced any prolonged personal distress or a decline in her wellbeing. However, rather than describe her experience of distress and the strategy she employed to deal with the cause of her distress, Felicity talks about her distress by presenting the same optimism and positivity that she described about Fredrick discussed in the previous sub-theme. Additionally, Felicity uses the word lucky to give insight to the distress she experienced preferring to talk about how she coped by attributing it to a series of fortuitous events or circumstances that conspired without her influence to help her avoid any detrimental effect on her wellbeing "it could have been so much worse…. he could have been paralysed, paraplegic or quadriplegic" (Felicity1: p. 4, line 138-139). At the same time Felicity uses the word luck not to describe 'sheer luck' or 'personal luck' but to emphasise how other mothers had to manage the loss of their son's life rather than the loss of their son's leg "we are seriously lucky here and that's not meant in a very trite way but actually we got our son back" (Felicity1: p.5, line 155-156).

Later in her interview Felicity talks about the adverse remarks of friends and strangers who perceived Fredrick to have been "very lucky to have done the things he has done" (Felicity1: p. 12, line 426). In her second interview Felicity talks more openly

about how she has defended her son against the short-sightedness of imprudence of others "the general public just see Fredrick as achieving achieving achieving……and that's one of the worst things when people say that he has had these opportunities isn't he lucky…but unaware that he has just cracked on with life" (Felicity1: p.12, line 437-438). The determined and optimistic way in which Fredrick regained his physical functionality served to underestimate the magnitude of his physiological and psychological adjustment driven by his determination to resume his life aspirations. In talking about her son, Felicity uses the word lucky this time in the context of downward comparison to improve her mood when recalling others disparaging views (Aspinwall & Taylor, 1993; Gibbons & McCoy, 1991; Wood, Michela, & Giordano, 2000).

Felicity's use of the word lucky is also indicative of her humble demeanour and allows her to talk about the challenges she and her family members have overcome. It also represents the understated way in which she acknowledges how she and her son, and all her family members, were able to call upon their 'family cohesion' to minimise the stressors they experienced during Fredrick's rehabilitation. For Felicity the close relationship with her family members became a 'hybrid' coping strategy which acted as a buffer against the harmful effects of their son's stressful event.

8.2.2   Lynn

After Lance returned to Headley Court following his second period of respite at home Lynn responded to 2 CRs on her ward in one day, which caused Lynn to leave work and travel to Headley Court to be with Lance "I only lasted a month at work I had a bad day when I had 2 in-house arrests and just completely couldn't stop, I thought I'm going to have to get a taxi home because I'm going to cry and I don't want to sit on the bus crying" Lynn1: p. 22, line 711-712). Lynn was unwilling to disclose whether the two CR's she had attended had resulted in the death of each or one of her child patients. However, Lynn's response reflects the research conducted by (Meadors & Lamson, 2008) who found that higher levels of personal stressors were positively correlated with higher levels of clinical stress among paediatric, neonatal, and paediatric intensive-care providers.

Lynn indicates how she had unknowingly supressed the distressing emotions inherent in her role as a paediatric nurse when she describes how she made the decision not to go to work the day after attending to the 2 CR's "I just phoned up one of the sisters who was on and I said sorry I can't come in today and I remember saying to her I feel so stupid for this but it's just hit me you know just the repercussions of bottling

stuff up" (Lynn1: p.23, line 737-738). Lynn's use of the phrase 'bottling stuff up' is referred to in nursing literature as compassion fatigue or burnout caused by suppressing distressing emotions (Meadors, Lamson, Swanson, White, & Sira, 2010). Moreover, suppressing the emotions associated with the trauma or death of a patient can have a detrimental effect, both personally and professionally (Brosche, 2003). Lynn indicates how she had unknowingly supressed the distressing emotions inherent in her role as a paediatric nurse "I work in children's intensive care, so I do stressful for a living" (Lynn1: p. 2, line 38-39). This leaves a strong impression with me of the significant day-to-day emotional stressors Lynn had to cope with prior to her son's TCI. It is not until Lynn in her second interview some twelve months later, talks more freely about the stressors she has experienced as a paediatric nurse, that she gives additional context to how she had 'bottled stuff up' and how attending to 2 CR's had been far more detrimental to Lynn's wellbeing than the experience of her son's TCI.

After informing her ward sister that she would be unable to come to work, Lynn felt compelled to travel to HC to be with Lance "I just ran away I went down to Headley Court where he was and stayed in the Norton House down there because it was very quiet at that time, so I went for a few days to kind of get myself back on track" (Lynn1: p.22, line 713-714). However, despite Lynn's attempt to alleviate her distress, upon returning home Lynn's anxiety persisted and she consulted her family doctor, "Doctor Lavine, she's brilliant, I've had her ever since the kids were little and I think I'm what you call an expert patient in that I'm very…all my conditions I'm very well aware of them, not because I'm a nurse but because I ask questions and research it for myself and I'm very in tune with what they're doing" (Lynn2: p.27, line 853-854). Lynn's consultation with her family GP not only reflects the person-centred approach recommended in NICE guidelines in which the treatment and care of patients should take into account the needs and preferences of the patient. It also complemented Lynn's need to make an informed decision about the care and treatment available to her in partnership with her doctor. This also emphasises how Lynn had benefited from her GP being intimately familiar with her medical history enabling Lynn to negotiate the most appropriate treatment plan for her symptoms and her past and ongoing health needs "I have arthritis and I have a mobility syndrome which has occasioned me to have some operations" (Lynn1: p. 1,line 27-28).

This contrasts significantly with Jennifer's disclosure that the only treatment offered to her was anti-depressants rather than her preference for counselling. Although there are a wide range of treatments for the symptoms of GAD, Lynn was prescribed a

combination of drug treatment and CBT. Additionally, Lynn took advantage of the staff counselling offered to her by her employer which provided her with support up to the start of her CBT.

Lynn talks with certainty about the efficacy of the interventions she engaged with and how they brought order to her thoughts and emotions "the counselling looked back and enabled me to see why I was feeling some things or reacting in the way I did" (Lynn2: p. 29, line 923-924). This reflects psychodynamic therapy characterised by "non-directive empathic treatment that emphasizes uncovering unconscious conflicts, personality dynamics, or working through transference reactions" Tomlin, (2010, p. 718). In contrast to counselling, Lynn describes how her CBT course enabled her to " improve dysfunctional thinking and beliefs" Dobson & Dozois, (2001, p. 7) by enabling her to rationalise her thoughts and the possible causes of her distress from a number of different perspectives "but the CBT didn't look at why, just saying this is how you feel am I right yes right okay how can we sort that out" (Lynn2: p. 29, line 924). Moreover, Lynn's engagement with counselling and CBT enabled Lynn to improve her existing stress coping competency.

In talking about the benefits of the therapeutic interventions she engaged with Lynn gives greater context to when Lynn talked about previous stressful events in her life in superordinate theme one and insight into the impact on her wellbeing the day she attended to two CR's on her ward 'and then one after Lance was injured'. This stressful event eclipsed the distress of her son's TCI which Jennifer had been able to adjust to because of her son's determination to recover from his TCI and return to Regimental duties and the emotional support he received from his network of friends "I felt fine to go back to work and then I was back at work for about 4 weeks and then it was at the end of the 4 weeks, that was what you would describe as a particularly horrible day" (Lynn2: p.13, line 415).

8.2.3   Patricia

Patricia gives an unequivocal answer to being asked whether she had experienced a decline in her mental health during the past 9 years of caring for Paul, "there were some dark days, some dark days" (Patricia2: p. 27, line 853). Patricia experienced her 'dark days' in a variety of different ways which ranged from how she felt during the initial period Paul spent in SO "in some of the early days it was when there was little hope" (Patricia2: p. 31, line, 969-970); when Patricia was on her own "there were dark days when he wasn't the best and Peter's abroad and the children are in bed and you're on

your own" (Patricia 2: p.31, line 974); and when Patricia's ex-husband and wife made demands of Patricia "and also some of the dark days is when his father and stepmother, why haven't you done this and why what's happening here" (Patricia2: p.31, line 976).

Patricia uses the phrase dark days to represent her periods of distress which are located in the past and not during the period of the interviews with her. This gives acuity to the lack of support Patricia experienced after the initial support she received from family and friends discussed in superordinate theme two and how Patricia was not always able to discuss her concerns and fears with her husband because he was out of the country "so they were dark days when you haven't got anyone to talk to and you don't want to talk about it to some people, I know that sounds daft you say you don't want to talk about something and you've got no-one to talk about it to" (Patricia2: p.31, line 983). In highlighting this contradiction Patricia is unwittingly describing the utility of two different types of coping strategy - distraction and emotional support discussed in superordinate theme one and two.

In talking about her 'dark days' Patricia provides further context to the sense of loss she perceived for Paul in not experiencing the normal events in his life as those his younger brother had experienced discussed in superordinate theme two. In taking about this, Patricia for the first time in both of her interviews gives insight to the depth of her sense of sadness "why has this happened why…just why aren't things happening, this shouldn't have happened, it shouldn't have been like this, it's just that little feeling sorry for yourself feeling sorry for Paul, feeling sorry on behalf of Paul," (Patricia2: p.31, line 967-969). The origin of Patricia's sadness is both a reflection of her maternal sensitivity and maternal insight described in superordinate theme one and two and how mothers of children who are not on schedule to becoming independent adults experienced strain and a sense of personal failure because of how mother "formed plans for their children and assumed that these would be fulfilled in the long run. They hoped that their children would grow up, establish themselves as functioning adults" (Hagestad, 1986, p. 685).

Patricia talked about her sense of sadness in superordinate theme two and how Paul had not been able to experience life as a 'functioning adult' when she talked about how Paul's TCI had stopped him from experiencing the same life events as his younger brother. Patricia gives insight into how she mitigates her sense of failure for Paul not progressing successfully as an adult by assuming responsibility for Paul's continued care and recovery "but it's worthwhile trying Paul wasn't too keen we don't really know why" (patricia2: p. line) and how she encourages Paul to engage with

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interventions that will help him to make progress towards independent living, "and he's doing more he's walking a lot more not by himself it's assisted walking but he's actually getting up and walking and he's talking more" (Patricia2: p. 11, line 362-363). Later, Patricia for the first time in her two interviews gives a measure of Paul's recovery and level of functioning "actually Paul you know you're not initiating you're not thinking for yourself people are still having to do a lot for you" (Patricia2: p.14, line 458). Patricia's disclosure gives clarity to not only her predispositions as a mother, her secure attachment to Paul but also how she is driven to provide the very best care for Paul but is also the motivation that pushes Paul to make progress towards his independent living. Until that point is reached Patricia's life, despite reaching retirement, remains on hold, while she gives priority to Paul's continued care and the life experiences he is yet to enjoy. Patricia talks about the insight and understanding she has gained from her experiences in the next sub-theme.

8.2.4   Sarah

Sarah's dark days began with her need to understand the emotions Steven was experiencing immediately after his discharge and return "I would have liked to have understood from Steven a little bit better what he was trying to work through" and attributes Steven's reluctance to share his emotions with her as a result of the medication he was taking to manage his pain "but of course he was drugged up to the eyeballs obviously" (Sarah2: p.24, line 765-766) and secondly Sarah's preconception that Steven's strong alliance to the identity he had gained as Royal Marine prevented him from disclosing his inner feelings and distressing emotions "he's a Royal Marine and doesn't share much" (Sarah2: p.24, line 766). These reasons for Steven's lack of emotional disclosure helped Sarah to accept the change in Steven and the change in their relationship compared to the emotional disclosure and reciprocity that existed between Sarah and Steven before his TCI discussed in superordinate theme 2. This lack of emotional reciprocity between Sarah and Steven as well as the sustained level of instrumental and emotional support she was giving to Steven motivated her to seek the help of SSAFA "I had approached SAAFA for help and they didn't respond" (Sarah2: p. 35, line 1122-1123).

    Seeking the support of SSAFA signified a departure for Sarah from her dispositional propensity to look inwards and rely upon her own resources for coping and an indication of how overwhelmed Sarah was by the demands made upon her in caring for Steven "I became suicidal, it was her lack of response that made me feel I'd had

enough and the next time I drove to Headley Court, which was November, (6 months after Steven sustained his TCI) I thought, all I need to do is turn the wheel and that will be the end of it, enough of this what I'm going through" (Sarah2: p.36, line 1128-1130). However, Sarah's momentary thought of suicide raised her self-awareness and motivated her to seek help from a welfare officer she had met at Selly Oak "Sandy suggested I wrote down my thoughts and I did and that was the beginning of the book" (Sarah2: p.38, line 1136-1138). Sarah refers to her written thoughts as 'a book,' rather than her intention to publish her experiences, reflecting the technique of written emotional disclosure (WED), or expressive writing (Pennebaker & Beall, 1986), and how the awareness, expression, and processing of emotions can be adaptive, (Gross, 2002; Kennedy-Moore & Watson, 1999) leading to reduced stress and thereby an improvement in health. The effectiveness of Sarah's use of WED is supported by research conducted amongst veterans returning from deployment to Afghanistan and Iraq, and how WED decreased marital conflict and increased marital satisfaction (Baddeley & Pennebaker, 2011).

Sarah talks about how she shared her writing with Sandy, "I've actually got a mum here who's really struggling would you mind sharing your story, so I sent it to him and later on that day he said that was incredible, he said no matter what I would have said wouldn't have touched her but her reading your story meant an awful lot, so that was really perceptive of him and kind" (Sarah2: p. 38, line 1138-1139) reflecting the views of Eisenberg, (2000) in how Sarah's response to the misfortune of another mother also enabled Sarah to regulate her own emotions. This also encouraged Sarah to ask her husband to read the thoughts she had captured in her book "I gave that to Shaun to read because I thought there's just so much going on in my head I can't really tell him everything and I was quite annoyed, I remember being quite annoyed because he kept on saying how difficult other people's situations were but not acknowledging the one that I was in" (Sarah2, p.36, line 1141-1142).

Sarah's disclosure provides a strong indication of how successful Sarah had been in the past in her role as mother and 'stand-in father' and her self-reliance discussed in superordinate theme 1, had been successful in both coping with the stressors in her life and concealing this from her husband during his frequent and long periods at sea. Unintentionally, Sarah's husband reflected society's general view of the role of mothers and Sarah often hearing the phrase 'the power of mums.' Both, reflecting the unspoken assumption that mothers were capable of caring for their adult sons during their period of rehabilitation without the provision of mental health support.

Support for this unspoken assumption is stated forcefully in a report published by the Army Families Federation (AFF: 2010):

> The AFF recommends that professional and immediate counselling is on offer to military families suffering injuries or bereavements due to operational tours as part of the Military Covenant. AFF understands that the MOD position on counselling is that families should access it through the NHS system however, it does not consider this a sufficient response from the Government. (p. 36)

Sarah like Lynn had recognised the need to seek help in accessing an intervention to help manage her distressing emotions more effectively "I felt writing was very therapeutic and when I wrote I began to feel that that was a way forward, it was a way of me offloading, I suppose I'm offloading onto a sheet of paper aren't I, but it worked for me" (Sarah2: p.39, line 1233). It is only in the present day some 9 years after Steven's TCI and Sarah's self-intervention, that she understands how her self-reliance epitomised by her 'charmed life' enabled her to cope effectively with the stressful demands of being a young mother and single parent "you have to remember I'm that person that wanted to be alone and cope because that's what I've always done" (Sarah2: p. 39, line 1249). Sarah's writing conforms to adaptive emotional coping "because my writing was so good when I was really troubled it was brilliant" (Sarah2: p. 40, line 1258), and instrumental in helping Sarah to ameliorate the distress caused by her efforts to console and comfort Steven during his rehabilitation and indicative of her maternal sensitivity and secure attachment.

8.2.5   Mary

Mary, had been able to access counselling through her son's Regiment "Mentally I think I just…I don't know…I don't…I just think I thought this precise Monday morning I need some help…I don't know….I don't know what drove me to it" (Mary2: p.27, line 851). Mary's reluctance to provide an explanation for why she perceived a change in her wellbeing was pursued further by the author with a series of questions which eventually encouraged Mary to be explicit about the cause of her distress "it's mixed up with the fact that he had a wife and she was coping and helping him and I personally and we weren't able to do very much or anything and we didn't see him that often because of course when he came home from Headley at the weekend he was knackered" (Mary2: p.27, line 958).

Mary's lack of contact with Martin and Melony and her rumination of the possible reasons became overwhelming for Mary which motivated her to seek the help of a counsellor through her son's Regiment "I found it useful because I could come out with what I wanted to say which I don't know what I did say and the feedback about flipping whatever I'd thought or said over the other side and thinking of it from a different view whether that was a military view or view from Martin or Melony" (Sarah2: p. 29, line 902-903). Mary's inability to recall what she discussed with her counsellor even in general terms is indicative of Mary's earlier responses in her first interview, however, Mary reflects the views of Jennifer and Lynn and the benefit they experienced from their counselling "just to flip it on its side and you know this may not be as you thought it obviously because there is another side to everything which you don't necessarily consciously think about" (Mary2: p. 29, line 909).

Despite Mary's disclosure of how beneficial her counselling had been "a good 8 or 9 if not 10" (Mary2: p.29, line 912), Mary later discloses how she had resigned herself to the poor relationship and lack of contact she had with Martin "there is no sense to be made of it" (Sarah2: p.29, line 918). Moreover, Mary discloses that rather than seek to discuss her concerns with Martin she preferred to engage in a technique suggested by her counsellor "write down everything in whatever language polite or otherwise you wish to do towards whomever you think is at fault and then burn it that night before you go to sleep" (Mary2: p.29, line 918-919).

Mary's reference to 'language polite or otherwise' is suggestive of anger and reference to 'fault' is suggestive of how Mary blames her son for the way she feels towards him. This technique for dealing with distressing or worrisome emotions is far removed from the emotion processing described by Rachman (1980):

> emotional processing is regarded as a process whereby emotional disturbances
>
> are absorbed and decline to the extent that other experiences and behaviour can
>
> proceed without disruption. (p. 51)

and how this was facilitated by the CBT programme Lynn was given access to by her GP discussed in superordinate theme two. Mary is emphatic about the effectiveness of her approach and how she has frequently called upon it in the past discloses how she has relied upon this same coping strategy to manage her wellbeing in the past " I related to that because I have often suggested to patients and particularly those undergoing termination that they don't particularly want to but need to do that

before you go into theatre for this termination so write down now why you cannot have this baby because tomorrow tonight, tomorrow, next week, next year, you will be convinced you could have coped" (Mary2: p.29, line 920).

Although Mary's strategy of writing down her thoughts has a similarity with Sarah's writing of events and her perceptions, it is important to make the distinction between the two approaches. Crucially, Mary's preference for putting her thoughts in a letter and then burning them enabled Mary's beliefs and assumptions to go unchallenged and importantly served to protect her from any unfavourable judgement from Martin. Moreover, Mary gives herself permission to relinquish responsibility for the actions of her son or to negotiate the conflict between herself and her son and daughter-in-law, leaving the cause of her distress unresolved. This is at variance to Sara's motivation for writing down her thoughts which not only reduced her level of stress and an improvement in her wellbeing but also facilitated her increased awareness, expression, and processing of her emotions (Gross, 2002; Kennedy-Moore & Watson, 1999).

8.2.6   Jennifer

In superordinate theme 2 Jennifer talks about the stressful events she encountered earlier in her life and the stressful events that coincided with her son's TCI, additionally, how she took anti-depressants to help manage a decline in her physical and mental wellbeing. However, it is not until her second interview that Jennifer talks about the support she received from her son's Regimental welfare Officer to help mitigate her level of anxiety "I did actually get 6 sessions…was it 6, it might have been 12, I can't remember now, I'm not sorry about the counselling being paid for by the welfare office but I had to push for it but I just thought actually this is for my son, I don't bloody well see why you shouldn't pay for me to have some counselling, so I did push for it because I knew that that would help me" (Jennifer2: p.25, line 828-830). This admission by Jennifer in her second interview , almost 12 months after her first interview creates a contradiction in how Jennifer felt the need for counselling despite having described her son's initial injuries as relatively minor "I thought about him having broken ankles and well that's alright they'll mend, he'll be back out there before they can say jack-knife so I wasn't the slightest bit worried about his feet." (Jennifer1: p.5, line 187-188).

In talking about the counselling Jennifer received in her second interview she provides new meaning and context to Jennifer's perception that her son's injuries initially and before his left heel became infected were relatively minor. This raises the

question why Jennifer at this stage of her son's recovery needed to access counselling. Jennifer's perception of her 'dark days' unlike the accounts given by the other mothers' is in fact represented not by her son's injuries alone but the distress Jennifer was experiencing from the depletion in her self-esteem and the unfavourable views of other family members. This deception encapsulates the battle Jennifer has in defending her self-view in the role of mother and how she was also motivated to protect herself from my unfavourable view of her during her interview.

In being unable to share why she had limited the support she gave to her son and daughter-in-law, Jennifer disguises her motivation for keeping her distance from her son and daughter-in-law by presenting herself as having sacrificed a closer relationship with her son by giving deference to her daughter-in-law's role as wife. Jennifer talks about this on several occasions during her interview and always without prompt from me. Jennifer's deception was not immediately obvious during the interpretive stage of Jennifer's narrative, reflecting the views of Moran, (2000a, p. 27) "the phenomenon can never disclose itself in its entirety and interpretative work is required to understand the meaning of the (partial) disclosure." This interpretation of Jennifer's hidden meaning also reflects the views of Smith et al., (2009, p. 86) "whilst it may be possible to bracket scientific and theoretical assumptions about the topic of interest, even these assumptions may only emerge once a researcher has started to engage with the data and is fully immersed within it."

8.3   Sub theme two: "It makes you more balanced."

8.3.1   Felicity

Towards the end of her second interview Felicity expresses her admiration for Fredrick's recent achievements "I mean, huge pride and, you know, and the great, yes, I mean, it was all over the world, it was on the national news………he's the only one-legged jockey there is" (Felicity2: p.1, line, 18-19) and portrays her pride in how Fredrick's aspirations to gain his license despite his amputation has enabled other disabled riders to consider a professional career as a Jockey "because of Fredrick they will now all have to be looked at on an individual basis…..so it was a huge landmark for the world of racing Felicity2: p.1, line 27). Felicity is also eager to talk about how Fredrick's personal achievements and successful adaptation extends beyond merely Fredrick's experience "Yes I think it does relate to other areas" (Felicity2: p.16, line 557) as well as the insight Felicity has gained about all of her son's attributes and personal characteristics "so I think probably from my point of view if this hadn't

happened, I probably wouldn't ever have had the knowledge of what Fredrick was capable of and probably of what my other sons have been capable of" (Felicity2: p. 15, line 546).

In gaining insight into what her sons have been capable of, Felicity expresses a fundamental aspect of maternal insight but also posttraumatic growth and how it is often associated with positive changes in how people value their relationships with other people, in their self-perceptions, and in their life philosophy (Joseph and Linley, 2006) "we wouldn't never have had, well we'd have had a glimpse of actually what was there underneath but not ever had a close look" (Felicity2: p. 15, line 549-550). Felicity has also observed positive changes in her 2 younger sons "I hope they would all sort of have enough of a social conscience to, if you're in a position to do something do it, Fredrick certainly has" (Felicity2: p.14, line 513-514). Furthermore, Felicity's positive adjustment to Fredrick's TCI has been supported by how Fredrick has made the transition from military life to a civilian life "he's now working for the Royal Foundation for Disadvantaged Children, so not actually children, really young adults and older teenagers and he's sort of setting up empowering learning facilities for them and courses and things to enable them to get out of knife crime and really push them forward" (Felicity2: p. 14, line 514-515).

Fredrick's adjustment and personal growth is characterised by how his own pursuit for meaning has gone beyond a causal attribution or an assignment of blame for his TCI, rather it has enabled Fredrick to adjust his self and worldviews (see, e.g., Park & Folkman, 1997; Taylor, 1983). Felicity adds "but if you ask him he would just say oh I work for a charity you won't get out of him quite what" (Felicity2: p.14, line 516), reflecting Felicity's own reluctance to ingratiate herself and emphasising further the attributes and personal traits which Felicity and Fredrick share. A glimpse of the attributes and dispositions Felicity and Fredrick share was first observed at the very beginning of Felicity's first interview in which she described her relationship with Fredrick as 'special', nurtured in the activity of horse riding when Fredrick was a child, and which contributed to their secure attachment discussed in superordinate theme 1.

The mutuality of their shared relationship also reflects the views of (Janoff-Bulman, 1989, 1992; Park and Folkman, 1997; Thompson and Janigian, 1988) who assert that posttraumatic growth is also associated with predictability, epitomised in how Felicity's secure attachment and maternal sensitivity and caregiving has not only contributed to the way in which Fredrick has developed as a human being and the love and admiration Felicity has for him "it's very hard to say no to him because you think,

well I'm very lucky to have you" (Felicity2: p. 18, line 659) but how Fredrick himself has been instrumental in enabling Felicity to experience the positive outcomes she now shares with all her family members.

8.3.2 Lynn

Lynn discloses how in adapting to her son's TCI she has also been able to give meaning to past stressful events "I think my life, and I don't put it down to just Lance, but I think all my experiences with my husband, my whole life experience has tailored where I am in my job you know and has made me make decisions" (Lynn2: p. 32, line 1020), reflecting the views of (Joseph & Linley, 2005) and how people change their views of themselves in some way after experiencing and adjusting to a stressful or traumatic event. Moreover, in calling upon her maternal sensitivity and maternal caring, reciprocal to her secure attachment with Lance, Lynn in the present day is able to understand the benefit of the support she gives to the parents of the chronically ill children she cares for discussed in superordinate theme one and two "I think this has probably affected me more profoundly as a mother, as a person, basically if you're a mother that's the person you are even when you're at work you're a mother because you're talking about your kids, your family, you're a mother, a grandmother" (Lynn2; p.33, line 1038-1039) and which further emphasises the strong sense of identity and purpose Lynn derives from her view of motherhood discussed in superordinate theme one.

Lynn also talks about the contentment in her life in the present day "I'm sitting in a council house I don't drive I don't own anything of great value but that doesn't bother me" (Lynn2: p.33, line 1042) and is a measure of the emotional processing Lynn experienced from engaging with all the elements of her stepped treatment plan discussed in the previous sub-theme "It doesn't cut like a knife anymore, you know, thinking about what happened and what he went through, it's a memory" (Lynn2: p. 33, line 1043). Moreover, Lynn perceives a change in her self-view "I think it rounds you out doesn't it and you feel you're able to discuss and maybe help other people" (Lynn2: p.33, line 1056).

Lynn's perceived change in her self-view reflects studies which have shown how people acquire greater insight from stressful or traumatic experiences and how they perceive this as a learning opportunity, motivating them to share with others the benefit of their experiences (Calhoun & Tedeschi, 1999; Cohen, Hettler, & Pane, 1998; Linley, & Joseph, 2004) "one of the guys I used to work with who was a mental health nurse he had said if something bad has got to happen choose it, not choose it to happen but

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choose that you will see something out of this no matter how much suffering you go through there will be something in there that you can take away from it" (Lynn2: p.34, line 1068-1069).

Lynn's 'suffering' represents the stressful life events Lynn briefly gives significance to in superordinate theme 1, comprising of her son's TCI and the 'other event.' which was the two CR's Lynn responded to during the very early part of Lance's rehabilitation discussed in superordinate theme 2. Lynn's 'suffering' and the enlightenment Lynn has gained from the emotional processing facilitated by her stepped treatment plan has given Lynn the motivation to pass on her experience to newly qualified paediatric nurses "we have a lot of very young new starters and they need a lot of support" (Lynn2: p.34, line 1079) but also to support other mothers in the future "I haven't got the time at the moment to take an actual role in any of these organisations but maybe when I retire I might spend some time with SAAFA" (Lynn2: p. 33, line 1056-1057) and which reflects the views of McKnight & Kashdan, (2009, p. 242) "gaining a sense of purpose encompasses an important component of one's identity that organizes and stimulates goals, manages behaviours, and provides a sense of meaning."

8.3.3 Patricia

Patricia is clear about the positive changes she has perceived in herself "I just think it makes you stronger it's made me stronger and not suffer fools gladly and probably be a bit more assertive a bit frightening" (Patricia2: p. 35, line 1105). This not only reflects Patricia's secure attachment style and adaptive coping strategies discussed in superordinate theme 1 and how she coped with her 'dark days', additionally Patricia epitomises posttraumatic growth (Joseph and Linley, 2004a) "it's changed me and you appreciate what you've got" (Patricia2: p.35, line 1106). Patricia adds "I don't know…you just feel a bit god-like in a way" (Patricia2: p.35, line 1108). Patricia's self-view is not sanctimonious, rather it reflects how effective Patricia's coping strategies have been in maintaining her wellbeing and the determination she has demonstrated in overcoming setbacks during the past 9 years.

Patricia's reference to God also reflects how the insight she has gained has informed her about the value of an holistic approach to meeting Paul's care needs "and we all need to pull together to do the best for Paul and to be as one for the best for Paul" (Patricia2: p.35, line 1109) and how this has to reach a wider audience. Patricia's insight also epitomises her maternal sensitivity discussed in superordinate theme 1 and 2 and how mothers generally have a "moral obligation" to help their children realize

"particular talents and interests and to raise a child equipped to become a responsible member and participant in family and community" Leonard, (1996, p. 129).

Patricia's commitment to act on Paul's behalf brings context to when Patricia without prompt talked earlier in her second interview about where she would prefer Paul to receive his full-time care in the future "one of the things we are hoping is more to do with the new hospital that the Duke of Westminster is building and putting into place" (Patricia2: p.12, line 383). The 'building' Patricia refers to is Standford Hall, a rehabilitation facility envisaged by the Duke of Westminster discussed in chapter 2. Patricia's expectations of the level of care Standford Hall will provide reflect the level of care she wants for Paul "I want the best for him that he can possibly achieve both for himself and for those that are around him that are going to care for him and look after him" (Patricia2: p.36, line 1130).

Patricia's commitment to Paul's care and recovery reflects the views of Damon, Menon, & Bronk, (2003, p. 121), who describe purpose as "a stable and generalized intention to accomplish something that is at once meaningful to the self and of consequence to the world beyond the self." Patricia has been the architect of her sense of purpose reflected by the views of (Joseph & Linley, 2005) in how a stressful event in one's life is a key motivation to search for meaning and an understanding of why the stressful event has been experienced. For Patricia her lived experience has provided her with the insight to judge herself and others with compassion, generosity and broadmindedness "I mean then life is a balance and that's how we're meant to be…well balanced…they say they're a well-balanced individual, so you see the good, the bad, the light, the dark, the sad, the happy all of this that and the other to make you a nice well rounded individual" (Patricia2: p, 38, line 1220-1221).

Towards the end of her interview Patricia talks about her intention to take Paul on holiday now that she has retired from work "now that I've finished work it'll be a bit easier…I'm thinking of taking him for a day trip over to Guernsey or Jersey or something because you go on the ferry so I'm looking at a cruise" (Patricia2: p.25, line 813). Examples of Patricia's paternity and maternity are abundant throughout her narrative and are expressed unintentionally, hidden amongst Patricia's keenness to share Paul's account of his challenges and the progress he has made towards gaining independent living. This gives a sense of the valiant way in which Paul has made progress in recovering from his TBI and how his recovery so far has been driven by Patricia's attachment, maternity, strategies for coping and her love for Paul. In doing so,

Patricia has been able to maintain her 'balance' while meeting her role of mother to all her children as well as the challenges she has encountered in caring for Paul.

8.3.4 Sarah

Like Lynn, Sarah indicates how she has also sought to find meaning from her experience. However, unlike Lynn, who quickly sought the help of health care professionals, Sarah, initially called upon her rational and detachment strategy for coping to learn more about Steven's experience of his "I wanted to know more, and I learnt quite a lot from other people…not from Steven…most of my book has been put together not through Steven but through other people…there's very little that Steven has told me…very little indeed" (Sarah2: p. 8, line 245). Sarah's continued motivation to learn about Steven's experiences of his TCI also reflects how attachment orientations can change because of combat trauma (Horesh, Cohen-Zrihen, Ein Dor, & Solomon, 2014) and the reason for Sarah and Steven's inability to engage in the reciprocal disclosure they experienced during Steven's teenage years discussed in superordinate theme one.

Sarah's need to know more is also related to how individuals search for meaning to undesirable life events (Tedeschi & Calhoun, 2004; Joseph & Linley 2005) and Sarah's need to find meaning in relation to the sacrifices Sarah has made "that's quite hard because you're going from a position where you're expected to care for them completely to then being discarded because you're not needed anymore" (Sarah2: p.9, line 255-256). This disclosure is aimed at Steven as well as the absence of support Sarah received from the MoD discussed in superordinate theme 2 and gives support to how Steven unlike Sarah's husband discussed in the previous sub-theme has not yet acknowledged the sacrifices Sarah made as a young mother and in giving up her 'charmed life'. In caring for Steven, Sarah was unwillingly reacquainted with the demands and challenges she overcame in the close supervision, care and maternal sensitivity asked of her as a young mother and indicative of her secure attachment with Steven. Despite the acknowledgement from her husband, in writing about her experiences, perceptions and emotions, Sarah has been able to give meaning to her experiences and acknowledge to herself the depth of her love for Steven and how effective she was in coping with distressing events without the support of others.

8.3.5 Jennifer

Towards the end of her last interview Jennifer attributes the positive view she has of herself to the actions of her son "I've taken something from Josh, he's given me a

wonderful gift and I'm much more positive and I'm moving away from the thistles in the field and looking more towards the optimistic whistling Winnie the Pooh" (Jennifer2: p.26, line 856-857). Jennifer's perspective is confusing in that on face value it appears that Jennifer in talking about how the experience of her son's TCI has provided Jennifer with important and lasting insight (Janoff-Bulman & Frantz, 1997) represented by her expression of 'a wonderful gift.' However, Jennifer's mixed analogy as well as its inaccuracy, serve to emphasise further Jennifer's propensity to use verbose language rather than state simply and explicitly what this 'wonderful gift' is and how it has helped her or provided her with insight about herself or the relationship she has with other family members. In talking of how she is moving away from 'the thistles in the field' Jennifer's intention is to claim that she has changed in some way and that this change has enabled her to respond and manage stressful events more effectively in the present day than she did before her son's TCI.

However, in Christopher Robins stories, rather than avoid thistles Winnie the Pooh regarded them as a delicious treat rather than an annoyance. Neither is Jennifer entirely accurate about Winnie the Pooh being optimistic, he was however depicted as having an unwavering sense of happiness and a close and affectionate relationship with Christopher Robin. Jennifer's inaccurate representation of herself gives insight to Jennifer's actual-ideal "they would have told me to behave they're going to tell me to not be so hysterical and buck up you know get on with it go and help Jacky" (Jennifer1: p.6, line 201-202) and actual-ought self (Mikulincer, 1995) "I wish I had behaved better, I wish I had been strong enough to not summon up other people, to help me" (Jennifer1: p.6, line 208). Jennifer's motivation for comparing herself with 'Winnie the Pooh is to create in the author a favourable view of herself as having overcome adversity to discover enlightenment and wisdom from her experiences and resolve the trauma of her son's decision to elect for surgical amputation. In presenting herself this way at the very end of her second interview, Jennifer provides the last part of her sometimes convoluted and contradictory account of her lifeworld. Jennifer uses the phrase 'thistles in the filed' to encapsulate the range of distressing emotions and events described throughout her narrative account. In doing so, Jennifer unwittingly reveals how the experience of her sons TCI ,which unlike the other injured sons resulted in Josh's decision to elect for the surgical amputation of his lower leg, has been unable to gain a different perspective to how she views her relationship with her son and daughter-in-law. Consequently, Jennifer's self-esteem related to her role as mother

remains vulnerable to attack. This vulnerability is exacerbated by Jennifer's continued propensity to adopt an emotion-orientated coping strategy when responding to stressors.

8.3.6   Mary

Unlike Jennifer, Mary is more explicit in attributing her son's marriage as the cause of the change in her relationship with Martin and how this had complicated the stressful event of her son's TCI "I don't know whether before he was engaged or whether he was engaged and before he got married I just said you know…don't forget your family…it's so easy…you know your son is your son until he takes a wife to be subsumed into the other's family and hers is quite attractive" (Mary2: p.41, line 1289-1291). This disclosure towards the end of Mary's second interview enables Mary to relinquish responsibility for the poor relationship with Martin "Lost the son we had who was a soldier" (Mary2: p.41, line 1315).

However, Mary mollifies this sense of loss and strengthens her view of her daughter-in-law as 'protagonist' by joining a SSAFA support group. This enabled Mary to listen to the experiences of other mothers who had been distressed by their son's TCI but were not in conflict with their son "sort of try and bring it out of them because they've got to talk about it you know" (Mary2: p. 36, line 1159). The benefit to Mary from attending these meetings and listening to other mothers accounts reflects the studies by comparative psychologists (Thiessen, Young, and Delgado, 1997) and the matching hypothesis studied by social psychologists (Feingold, 1988), and ingroup preferences (Greenberg, Landau, Kosloff, and Solomon, 2009). These studies point to how Mary looked beyond any personal differences that may have existed within the SSAFA support group and herself (Gaertner, Dovidio, Anastasio, Bachman, and Rust, 1993), giving priority instead to the distressing accounts each mother shared with Mary about their stressful experience. However, Mary indicates how this strategy had eventually run its course "we've been quite a few times over the years…not a hundred percent sure we'll go again because it's almost now as though you have to go back to that time all the time and go forward so I don't think either of us need it in that way if you see what I mean" (Mary2: p.37, line 1161).

Mary has recently replaced the SAFFA peer group with a book written by a mother whose son committed suicide "it goes further than ours but obviously some of it does…I haven't read it in a long while but this one was…it's about people dying and people's…different people's reaction to that death but of course some of those feelings are very similar" (Mary2: p.41, line 1310-1311). In periodically reading about a

mother's grief for the loss of her son Mary endorses the disconnect and lack of interaction and intimacy with her son and how she perceives it to have been beyond her control. This strategy also resonates with Mary's suppression of attachment-related thoughts and emotions (Mikulincer & Shaver, 2003), enabling Mary to change her perceptions of the cause of her poor relationship with Martin to coincide with those of psychologically salient others in the SSAFA support group and the book she sometimes reads (Asch, 1951; Hardin and Higgins, 1996; Sinclair, Huntstinger, Skorinko, and Hardin, 2005) .

The solace Mary experiences in reading the book she talks about resonates strongly with existential isolation. Yalom, (1980, p.355) contests that "People feel existentially isolated when they feel alone in their experience, as though nobody else shares their experience or could come close to understanding it". The strategies Mary adopted to validate her beliefs and protect herself from existential isolation is strongly supported by studies conducted by (Helm, Lifshin and Greeberg, 2016) who found existential isolation to correlate positively with insecure attachment and with dismissing avoidant attachment in particular.

Towards the end of her second interview Mary talks about how she maintains her disconnectedness from Martin for fear of him preventing Mary's access to her grandchildren "I don't want to rock the boat too much…I don't think ultimately, he would but I just don't want to rock the boat" (Mary2: p41, line 1293), emphasising further Mary's distrust of intimacy or dependence upon Martin (Mikulincer & Shaver, 2007). However, despite her continued disconnectedness from Martin, Mary gives no indication during her 2 interviews that she is receiving treatment for a decline in her mental wellbeing. This is significant on two levels: firstly, this counters research evidence which suggests that Mary's insecure attachment and avoidant coping strategy can lead to poor mental health (Mulkincer & Shaver, 2003); and secondly, supports research which suggests that repressive coping may protect individuals from adverse emotional consequences in the wake of extremely stressful events (Ginzburg, Solomon, and Bleich, 2002). For Mary her avoidant attachment and repressive coping serves to protect her not from the stressful event of her son's TCI but from the relationship conflict and disconnect she has with Martin and Melony.

8.4   Summary of superordinate theme three

Felicity, Patricia, Sarah and Lynn all demonstrated how their distinctly different coping strategies enabled each of them to control their levels of distress, rather than be

consumed by it. This ability to control their emotions was mediated by their motivation to take care of their sons. The source of their motivation came from their predisposition for mothering, their maternal sensitivity and their maternal insight, indicative of the way in which they talked affectionately about their sons and the strong personal belief that it was their responsibility to assume the role of caregiver. Most strikingly of all was the different strategies adopted by Felicity, Patricia and Sarah and how they relied upon either family members or/and their own personal coping resources rather than seek the support of health care professionals to manage their distress and maintain their wellbeing. Mothers who had a poor relationship with their son and daughter-in-law demonstrated withdrawal from the relationship, maladaptive coping strategies and relied less upon the support of family and social networks.

For Felicity, Patricia and Sarah exposure to the stressors of meeting the challenges they experienced served to build a barrier against developing MH problems as much as the effectiveness of their coping strategies and the support of others served to mitigate their distress. This was particularly evident in how Patricia and Sarah did not become disabled by the frequent distressing events they experienced. This is largely as a result of the personal resources and coping strategies they drew upon to enable them to confront their distressing emotions rather than employ distracting or avoidance coping strategies. Lynn also confronted her negative emotions by quickly recognising that she did not have the personal resources to resolve her levels of anxiety and distress and quickly sought the help of health professionals which also demonstrated her problem orientated approach to dealing with stressors in her life.

It is also significant that these four mothers also talked about how they had experienced a sense of personal growth from their stressful event. Most notable was their increased sense of self-esteem, optimism and self-efficacy in their second interview, as compared to when they first spoke of how they coped with the stressors at the beginning of their sons recovery and rehabilitation. stressful event.

In stark contrast neither did Mary or Jennifer talk about any profound sense of benefit or insight gained from their experience. This is consistent wih their descriptions of the poor relationship with their son and daughter-in-law, their withdrawal from providing support, the use of maladaptive coping strategies to mitiagate the distress caused by their withdrawal from the relationship with their son and daughter-in-law and the limited support of family and social networks.

Absent from the mothers' who had a close relationship with their sons was the provision of MH support during their sons' rehabilitation programme. However, Mary

and Jennifer did receive MH support through the welfare officer at their sons' units at a very early stage after their sons' discharge from hospital, despite there being no mandatory provision for this in 'OPSP, JSP 950', discussed in Chapter Two. Significantly, the counselling both Mary and Jennifer received was ineffective in resolving the distress they experienced later from the relationship conflict and lack of interaction with their son and daughter-in-law during their sons' rehabilitation programme. This brings into sharp contrast the breadth of physical and mental care at each stage of their sons care pathway described in Chapter Two , compared to the absence of MH support during their sons rehabilaiton programme.

Overall, Chapter Six to Eight have emphasised the views of Finlay, (2011, p. 261) who states that "good phenomenological research evokes the lived world. It challenges or deepens our understanding of the lived experience being studied." This understanding of the mothers experience is given context in the next chapter in relationship to the unique contribution made to existing knowledge by the findings of this study, the contribution made by recent studies, the implications to policy and practice in addition to the strengths and limitations of the study.

Chapter Nine: Conclusion

9.1   Introduction

In the previous three chapters, the results and discussion were combined to represent the three superordinate themes and the eight sub-themes which emerged from the stages of the analysis used in the IPA. This approach also enabled me to present the psychological dialogue between the lived experiences of the mothers and psychological constructs and evidence found in literature.

      In this chapter I discuss the conclusions of the study in relation to "How does some existing work shed light on what you have found" ….. and "how does what you have found illuminate or problematize what other studies" have found (Smith et al., 2009, p 112). The psychological dialogue also enabled me to "elucidate socio-cultural processes which explain effects documented by studies in quantitative studies and other research domains" (Yardley, 2000, p. 278). Additionally, the findings of this study give insight to "practical solutions to local problems, rather than to produce a transferable piece of knowledge which can be evaluated as an academic product" (Oliver, 1992, p. 107). Moreover, the extensive quantity of phenomenological text collected from each of the two interviews each mother gave reflects that the purpose of this qualitative study was to 'illuminate', rather than to 'measure' (Charmaz, 2014; Medico & Santiago-Delefosse, 2014).

      I begin this chapter by providing a review of findings from recent research and their relevance in relation to my study. These studies are summarised in table 15 beginning with the most recent. I then continue the chapter by stating the contribution made to knowledge by the current study. This is followed by a discussion of the implications for practice and policy, the strengths of the methodology, the current study's contribution to theory, the strengths and limitations of the study, as well as identifying the potential for future research. I close the chapter with a personal reflection.

9.2   Recent research

Table 15 represents a review of findings from recent research. I then discuss each study in relation to their reliance to the findings of my study

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Table 14. Recent studies relevant to the findings of the current study.

	Title of study	Study citation	Who?	Study design and methods	Analysis
Study One	Caring and Coping: The Family Perspective on Living with Limb Loss	Engward, Fleuty & Fossey (2018)	A total of 37 UK individuals took part: 16 family members (1 female, 14 partners (1 male, 6 children) and 1 extended family member	Semi-structured interview conducted with the PWLL and either 1 or 2 family members	Grounded Theory
Study Two	The support needs and experiences of family members of wounded, injured or sick UK service personnel	Verey, Keeling, Thandi & Stevelink (2017)	37 family members of UK WIS personnel. 22 spouse/husband 3 Partner, 8 Mother, 4 Father	semi-structured, in-depth telephone interview	Thematic analysis
Study Three	Military Deployment of an Adult Child: Ambiguous Loss and Boundary Ambiguity Reflected in the Experiences of Parents of Service Members	Crow, Myers, Ellor, Dolan & Morissette (2016)	21 USA parents of sons deployed to Afghanistan or Iraq	Semi-structured group interviews consisting of between 2 and 4 participants	IPA with initial use of computer software to identify themes
Study Four	Informal caregiving and intimate relationships: the experiences of spouses of UK military personnel.	Thandi, Oram, Verey, Greenberg & Fear (2016).	25 UK spouses of WIS service personnel	Telephone interviews	Thematic analysis

9.2.1   Study One (Engward, Fleuty & Fossey, 2018)

An important aim of this study was to explore the family perspective of living with limb loss, irrespective of whether the person with limb loss (PWLL) was biologically or maritally affiliated to the family. Moreover, unlike the current study, the participants were recruited on the basis that the loss of their limb occurred after their military service. This difference is significant in that this cohort did not sustain their limb loss while exposed to combat and accompanied by the possible MH disorders associated with it, as discussed in Chapter Two of the current study. The study also recruited on the basis that the experiences of the PWLL was seen in the context of the family unit, rather than the experiences of the mother of the family in the role of caregiver. In the case of Study One, the focus is on all members of the family and their involvement in providing care to the individual with limb loss. Although the study makes 22 recommendations, key to the study is the Living with Limb Loss Support Model (LLSM).

The LLSM provides the family with a practical guide as to when support is needed at specific points for the PWLL and for the family unit. This is important in that it corresponds to the sequence of events described by the mothers in the current study from the point of learning about their son's TCI, the period during their son's recovery in hospital and the period during their son's rehabilitation. Although the LLSM is important in having identified the stressors involved in caring for a PWLL and in forecasting the critical points when support may be needed, it also has utility in how it has the potential to provide guidance to health care practitioners on how to manage the stressful demands made on families supporting a PWLL. However, although this is beneficial, the study did not include the idiosyncratic coping strategies of individual family members. Rather, the authors gave priority to the sequalae of stressful events during the lifetime of the PWLL and how this corresponded to the overall demands made on their family. In not exploring the range of responses individual family members might experience, the authors have omitted to acknowledge the repertoire of coping strategies an individual may call upon and how these might be effective in mitigating levels of distress or indeed how maladaptive coping strategies might elevate the stress response of family members. Similarly, the authors did not identify the

importance of social support and whether this had a moderating or mediating effect on the PWL or family members.

A key recommendation of the study is the implementation of access to advice and information which might benefit family members after learning of their son's injury, but particularly how priority should be given to signposting family members to support groups and veterans' charities commensurate with the individual's level of low, medium or high levels of coping. However, the authors provide no indication of who makes this appraisal or who initiates the signposting to the appropriate support group or charity to help the family in the coping process. Despite this, the need for signposting to veterans' charities is relevant to the findings of my study. Although the availability of support from veterans' charities was not a point of enquiry in my study, none of the mothers talked about access or the availability of veterans' charities during their sons' recovery in SO or after their sons' discharge. The only mention of support came from two of the mothers who acknowledged the emotional support they received during their stay at NH which was staffed by SSAFA personnel. Identify the need for signposting adds support to the absence of MH support disclosed in my study.

9.2.2   Study Two (Verey, Keeling, Thandi & Stevelink, 2017)

The aim of this study was to examine the changing needs and experiences of family members of WIS personnel in the UK, in addition to identifying best practice which will inform future policy relating to the support provided by the MOD, other governmental departments and service/civilian charities. The study recruited 37 family members of WIS personnel. Each participant took part in a semi-structured, in-depth telephone interview to determine their support needs, their family relationships and their use of UK support services. A thematic approach was used to analyse the interviews.

However, a limitation of the study is the lack of distinction made between the different types of relationship between family members and injured service personnel. Although several of the participants (8) were mothers, there is however, no reference to the mothers' personal experience of taking care of their WIS or whether the mothers experience was different from the experiences of spouse/husband or father. There is also an absence of insight into the origin of the family member's distress, whether this required intervention, or whether the stress they experienced was mitigated or exacerbated by specific types of coping strategy or by the quality of their relationship with the WIS family member. In my study the relationship quality and type of coping strategy moderated the mothers' mental wellbeing.

A key limitation of the study is how the analysis focused on similarities alone. Not including individual experiences of family members strongly suggests that shared experiences have been used to strengthen the overall findings of the study. Despite the limitations of the study, especially the mixed nature of the research sample, the study identified the need for empathetic and effective support for family members who find themselves suddenly in the role of caregiver to an injured family member irrespective of their relationship and gender. It is surprising, however, that the authors suggest that the charitable sector provide a 'family care coordinator'. This recommendation is in opposition to how the same authors were hesitant about trusting the efficacy of the range of services delivered by the charitable sector and the unwillingness of the primary main veterans' charities discussed in Chapter Two, to have the efficacy of their interventions independently evaluated. Despite this, the study is the first to acknowledge the care needs of UK veterans and the impact on their family members. In doing so, the study adds weight to the absence of MH support to the mothers who took part in my study.

9.2.3 Study Three (Crow, Myers, Ellor, Dolan & Morissette, 2016)

This study explored the experiences of parents of service members. Reflections on the deployment of military adult-children were gathered from twenty-one parents in semi-structured group interviews. The parents' deployment narratives were coded within the framework of ambiguous loss theory, to enable the authors to understand the parents' reflections within each phase of the deployment process. There are two limitations to this study when considered in the context of the findings of my study. Firstly, the focus is on the effects of deployment on mothers' wellbeing, and secondly, the findings come from a United States Army cohort and, therefore, cultural differences make transferability to the cohort in the current study unreliable. However, the findings are pertinent in emphasising how the close relationship between mother and son is sensitive to a mother's perceptions of uncertainty about the safety of their son and how this can cause levels of distress which affect the parent's mental wellbeing.

The findings of the study also give support to how the mothers in my study talked about the change in the relationship with their son. This was attributed to their son's transition to adulthood and the limited communication with their son afer each mother withdrew support to their son and daughter-in-law. One of the coping strategies used by the parents in the study referred to 'reciprocal communication' and was a characteristic of the emotional support they gave to each other, as well as a measure of

their close relationship. In my study, communication between mother and son was a feature of their 'reciprocal disclosure', as well as an indication of their maternal sensitivity and maternal insight.

Several of the themes which emerged in the study by Crow et al. (2016) and my study converge on how coping strategies, emotional support, reciprocal disclosure and the relationship between mother and their adult son have an influence on how the mothers in both studies managed the cause of their distress or anxiety so that they were able to optimise their mental wellbeing. In this sense, both studies give support to the themes which are indicative of secure and insecure attachment style and the adaptive and maladaptive coping strategies they are respectfully associated with.

9.2.4   Study Four (Thandi, Oram, Verey, Greenberg & Fear, 2016)

The aim of this study was to investigate the relationship experiences of non-military partners caring for WIS UK military personnel. A limitation of this study is that it investigated the relationship between the WIS and their spouse, rather than the relationship between the WIS and their mother. This prevents a direct transfer of the findings to my study. However, the impaired relationship functioning experienced by partners reflected a similarity to the relationship conflict experienced by two of the mothers in the current study and how this developed into diminished mental wellbeing. However, the caregiving burden experienced by partners of WIS military personnel originated from arguments and a lack of physical and emotional intimacy. In my study the caregiving burden was associated with the mothers' perception of competency, which was exacerbated by the absence of MH support for the mothers after their sons' discharge from hospital. This reflects the differences in a matrimonial relationship compared to biological or maternal relationship. Despite these differences the findings add additional insight into how a veteran's poor physical and MH can influence the overall health of family members.

9.2.5   The relevance of TILS and CTS

The introduction of TILS and CTS was discussed in Chapter Two. These two initiatives represent a mind shift in how the NHS intends to meet the MH needs of veterans and their family members who may have a caring or a non-caring role. It is unclear, however, whether the TILS and CTS serve to augment or supersede the twelve mental health services introduced in 2010, discussed in Chapter Two. Support for the TILS model of care is provided by the findings of Studies Three and Four and the earlier studies conducted by a small but growing number of researchers (DeVoe & Ross, 2012;

Riggs & Riggs, 2011; Wadsworth et al., 2013). Collectively, these studies recognise the value of invoking a family systems' perspective (Minuchin, 1985; Paley, Lester, & Mogil, 2013). Moreover, the findings of these studies advance our understanding of the dynamic and complex nature of military families' experiences and the concepts discussed in Family Systems Theory.

The introduction of TILS and CTS represents a leap forward in the provision of MH care to veterans and their families. The CTS commenced in April 2018 and offers a treatment pathway that is expected to to take a minimum of eight months to deliver. This means that it is not yet possible to assess effectiveness as veterans are only just beginning to leave CTS. A services evaluation in the future may also bring clarity to the division of responsibility for MH support between the DMS, the NHS and the charity sector, as discussed in Chapter Two. Moreover, a positive appraisal of the TILS intervention has the potential to streamline the range of services delivered by the twelve mental health services and the efficacy of the interventions and treatment provided by veterans' charities, local partnerships and support groups, as discussed in Chapter Two.

9.3   Contribution to knowledge

In Chapter One I drew upon previous studies in the general population to give me insight into the possible nature of the experiences the mothers may have experienced so that I was better informed about the types of questions to ask and the topic areas to explore. In doing so the absence of studies gave me the academic reason for conducting this study. Whilst there is some transferability from these studies and from the most recent studies reviewed in the first part of this chapter, this study has highlighted areas which have not been previously considered and therefore add to the existing body of research about the deleterious effects of traumatic combat injury on the wellbeing of mothers. This is the first study to examine the impact on a mother's wellbeing whose adult son has been traumatically injured in combat. An unexpected finding of the study was the absence of mental health support for all of the mothers after their son's discharge from hospital. Although this is a small study, a number of contributions to knowledge have been made, largely because of the absence of any previous similar study and the challenging of assumptions about the transferability of other studies and theories about the deleterious effects of traumatic injury on the wellbeing of mothers.There are 12 main areas which add new knowledge that could provide greater understanding to how best support mothers who adopt a caring role during their son's rehabilaition from traumatic combat injury:

1. The importance of reliable, proactive and well-coordinated mental health support for mothers after the discharge of their sons from hospital.

2. Interventions for mothers who provide care might usefully address the dynamics of the mother-son relationship and the importance of healthcare professional's awareness of these issues in their interactions with mothers during the period of son's rehabilitation programme.

3. The current lack of research which has investigated the characteristics of military, civilian and medical staff who deliver emotional support to mothers and other family members.

4. The type of training and emotional support this group of people receive before they encounter the distress of patients and their family members.

5. The most effective intervention in response to those mothers with diminished wellbeing was a combination of anti-depressants and a course of CBT as recommended by NICE guidelines.

6. The experiences of three of the mothers in this study indicate that adherence to NICE guide lines might vary amongst health care professionals and which may have added to the difficulty two of the mothers experienced in responding to the distress of their sons TCI.

7. The short term and long term instrumental and emotional support of family has limited benefit to mothers who have impaired relationship functioning with their son and ineffective strategies for coping with personal distress.

8. Relationship conflict between family members can add to a mother's distress and have a detrimental influence on future coping strategies.

9. The differences in emotional disclosure among the three attachment groups provided a strong indication of the three different attachment styles.

10. A willingness to emotionally disclose with a stranger or trusted person other than a family member was a strong indication of the mother's preferred type of mental health support.

11. Identifying a patient's attachment style and strategy for coping with distress by using a semi-structured interview approach may provide an alternative to the numerous psychometric attachment and coping self-report questionnaires and could be useful in guiding a mental health care professional to psycho-social

factors which might contribute to identifying the underlying cause of the patient/client's distress/anxiety and concomitantly lead the practitioner to an earlier treatment strategy.

12. Other than the staff provided by SSAFA at Norton House there was a distinct lack of support from the various primary veteran's charities reflected by the absence of any mention by each of the mothers.

9.4   Implications for policy

The findings of this study subscribe to the views of Yardley (2000, p. 223), who states that "the decisive criterion by which any piece of research must be judged is, arguably, its impact and utility." In the literature that was called upon to give the background to this study presented in Chapter Two, there was no reference made to the provision of MH support and services to mothers. The absence of research in this area also supports the view that there was a lack of awareness generally by the government, the MOD, NHS or veterans charities that mothers have need for support when caring for an injured son and even less awareness of the the burden and emotional distress it may have caused as a result of the dynamics of the mother-son relationship.

Support for this lack of awareness and the absence of MH it gave rise to was recently provided by the oral evidence given by Dr MacManus as part of the House of Commons Defence Comitte review of MH support available to veterans and their families. According to Dr MacManus support for spouse or partner of the veteran continues to be accessed by them through their GP, rather than via the services available to veterans "If family members have specific mental health problems of their own, they will be signposted into generic mental health services. Of course, they then fall foul of the waiting times that we know exist within those services" (House of Commons, 2018b). She went on to add "although we provide carers' assessments and assessment of family need, we are not currently in a position to provide that. We are currently bidding for further funding to develop services for that, but it is a definite gap" (House of Commons, 2018b).

In declaring that a gap exists in the deliver of MH services to family members, Dr MacManus provides an explanation for the lack of MH support made available to the mothers in 2009 and that it continues to be unavailable in the present day. To address this shortfall, the government and the NHS are urged to adjust a core principle of the Armed Forces Covenant, namely, 'special consideration is appropriate in some cases, particularly for those who have been injured or bereaved' (House of Commons 2017).

The meaning given to 'special consideration' should be adjusted to include mothers so that it acknowledges the MH support needed by mothers to protect and maintain their wellbeing when caring for their injured sons during their lengthy rehabilitaton.

The government is also urged to set out in its forthcoming veterans' strategy at the end of 2018, that the provision of priority MH support and treatment to veterans and their families must also include the mothers of sons who have sustained TCI.

9.5   Implications for practice

It is recommended that running concurrently with role 3 and 4 of a son's recovery and rehabilitation programme, all mothers should receive emotional support from a counsellor who specialises in psychodynamic family therapy. In the context of this study, atachment theory would have been beneficial in guiding counsellors using a psychodynamic framework to identify the extent and nature of the mother's 'psychological disturbances', by facilitating a 'change in perspective' about their IWMs of self, their relationship with their sons and how to cope effectively with the cause of their distress. This 'change of perspective', characteristic of the relationship between secure attachment and good mental health discussed in Chapter Five, can be achieved with a client when a therapist becomes a secure base and, in doing so, fulfils the position of a trusted attachment figure (Sonkin, 2005). Drawing upon attachment and coping theory will enable the counsellor to identify the psychosocial stressors associated with caring for their injured son and concomitantly lead the counsellor to an earlier treatment strategy and level of support appropriate to the mother's needs.

Army Welfare Staff should also be familiarised with the findings of this study so that they are equipped to support the emotional and instrumental needs of mothers adjusting to their son's traumatic injuries during their initial recovery in hospital. Mothers would also benefit from being signposted to the Armed Forces charity Soldiers, Sailors, Airmen and Families Association (SSAFA) , who provide specific support to family members of wounded, injured or sick (WIS) service personnel.

Implementing a system of support for mothers caring for their injured son will also help to counter the myth of motherhood. The degree to which societies beliefs about motherhood and the caring role of mothers influenced the absence of mental health support given to the mothers who took part in this study was not an aim of the study. However, the myth of motherhood emerged as a sub-theme as a result of the mothers' strong descriptions of how they were either the first point of contact or the parent who became responsible for visiting their son in SO and then caring for their son

after his discharge from hospital. Examples of this were given by four of the mothers in the way they talked about learning of their son's TCI and the way in which they talked about the change in their relationship with their son and how they felt their relationship boundaries had changed in their adult son. The linked lives each mother had with their son's is in itself a reflection of motherhood and how the mothers' maternal insight and instinctiveness maintains a strong and enduring link with their son throughout each of their lives.

9.6   Implications for future research

The findings of this underscores the need for further research in the area of veterans and their families. Mothers' experiences with their injured adult child have not been systematically studied in the past and, while this study begins to examine the mothers' experiences, it leaves some important questions unanswered. The findings of this study suggest that the mother's experience was not isolated to them alone. It would, therefore, be beneficial for future research to gain an insight into the experience of the fathers and of the spouses of servicemen who have sustained TCIs.

Consideration could also be given to evaluating the effectiveness of the self-help support group from which the mothers of this study were recruited. This would help to identify the variation between the benefit of perceived and received support, as well as instrumental and emotional support. In addition, it may be beneficial to evaluate whether sharing distressing experiences was helpful in the strategies the mothers adopted to ameliorate the distress they experienced from the demands of caring for their son, providing emotional support to their son and the strain they experienced in the relationship with their son.

Research could also investigate the accessibility and effectiveness of the welfare services provided by the various veterans' charities discussed in Chapter Two. These charities claim to provide welfare support in times of great need to the family members of injured, sick and wounded veterans. However, to date, these charities have been unresponsive to the invitations of researchers to independently review the effectiveness of how they deliver their services and the long-term MH outcomes to their beneficiaries.

Although many veterans grapple with physical or psychological wounds, the range of challenges is broader and deeper than most realize and has been beyond the scope of this study. Further research might also explore the lived experiences of parents (mother and father together) and parent–adult child dyads, as well as conducting a survey of a random sample of parents of service personnel who have subsequently

married and become parents themselves, using both quantitative and qualitative strategies. This would likely reach a more representative, albeit still self-selected, sample. Findings from the current study and the very few others that have attempted to investigate parents' (mothers' and fathers') experiences with the deployment of their adult children could be used as a starting point for developing such a survey.

9.7   Strengths and limitations of the study

9.7.1   Strengths

The IPA methodology called upon in conducting the current study reflects the views of Cassidy, Reynolds, Naylor and De Souza (2011, p. 274), who suggest that "[t]he idiographic nature of IPA, paying close attention to individual accounts, may disclose interesting and valuable insights for practice that challenge psychotherapists' everyday assumptions". Moreover, the rigorous approach taken in conducting this study highlights how qualitative research provides a more advanced level of evidence than the anecdotal evidence that formulates much of clinical practice (Green and Britten, 1998; Kearney, 2001).

The interpretative nature of IPA, operationalised by the hermeneutic cycle discussed in Chapter Five, and which was employed during the analysis of each mother's extensive transcripts, presented the opportunity to explore in detail the phenomenon of the mothers' individual experiences and the mothers' shared experiences. The plurality of themes presented by some of the mothers, as well as the contradictory themes, was an important contrast in emphasising the different attachment types, the different coping strategies and the access to support experienced by the mothers. This feature of the analytical stages of IPA, however, is a somewhat underestimated outcome of the hermeneutic cycle in that, in one case, the potency of one mother's experience provided clarity to the interpretation of another mother's experiences, as well as giving additional support to the psychological constructs that emerged during the hermeneutic cycle and reflexive practice discussed in Chapter Four. This has added to the critical analysis and impartiality of my interpretation.

Unlike self-reports, the number of semi-structured interviews gave each mother the freedom to 'voice their experiences' and to give significance to their perceptions, predispositions and motivation. The volume of phenomenological text this generated exceeded 150,000 words. The analysis of this volume of text, particularly in conducting the hermeneutic-cycle, which involved reflexivity and the author's fore-understanding, described in Stage 3 of the analysis, was time consuming and mentally effortful. In

doing so, it reflects the principle of research rigour defined by Yardley (2008, p.222) as "prolonged contemplative and empathic exploration of the topic together with sophisticated theorising". However, this is the nature of the IPA methodology and needs to be embraced by researchers from the very start of their study when adopting this type of qualitative approach.

The benefit of using IPA for an under-researched phenomenon is emphasised further in that by using self-reports, although beneficial in collecting data and the analysis of numerical data from a large sample of participants, it is nevertheless ineffective at discovering the hidden nuances buried deep in the meaning the mothers had given to their lifeworld. This is particularly evident with each mother's relationship with her son, the personal nature of their strategies for coping and the motivation which four of the mothers had for assuming the care of their sons. The use of self-reports would not have enabled the author to identify the hidden motivations that two of the mothers portrayed in their reluctance to disclose the relationship conflict with their son or their daughter-in-law. This facet of IPA is a strength but is only accessible if the researcher engages with the iterative process of the hermeneutic-cycle, with reflexive practice and with the periods of 'dwelling' needed to negotiate alternatives and counter-arguments before arriving at a version of the meaning given by each mother to their lived experience of the phenomenon.

An additional strength of the current study was the strong association with the psychological dialogue, which began to emerge during the second stage of the analysis and was constantly 'tried and tested' during the subsequent stages of the analysis leading to the write-up of each mother's narrative account. This psychological dialogue also guided the author to investigate the hidden scripts which ran beneath the face value of each mother's narrative. The outcome of this was twofold. Firstly, my critical examination of the psychological dialogue extended my understanding of the meaningful extracts which represented each mothers storey. Secondly, the extensive bibliography I called upon in constructing Chapter Five, facilitated my critical analysis of my fore-understanding, and therefore, my interpretation of the mothers' narratives and the validity of the themes that emerged. This contributed to the reflexive practice discussed in Chapter Four and how it became embedded in the stages of the analysis and in the write-up of the accounts. This was an unforeseen outcome of the practical steps described by Smith et al., (2009).

9.7.2 Limitations

A criticism of this study could be made in relation to how the interviews reflected each mother's retrospective perceptions of the events which took place in 2009. However, for all the mothers, their son's recovery and rehabilitation represented several years of prolonged commitment, which had remained a vivid and memorable account of experiences which had not eroded over time or become enmeshed with more recent events. It is also highly possible that the ease with which each mother recounted their lived experience was helped by the number of times each mother had relived their stressful encounter with family members, friends, support groups and, for some of the mothers, with therapists or counsellors.

9.8 Attending to the rigour of the study

In Chapter Four, I described how I had been guided by the 'four principles' of research rigour described by Yardley (2000; 2008) and how commitment and rigour could only be evaluated once the findings of the study had become visible. Commitment and rigour in relation to how the IPA approach has been applied to this study was achieved by calling upon the expertise of my supervisory team to confirm the efficacy of how I had applied the IPA approach discussed in Chapter Four and to confirm the validity of each participant's analysis. In addition, in Chapters Six to Eight, I also provided as many 'meaningful descriptions' as possible from each of the participants. This was intentional, as it attends to the claims of Osborne & Smith, 1998) who claim that adequate evidence from the participants should be presented in a study to allow the reader to question and, in principle, "independently audit the legitimacy of the interpretation" (p. 54). The legitimacy of the interpretation is strengthened by how, in Chapter Four, the analytic process has been transparently described, and how the results and discussion have been presented in Chapters Six to Eight. The background to this study presented in Chapter Two and the extensive range of studies presented in Chapter Five, in addition to how the findings of this study contribute to existing knowledge and implications for policy and practice, are evidence of how the structure and content of this thesis has been accountable.

An additional approach used by researchers using IPA is to demonstrate coherence and transparency by sharing the researcher's narrative account with each of the participants. I abstained from doing this, based on the views of Meyrick (2006, p. 806), since "this can move the analysis away from the 'researcher's' interpretations of the data". If the mothers had read their transcripts, this may have encouraged each

mother to describe their perceptions or recollections differently, which would have placed me in the invidious position of having to adjust my interpretations to satisfy the mothers' revised accounts.

9.9   Personal reflections

It was not until I had conducted the second interview that I became aware of my feelings and expectations of the research, along with gaining a measure of how I had underestimated the amount of data that would be generated. As a result of this, I realised the challenge of the time-consuming activity of the transcription process and the re-adjustment I needed to make in experiencing the mechanisms associated with the hermeneutic-cycle and reflexive practice discussed in Chapter Four. This experience was far removed from the relative simplicity of planning and organising the different phases of the study. On reflection, the volume of data was also a pre-requisite of how I had intentionally limited my assumptions regarding the objectives of the study, so that I would be able to conduct each interview from a position of neutrality. This reflects the views of Moustakas (1990: p. 9) who talks of a "growing self-awareness" that occurs while undertaking qualitative research. A broader perspective is offered by Shaw (2010):

> Through making ourselves aware of our own feelings about and expectations of
>
> the research, we can begin to fully appreciate the nature of our investigation, its
>
> relationship to us personally and professionally, and our relationship as a
>
> researcher and experiencer in the world. (p. 235)

The methodology during the first transcriptions also presented a few challenges. The methodology was often something I had to grapple with, and at times, the volume and richness of the data was intimidating and emotionally wearing. There were several interviews where I instantly recognised the pain and distress of the mothers, comparing it with my own experience of distressing emotions. This required me to reflect on these parallels during the journey home after each interview with all the mothers. The three- or four-hour train journey which followed each interview became a period of reflection and an activity which became useful in rationalising my experience of each interview, serving to provide a provisional insight to the participant's experience. This perception of each mother was re-visited during the analysis of their first transcript and the interaction of the double-hermeneutic, reflexive practice and my fore-understanding

discussed in Chapter Four. This emphasised to me, far beyond any readings and teachings I had engaged in before the start of this study, how researchers using IPA are vulnerable to biases when engaging in IPA, and how each mother and I became co-researchers in the study from the beginning of the analysis of each mother's transcripts and up to the several re-writes required before each mother's story reflected their lived experiences.

My prolonged involvement with each mother's lived experiences and the numerous periods spent in dwelling upon the write-up of each analysis prompted me to reflect on my childhood experiences and how the relationship with my parents changed when I joined the armed forces, and how it changed again when I married. This new perspective brought clarity to my understanding of each mother's relationship with their son and how their son's transition into adulthood, which coincided with them joining the armed forces, had for four of the mothers strengthened their relationship. For two of the mothers, their son's TCI had served to expose the fragility in their relationship, which had existed without them being aware of this. Above all, the mothers' lives reinforced my view of how military service connects so many individuals and families across our society and, regrettably, how the injury and sickness of service personnel has resulted in hardship and unbelievable distress that is felt, not only by the service personnel, but also by their immediate family, as well as their extended family and friends.

Whatever their reasons for entering military service, or the politics behind the conflicts, a minority group of the armed forces are a high-risk population who have specific and lifelong needs after making the transition to civilian life. It could be argued that there is a moral duty to support and care for ex-service personnel, equal consideration should be given to family members including parents during their service within the armed forces and their reintegration to society. Understanding mothers'experiences and the relationships between mothers and their adult sons with a TCI will be paramount in designing timely, well-coordinated and effective MH support to mothers. The Government, the DMS, the NHS, the DSC, COBESCO and the veteran charity sector are urged to acknowledge the contribution this study makes to existing knowledge in relation to how an adult son's traumatic injury can impact on the mental wellbeing of their mother and reflect this in policy and practice so that the services provided by the NHS and the veterans' charities provide an appropriate level of MH to run concurrently from role 4 of the trauma care pathway received by trauma injured service personnel.

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Appendix 1: Extract of studies identified by Fossey and Hacker-Hughes, (2014, p 9-14)

'Traumatic Limb Loss and the Needs of the Family'

Using the search terms identified in the methodology we were only able to identify six papers of some relevance. Three of these studies followed up traumatic limb-loss victims in Iran. All of these descriptive studies used medical examinations and history taking to elicit the physical and psychosocial impacts of traumatic amputation. Afshar and Afshar (2007) considered the long-term follow-up needs of seven Iranian male bilateral hand amputees who had lost their limbs as a result of land mines. The authors considered the psychological and economic impacts of bilateral hand loss on the participants and noted that this catastrophic injury had little impact on marriage or relationships. The sample size was (thankfully) small and it is difficult to establish if the sample is representative. Similar results on social functioning were reported by Ebrahimzadeh and colleagues in studies of other amputations with larger sample sizes. In all of these studies family members were not interviewed and the authors did not consider the impact of the injuries on the wider family or how the families were involved in rehabilitation.

In an international study of the impact of traumatic limb loss on land mine survivors, Ferguson et al (2004) identified a dynamic relationship model between economic opportunities, social integration and physical and psychological health. Although families and family dynamics are identified as important in an ideal rehabilitative pathway, the impact on the family, or indeed their contribution to rehabilitation, is not explored, even though 10 family members were interviewed in the course of the study. This qualitative study was quite extensive, with 85 participants, but its international scope and exploration of impact across a vast range of cultural and socio-economic differences need to be taken into consideration.

In a cross-sectional survey by Dougharty et al (2014), Vietnam era amputees were compared with those injured in current operations. The authors found no significant differences in measures of quality of life between the two groups. This survey looked exclusively at the amputee and did not consider the objective experiences of family members.

In the most informative of the papers, Friedmann-Sanchez et al (2008) used a Rapid Assessment Process (RAP) methodology to obtain in-depth qualitative information. The perspectives of USA VA rehabilitation providers on the involvement of polytrauma patients' families in rehabilitation were assessed. The authors

acknowledged that there is very little comparable literature, but noted that compared to other VA rehabilitation services, families of polytrauma patients were much more involved in rehabilitation and needed much more intensive support themselves – although the nature of this support was not discussed.

None of the papers identified in the review of the literature looked directly at the experiences of families, although social functioning and relationships were an important element for the participants in the research. As we were unable to identify any literature of note specifically relating to traumatic limb loss and family impact, the authors extended the search terms to incorporate "polytrauma". The meaning of the term polytrauma is discussed in more detail below. Even though the term has an American aetiology and refers to multiple injury (and is not strictly related to traumatic limb loss), it was felt that any literature relating to the impact of polytrauma on families may be of interest.

We used the ProQuest family of 24 health and social care databases and searched using the following string: "polytrauma" AND "family" AND "support". We identified 384 articles, 14 from peer-reviewed journals. A brief abstract review of the 14 articles identified six for further consideration; these are detailed in Table 3 Impact of Polytrauma on Families. Of the six, three of the papers were more focused on the impacts of traumatic brain injury (TBI) as the primary presenting condition. The review findings using both the original search terms and the new "polytrauma" string were augmented using a snowball approach where we considered key citations in articles of interest. The outcomes of this expansion of the search criteria are considered in the discussion section below.

There is much that is not understood about the impact of caring for severely injured personnel on the family. In a comprehensive review of the literature Griffin et al (2009) have identified seven keys areas where there is a paucity of research and more needs to be understood to inform the research policy agenda and practice delivery. They identified specific staff training in delivering polytrauma care and communicating important information as requiring further investment, an issue discussed at some length by Friedemann-Sánchez and colleagues (2008), who conclude that polytrauma providers require much more information about what families need to know, and where, when and how to deliver this without having a deleterious impact.
Griffin et al (2009) found that little is understood about the long-term impact on the families of care giving, whether this is financial or psychological. They also identified that very little is known about the impact of family attitudes towards polytrauma

recovery, something that has been well documented in other health conditions and even less is known about the psycho-social adjustment of family members to some of the unique traumatic injuries associated with combat.

Griffin et al (2009) also found that negotiating the system of care is particularly problematic. Even though this research was mainly based on US studies the myriad of different charities that are present in the UK make informed decision making difficult for families. Whom should they trust to deliver evidence-based interventions? Schaaf and colleagues (2013) looked at perceived needs and whether these had been met amongst a sample of 44 military families in a polytrauma setting. They identified that most of the civilian research had focused on the needs of carers of patients with TBI and had used the Family Needs Questionnaire (FNQ), a tool specifically designed for families of patients with a brain injury.

Civilian studies using the FNQ have identified that family members consider health information as one of the most important needs20-25 and that emotional and instrumental support are more often cited as being less important and indeed less likely to be met. Schaaf et al (2013) found that the findings amongst their military population were consistent with civilian findings.

With the exception of a small study, carried out in Northumbria by Moules and Chandler (1999), most of the research into family experiences has been conducted in the USA. It is likely that the structural and systemic differences between the US and UK system of care may impact on family needs and perceptions, and their access to different statutory and voluntary sector services.

The Schaaf et al (2013) study was cross-sectional, that is considered the issues at one point in time. There has been very little longitudinal research considering the impact on families over an extended period of time. Griffin and colleagues (2012) studies a comparatively large sample of family caregivers for injured US Service personnel and veterans (n=564). They found that interested parents rather than spouses tended to be the main providers of care. This is an important finding as when we consider the more conservative definition of family used by the UK MOD, where parents may be excluded in decision making, even though the US evidence suggests that they may have a more important role than thought. Griffin et al (2012) also found that within the post-injury range (<1 to >7 years) of the families they interviewed, the intensity of the care giving did not alter. Very little is known about caregiving patterns and even where there is a more considerable research base, such as with TBI research, no literature considers issues beyond five years post-injury. There is little clarity about

what the long-term needs of severely injured US Service personnel may be, especially the impacts on the family and the caring relationships.

Collins and Kennedy (2008) argue the importance of the family in polytrauma care and rehabilitation, however in their case review paper the focus of discussion is towards traumatic brain injury as the principal polytrauma injury. In the US, the Veterans Administration has taken steps to try to standardise the care and support that families of injured Service personnel receive. Hall et al (2010) evaluated the changes associated with this "Family Care Collaborative" approach and found a cultural shift towards a more family-centred care delivery model. The greater numbers of injured US Service men, the geographical spread of services and the systemic differences, compared to the UK make comparisons difficult, however the product of the collaborative approach of closer family working may have longer term social and clinical benefits.

Discussion

The literature review failed to identify any UK research looking predominantly at the impact of traumatic limb loss on the family. This was the case for both military and civilian cohorts. However, a number of interesting questions have been raised in particular whether the findings of the US research are translatable or replicable in the context of the UK health and social care system.

Appendix 2: Participant Information Sheet

Title of Project: A Mother's Experience of her Son's Combat Illness: An Interpretative Phenomenological Analysis.

Invitation

I would like to invite you to take part in a research project. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve. Please take time to read this carefully and please direct any questions you may have initially through Julia Mahoney and Susan Hawkins who will pass them to me by email which I will reply to within one or two days. Julia Mahoney and Susan Hawkins are acting on my behalf in coordinating the invitations to members of The Ripple Pond to provisionally take part in the research. Once I have received ethical approval from the University of Central Lancashire Ethics Committee I will be able to contact you directly to answer any further questions you may have about the research and to arrange a date for the first interview.

What is the purpose of the study?

Recent research conducted in the United States of America with military families provides strong suggestions that the resilience of immediate and extended family members are threatened by the impact of combat illness. However, research has not yet investigated the impact of combat illness on the parents of British Armed Forces personnel. This research intends to address this gap in the literature by investigating the impact on mothers' emotional resilience by the combat illness of sons returning from deployments to Afghanistan and Iraq.

There are four main objectives to this research:
1. To identify qualitatively the range of stressors experienced by the mothers of male service personnel who have sustained combat illness.
2. To identify qualitatively the range of coping strategies adopted by mothers' during the various stages of injury, recovery and adjustment of their sons' combat illness.
3. To examine the issues faced by mothers in accessing primary health care services and the type of treatment plan prescribed to them for the symptoms presented during their initial appointment.

Why have I been invited to take part?

You have received this invitation because of the following criteria:

1. You are the mother of a serving or ex-serving member of the Army, RAF or Navy who has a son who have sustained combat illness as a consequence of deployment to Afghanistan or Iraq.
2. You have experienced a change in your mental health and well-being as a result of your son's combat illness.
3. You feel confident that you will be able to discuss in detail your experiences of coping with your son's combat illness without compromise to your well-being.
4. You are a member of The Ripple Pond self-support network.

Do I have to take part?

It is up to you to decide whether or not you want to take part in this study. Please take your time to decide; you can decide not to take part or to withdraw from the study at any point during each interview or after each interview and up to 28 June

2016. If you wish to have your data withdrawn once the research has started please contact me and your data will be removed from the research and destroyed.

What will happen to me if I agree to take part?
If you are eligible you will be invited to contact either Julia or Susan via email to express your provisional agreement to take part. At our first interview you will be asked by me that you understand the content of this information sheet and if you have any questions or require clarity on any point. If you do decide to take part, you will be asked to sign a consent form before the start of your first interview.
There are 4 stages involved in your participation. Each stage will consist of an interview lasting between 60 to 90 minutes and will ideally take place in your home or at a place of your choice which offers privacy from the public. All interviews will be audio taped. You have the right to stop the interview at any point without explanation and there will be no consequence to you. Several weeks after each interview you will receive by email a transcript of your narrative which I will ask you to read to ensure that you agree it was an accurate representation of what you said during interview. The transcript will be placed in a folder which will be password protected to prevent its unauthorised access should it be onerously received by an email address not specified by the researcher. The password to the folder will be sent via a text message to your mobile telephone number provided by you with your email address.

What are the possible advantages or disadvantages of taking part?
There will be no cost to you taking part other than your valuable time, neither is there financial reward for taking part in this research. However, it is intended that your participation in this research will help to raise awareness within the academic community, other researchers, primary and secondary health care providers and Veterans charities, in the health care needs of parents and particularly mothers' who have been affected by their sons' combat illness.
There are no risks or disadvantages to you in taking part in this research. However, I am mindful that agreeing to take part in an interview may cause you some distress. Should you feel distressed in any of the interviews the interview will be paused until you feel able to continue? If, however, you feel unable to continue, the interview will cease and with your agreement continued at a later date. If you should become distressed at some time after the interview you will agree to call upon whichever level of support you feel appropriate outlined in the table below:

Table 2: Levels of participant support

Level of support	Type of support
Level 2	The Ripple Pond help-line accessible Mon – Friday 0900 – 1600 (interviews will be conducted between these hours).
Level 3 (during interview	Husband of participant (where applicable i.e., a number of husbands are retired and were within easy reach at the participant's home address)
Level 4 (after interview daytime hours)	Family GP (when level of distress is persistent and beyond the support of levels 1 to 3
Level 5 (after interview out of hours)	The Big White Wall (when level of distress is persistent and beyond the support of levels 1 to 4.

Will the information I give stay confidential?
All interviews will be recorded and then transcribed into an electronic document. These will be identified by participant code not by your name and will be stored in computerised files only accessible by a password known to the researcher. No paper transcripts will be produced. To ensure your anonymity pseudonyms or false names will be given for yourself and members of family, friends, work colleagues or military personnel if used in the results section of the thesis. Place names, military unit identities and civilian organisations will either be omitted or given a pseudonym. This will ensure that personally identifiable information will not be used.
Only electronic copies of your narrative data (transcripts) will be made, no paper copies will be produced Electronic copies will be stored on the researcher's external hard drive and a back-up copy on the computer used by the researcher. The computer and hard drive is the property of the researcher and is used solely for the purpose of the research. The computer is password protected and only known by the researcher. All interviews will be transcribed at the home of the researcher in Worcester. Breaches of confidentiality will only occur if the Director of Studies is made aware that there is a risk to the safety of yourself or another individual. This is in line with the British Psychological Society's Code of Ethics and Conduct (2009). Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else

What will happen to the results of the research study?
This research is being carried out as part of my Doctorate research degree at the University of Central Lancashire (UClan). Selected extracts from your narrative data (interview transcripts) will be used in the researcher's thesis, academic articles/publications and conferences at some point in the future after the completion of the research in April 2017. A summary of the research findings will be made available to you on completion of the study. Personal identifiable information (e.g. name and contact details for the purpose of arranging interviews) will be securely stored electronically for up to 6 months after the project ends in April 2017 and will then be destroyed by the researcher. The electronic interview transcripts and analysis data will be securely stored on the hard disk referred to earlier and may be used for follow-up research or for other unrelated research purposes for up to 5 years after the submission of my thesis in January 2017. After this point all electronic documents and material relating to the study will be deleted from the hard drive and the research computer. The hard drive will be destroyed by the researcher.

Who is organising the research?
This research has been approved by the University of Central Lancashire Ethics Committee.

What happens next?
Please keep this information sheet. If you do decide to take part, please either contact the researcher using the details below.

Thank you for taking the time to read this information
If you decide to take part or if you have any questions, concerns or complaints about this study please contact one of the research team using the details below.

Student researcher:	**Prime research investigator:**
David Sacree	Professor Mike Thomas PhD, MA, BSc, FRSA, MBPS
Email: DSacree@uclan.ac.uk	Vice-Chancellor
Mob: 07583828254	University of Central Lancashire,
	Preston PR1 2HE
	Email: MThomas14@uclan.ac.uk
	Mob: 0781 4221214.

If you have any concerns about the research at any time, please address these to the University Officer for Ethics at OfficerForEthics@uclan.ac.uk. Please include the study title or description (so that it can be identified), the principal investigator or student investigator or researcher, and the substance of the complaint.

Appendix 3: University of Worcester Ethics Approval

IoHS ETHICS REVIEW FEEDBACK

14th January 2015

Dear David and Matthew

Re: A Mother's Experience of her Son's Combat Injuries:An Interpretative Phenomenological Analysis.

Thank you for submitting this project for review by the IoHS committee. The committee has now completed their peer review of your project work and would be happy to grant this project ethical approval to proceed.

I would like to thank you and your supervisor for attending the recent meeting with members of our ethics committee to discuss your project work and for addressing reviewer comments as requested.

You can now commence with your research project – you will shortly be forwarded a REC approval number for your records.

If you make any amendments to your research project, you should notify the IoHS ethics committee with any further information. If major amendments are proposed, these may require additional ethical scrutiny from the committee. As part of our annual audit procedures, you may be contacted and asked to complete a brief questionnaire to summarise your research activities.

Thank you for submitting your research project to the IoHS ethics committee and good luck with your research.

Kind regards

Eleanor

Professor Eleanor Bradley CPsychol AFBPsS
Professor of Health Psychology
Chair, Institute of Health and Society Ethics Committee
IHSEthics@worc.ac.uk

Appendix 4: UClan Ethical approval

uclan
University of Central Lancashire

20ᵗʰ May 2016

Michael Thomas/David Sacree
School of Health Sciences
University of Central Lancashire

Dear Michael/David,

Re: STEMH Ethics Committee Application
Unique reference Number: STEMH 452

The STEMH ethics committee has granted approval of your proposal application 'A Mother's Experience of her Son's Combat Injuries: An Interpretative Phenomenological Analysis'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer. It is your responsibility to ensure that:

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify eoffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely,

Colin Thain
Chair
STEMH Ethics Committee

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Appendix 5: Participant Consent Form

Participant Consent Form

Title of project: A Mother's Experience of her Son's Combat Illness: An Interpretative Phenomenological Analysis.

Participant Identification Number for this study:

Name of Researcher: David Sacree

	YES	*NO*
I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.	☐	☐
I confirm that I have had sufficient time to consider whether I want to take part in this study	☐	☐
I understand that I can withdraw from the research at any time up to and including 28 June 2016. I also understand that upon receiving notification of my withdrawal the researcher will exclude the inclusion or reference to my narrative data in his thesis or subsequent academic publications or conferences. All verbatim transcriptions and narrative analysis will be subsequently destroyed.	☐	☐
I agree to the research interview being audio recorded	☐	☐
I agree to anonymised extracts of my data narratives being used in academic publications, internal reports between the researcher and his research team and at conferences	☐	☐
I have been made aware of support services that are available if I need them.	☐	☐
I know who to contact if I have any concerns about this research	☐	☐

I agree to take part in the study:

Name of participant_____

Date_____   Signature _____

Name of person taking consent   _____

Date_____   Signature _____

Appendix 6: Interview Schedule

<table>
<tr><td>PhD Data collection

Participant Interview Schedule one</td></tr>
<tr><td>Participant ID…………………………………..
Date interview conducted………………………</td></tr>
</table>

Themes		Interviewer's notes
1. Establish Rapport	Introduction and brief explanation of the aims of the research and how it is relevant to the participant. [shake hands]	
2. Purpose	Ask for the name of son I would like to begin by asking some questions about you and then about your son, life before he joined the army and then move onto the day you received the news of his injuries and then to finish with your recollections of how you felt during the first few days of your son being cared for in theatre and prepared for the return to UK and then the first few weeks of being cared for in hospital in UK .	
3. Motivation	There has been a large amount of research and interest in how ex-service personnel adapt to the changes they have to make when transiting from military to civilian life. There has been very little research conducted in the UK about the stress parents experience when their son's deploy to operational theatres and the changes they face when they experience traumatic combat injuries. Sharing your	

	experiences will help us to have a better understanding of how mothers' injuries impact on their own wellbeing and whether existing health provision meets the needs of mothers. Additionally, your experiences may add to the growing interest in self-help groups as an alternative to traditional primary health care interventions for the symptoms of functional illness.	
4. Time Line	The interview should take about 60 to 90 minutes. If you feel you need to take a break at any time, please don't hesitate to say and we can stop for as long as you need.	
5. Consent	Ask the respondent to sign the consent form, explain to her if necessary Confidentiality and boundaries of confidentiality	
6. Permission	Ask the respondent for permission to record the interview	
Theme	Question	Notes
	What I want to discuss in this first interview Jennifer is the weeks leading up to you receiving the news of your sons combat illness/injuries, how your life felt generally and then the day you received the news and how life felt in the first few weeks of your son receiving treatment and support at Selly Oak. I would like to begin by asking some questions about you, your past and how you manage life's daily hassles or significant events?	
	Situational factors	
	• Can you describe your life just prior to receiving the news of your son's injuries? What was the key components of your life? Was it family and friends, work colleagues, hobbies, was there a particular challenge or joy in your life? • Can you share with me your recollections of what used to worry you on a daily basis? • Can you describe to me what you think was the most stressful event in your life up to the day you received the news of your son's injury? • Can you share with me how you think you had coped with this stressful event?	

	•	Having experienced this stressful event and coped with it in the way you have described do you think you coped with stressful events differently after that?	
	•	Would you say that you try and avoid stressful events or prefer to hit them head on and resolve them as quickly as possible?	
		Son's motives for joining the armed forces	
	•	Can you describe your son's life prior to joining the armed forces	
	•	Did you and your son share a passion or interest in anything?	
	•	Did you engage in one particular activity together more than any other?	
	•	Would you describe your relationship as one built on a strong sense of attachment to each other?	
	•	Can you describe the reasons why your son decided to join the armed forces?	
	•	Why did he join the branch of army he chose?	
	•	"Did you feel that you were part of his decision to join" By that I mean did he ask how you felt about him joining"?	
	•	"Can you describe to me how you felt the day that he left home to begin his basic training"?	
	•	So bearing that in mind that he had gone through the transition of leaving home, what was the relationship with your son at the time he joined?	
	•	"Did the relationship with your son change in any way when he joined the arm"?	
	•	"How would you describe the relationship you had with your son during his initial years in the army".	
	•	"When you reflect on those years before the injury were you aware of being overly concerned about his safety when he was deployed operationally"?	

	"Had you ever discussed with your son how concerned you became when he deployed on operations"? Can you describe how you would feel leading up to his deployments"? - Can you remember consciously putting a brave face when your son went to Iraq/Afghanistan or were you very open with him about how your felt? - Did you share your concerns with any other family member or perhaps a close friend? "Can you describe how you would feel once you knew he was back in UK safe and sound"? "Is your son married"? "Did the relationship between you and your son change after he was married"? - Can you describe the relationship you had with your daughter in law prior to your son's injury? - Did the relationship change for the better or worse during your son's rehabilitation?	
	Response on receiving news of son's injury	
	These next questions [name] will potentially be upsetting because they will be asking you to recall your feelings and thoughts the day you received the news of your son's injuries. Would you like to take a short break or do you feel comfortable to carry-on? "Can you describe to me where you were when you received the news"? "Can you describe how the news was communicated to you? - Did members of his regiment call to tell you personally or did you receive a phone call? "Can you describe your feelings immediately after receiving the news? "Looking back do you think your son's injuries were described accurately to you"?	1, The purpose of this part of the interview is to gain insight into the participant's stress response on hearing the news of their sons injuries. 2. Receiving news of your son's injuries: Location How were you told Were others with you? Extent of his injuries

	• "Can I ask you to briefly describe the nature of the injuries"? • "Was there anyone else with you when you received the news"? • "Can you recall whether you were able to discuss how you were feeling with a significant other, family member or close friend"? • Were you able to discuss the news with your parents or a parent? • How much do you think your parents influenced your way of managing distressing events as you were growing up? • Who else did you feel you had a responsibility to inform about your son's injuries? • Was that a difficult conversation to have? • "Who do you remember being important to you during the first few days of trying to come to terms with the news"?	Immediate thoughts and emotions What were your actions? What was your perceived role in relation to other family members?
	"I would now like to ask some questions which refer to your experiences during your visits to the hospital and up to your son's discharge and return home?	
	• "Can you describe to me what you saw and felt when you stepped onto the ward for the first time • Were you shocked by what you saw and heard the first time or during subsequent visits to the ward • "Can you describe to me what you did once you had realized that your son would be coming home"? • "Looking back now do you think you responded in a practical way, that you had a very clear understanding of what you thought you needed to do next"? • "Did you inform other members of your family about your son's injuries"? • "Was it natural that it should fall to you"? • "Did you visit or talk to your daughter in-law"? • "When you look back do you think that you and your daughter in-law supported each other as well as you did"? • "Was it difficult for you and your daughter in-law to support each other"? [Did you perhaps feel that you were stepping on her territory"?	

	• "Has your experiences strengthened the relationship with your son"?	
1. Summarize/Debrief	[Name] "I would like to bring this first interview to a close if I may and first of all thank you for sharing your experiences and what must be associated with strong emotional feelings". This first interview has focused on life before you received news of your son's injuries, your reaction and response to receiving the news and how life felt for you during your son's initial care in hospital. In our next interview I would like to discuss what happened next, how you experienced and understood a change in your well-being and your experiences when you visited your GP for the first time.	
2. Maintain Rapport	"Can I thank you for sharing what you have with me, I hope it wasn't too difficult or distressing for you to answer such searching and emotive questions? I will convert the recording of our interview together into a word document and send you a copy to read. I will send this in an email and ask you to make any corrections or provide any additional information which you think is important but not to change any of the text you read. I will explain this in the email.	

Appendix 7: Sample pages of Jennifer's verbatim transcript interview 1

Line No.	Jennifer's Transcript 15 January 2015
	Q: Can you describe to me how life felt generally on a day-to-day basis before receiving the news of Josh's injury:
	I would say that I am naturally optimistic person and had coped with Josh and Jeremy being on active duty in either Northern Ireland or Iraq since 2003. They were away every summer. So there was a level of tension there but I had put in place certain coping strategies I made sure that I never watched the news I made sure I never listened to the news I had this weird belief that I would hear through the news rather than from some other source so it was a protection thing . So I coped and I think I was getting to the point that you know I could relax a bit , he's been well trained and he wasn't there at the moment we went into Iraq or Afghanistan. A false sense of hope. John and I had just got married in 2008. That was a happy time and all the boys were there. And I know that we had decided to postpone our honeymoon until the Feb because we were going to south Africa. I wasn't going to leave the country while Josh was away and John was going to be 60 in September 2009 and so we put the honeymoon between the two events. It was a happy time Jeremy and Laura my eldest son were expecting their first baby, Josh and Jessica were expecting their second baby 15 and my counselling course was coming to an end. And I think I was …yes I had lovely daughter in laws, everything seemed to be going ok , Jacob my youngest had managed to stick out university, none of my other sons had managed to do that and we were looking forward to him graduating and although there was a level of tension because of having had the previous 6 years at that sort of worry level, as one of the son's had said "mum if you didn't have something to worry about you would find something ". But I had consciously been trying to change that frame of mind and to be more positive. So I think I was probably on a scale of

1 to 10 as far as anxiety is concerned I was probably at maybe 6 or 7 but previously had been up to the 10 mark when Jeremy went to Iraq and that first flood of stuff and Josh went out to Iraq and bombs were going off so I had come down and got used to it .

Q: Do you think you had got used to the fact that there had not been any incidents and therefore you had confidence in your son's ability to take care of themselves and the MOD taking care of them all?

I think there was two bits one that I had got used to being that anxious, so it wasn't unfamiliar anymore it's hard to tell although Josh/James had been in a near miss and Josh had lost two soldiers when he was at home on R and R (rest and recuperation) while on leave and he had reacted and thank goodness he had reacted but he reacted in a way which was pretty uncomfortable for the rest of us so I think I knew it happened but they had survived that we had been blessed and had got through it I think there was an element of that but not sure how much hope I had in the MOD

Q: What was Josh's motivation for joining the army?

Ever since he was old enough to pick up a stick he and James had wanted to be in the army. We come from a military family on both sides and certainly in the case of my family both my mother and father were military so it was sort of in their blood I think .

Q: So knowing that it was a family tradition did that in any way make it easier for you when your sons wanted to join the army? Was there a certain sense that it was fine because family had done it in the past or wasn't it that simple to rationalise?

For me …I don't think it was that simple to rationalise because I'm basically a whoose and I didn't want that level of stress while my mother would have been saying stiff upper lip, don't be over sensitive, don't be like that . For me it was a very split thing, my maternal side of me that said I don't want you to go and the other side was a generational thing…. and I am proud of all of them it wasn't that I wasn't proud of them and I'm lucky that I understand the system but there was a part of me that wished perhaps that generationally they would have been doctors .

Q: So you always thought that the playing with sticks would lead to them joining the army?

Yes, I think that during their childhood my biggest fear was that they would have an interest in bikes. Because there wasn't the same sort of level of wars going on, that there experience wouldn't be any different from mine as the daughter of someone in the army which was places like Singapore or Germany. So I sort of saw it as that. But of course once they joined up we were in Iraq .

Q: So did you have any fears at the point at which Anthony joined the army? 10 minutes

My overriding thought was the incredible pride that he had been to Sandhurst and had passed out and would go to Iraq if needed .

Q: So you had resigned yourself to that fact that he might get injured but nothing more than that?

I think that's true.

Q: How did life change for you on the day he left? Did life feel as though it had changed for you

There was longer absences in terms of communication but no not really he went to NI and I think by the time he went to NI yes there was some dodgy things going on but nothing like there had been out there in previous times when it was really bad so I didn't think he would get injured and certainly communication wasn't very good between the welfare office in the early days when they went out to Iraq but it got better and better but we weren't told anything but when James went out to Iraq we got given a card by James you know if something happens to you or dad or James ring this and here's my postal address .

That felt very isolating by the time Josh went to Iraq things were better we got a booklet but the lead into going into Iraq was difficult you were told one day and so I made plans to go up there so I could see him before hand and then it was called forward and then it was put back but it was extremely disruptive for me and Jackie Josh's wife because she had to take care of her son as well as her own feelings and I thought it was very cruel and actually bad planning by the MOD. It would have helped massively if you were told when you were going that's when you go .

Q: Why was it important for you to say farewell? And how important for Josh?

I suppose I have grown up with the belief that you should never go to sleep on an argument. Not that I had had an argument with Anthony but one of his brothers had. They had a massive argument and hadn't been talking and I found out and I managed to broker a peace between them

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and for that I feel eternally grateful. But there was something ….I think I just thought I want to have just one last chance of seeing him before he goes away for 6 months I want to be there .

Q: And was that because you had had an internal narrative with yourself that he might not come back?

No , I just I wanted to see him one more time, 6 months was a long time and also I knew because I had said so I knew what I had said that I wanted on the precious minutes home on the telephone calls I wanted him to have them with his wife Jackie not with me and I would always be there for him, and I wanted him to keep his relationship with his wife and I have done that with all the boys even if it has been a girlfriend or person, if you want to keep a relationship with that person you spend your precious minutes talking to them. So I thought it was actually my last chance to talk to him and I wanted to have that to hold in my head for 6 months.

Q: Can you describe your feelings after you said goodbye and walked away?

He had to go to the barracks at midnight, and to report to the barracks and so George and I went up to London where they were stationed, Jack baby sat and Jackie and I took Josh to the barracks with the intention that I would drive back because Jackie wasn't sure how she was going to be feeling so I said goodbye to him and felt quite sick I think very tearful but wanted to put a brave face on it, I didn't want the last thing that he remembers was of me sitting there sobbing, so smiles, told him how much I loved him and how proud I was of him and that he would be in my thoughts all the time and would write soon, gave him a big hug   got back in the car and left them to it and sat there thinking that real sense, I'm not very good at saying goodbye's I just want to go, so I had to just sit there and I remember looking in the rear view mirror and Jackie and Josh were standing very close to each other and they were laughing and I just thought to myself god Jackie you're an amazing women what a gift to give your husband before he goes off your laughing face not your tearful face, if she can do it I can do it too . So I hung onto that really because saying goodbye to him, I didn't have any foreboding, I just knew how much I was going to miss him.

Q: Had you experienced that feeling of missing him before?

Yes when he went off to Afghanistan, sorry when he went to Iraq, when he was posted to Cyprus, and I knew it would be some time before I could save the pennies to go and see him so it wasn't a new experience, I was missing him and I think at one level I was lucky that it was

April 2009, things had not kicked off so at that point was just thinking you know he coped with Iraq he had coped with tours of duty there and that now I have got to look after his wife and I've got to ……so there was not any foreboding.

Q: Do you think that was something that was intuitive, that not having a tear stained face is something you may have learned from your parents?

Yes   I do, you've got to see them off with a smile on your face, yes absolutely.

It's not how I felt but I wanted him yea, and that it was not foreboding.

Q: Was it also important for Josh's wife to have the same perception of you as the one you wanted Josh to have?

For me it was important that she saw me that way, I wanted Josh to focus on his job and if he thought that he was leaving behind a neurotic mother, waling and falling apart his mind might not be there and I think Jackie had the same intent but I wanted Jackie to know that I was strong and that I could cope and that she didn't need to look after me ?

Q: Do you think Josh is aware that you had concealed your true feelings?

Yes, they all know.

Q: Is that a discussion you've subsequently had or did they just learn of it.

In as many words no….but in a sort of roundabout way yes we have had a discussion about it but not in the sense I wanted to weep I wanted to wale. I suppose they know that I love them, they know that I'm hurting when they go but they also know that I'm proud of them, they do know that .

Q: And so when you did share that was Josh surprised when he learned and understood that is what you deliberately do when you say goodbye and conceal your true feelings?

I don't think he was surprised I think he was grateful that it enabled him that it gave him the space to think right I'm here to do a job, that's what I'm doing, mum can take care of everyone back home and I think yes he knew that and I think it gave him permission to do his job and not think about family.

Q: How did your relationship develop with Jackie during Josh's deployments?

Massively, for example we were due to go out and see them in Cyprus before they actually got married, Jackie went to live with him out there before they got married. We were due to stay with them but it was called off because he was warned for deployment to Iraq so she had to cope with this women who wasn't even her mother in law, and we just get on so well and I think I do think part of it is you've got to work at it but there's working and there's working at it and I haven't had to work at it too hard with Jackie. I think the fact that I have always said to the boys you must keep the relationship with your girlfriend, wife because I know and you know that we're here for each other at all times and I think that Jackie was very good she used to text me after he'd phoned or would phone me if she could to say that he was fine or that she had received a letter from him she would let me know . We talked a lot about him when we met up, she was very inclusive about having us over there if he was away not in Cyprus but other occasions when he was away and she was very good about letting us help which gave me a role in Josh's life.

Q: Was that before his injuries?

No before when they were stationed in Germany she said would you come over and see her and we did and Cyprus obviously, so she's always been very inclusive .

Q: So if that closeness had not been there and the ease at which you were able to talk about Josh's would that have made it more difficult?

Absolutely. Being able to be with her and share him meant a lot to me, it meant his presence was not so far away, I knew she had been talking to him, I knew she had had letters from him and then Joseph was born and there was a part of Josh there in Joseph and just being able to be there with her and Joseph I felt closer to Josh which is silly because I was still close to him here but having that relationship meant an awful lot of difference.

Q: You mentioned role earlier on, did you take that role on naturally or was there a discussion about divisions of responsibility between you and Jackie?

No I think it just sort of happened.

Q: It evolved in a sort of natural way?

Yes it did evolve in a natural way, no I think the only thing that I was overt about was about Josh keeping Jackie as his priority contact otherwise things evolved and I think that the importance of Jackie asking me to go with her to Selly Oak I really can't explain how massively important that was, now if we hadn't had the sort of relationship that we did have.   (Participant becomes a little emotional and unable to finish sentence.)

Q: Do you think Jackie invited you because she felt a sense of obligation because you were Josh's mother and it was important for you to see him or to support her?

I don't think it was to support her alone I think it was a combination of both, Josh left at the end of March, Emily was born 8 May, Anthony was blown up on the 21 May. So Julie was 2 weeks old. Most new mums would turn to their mothers, the first thing Jackie did when she learned the news of Josh's injuries was to phone me and then a few hours later she phoned me again and asked me if I would travel up to Kingston and help her . I don't think it was because she needed time to think about it… I think she needed time to think about what am I going to be doing how am I going to cope with all of this….. I know I'll ask Jennifer to come with me . I think it was more she, well you would have to ask her but I got the feeling that she asked me because she wanted me to go with her and then I think she thought that I would want to see Josh. I think there are other daughters-in-law who may think that if they didn't ask their mothers to do it I think they may have put it the other way round.

Q: The way in which you have described the consideration you were given is that something that you understand now or did you have that perspective at the time?

I've always known before Josh went away that Jackie and I had a very good connection, had a very strong relationship and a friendship and support for one another. Although I knew that, I think I was a little surprised that she asked me and not her mother but that was so quickly swallowed up by being so extremely grateful that (a) I had a role in this and (b) I was going to get to see Josh at sometime around the same time as she would and quickly.

Appendix 8: A sample of Jennifer's analysis stage 3

This sample depicts the synthesis of meaningful extracts, codes and exploratory comments and conceptual interpretations prior to the write up of theme 1.

Narrative	Codes	Exploratory comments and conceptual interpretation
Q: So you received the news by telephone? Yes. **Q: Can you describe how that felt?** Physically it would be true to say that I felt sick and completely numb…I went onto a sort of autopilot, was very calm, Jackie did say have you got anyone with you here and I said no I'll phone someone and she said I know Josh wants to phone you himself and so I checked out that she was okay and then she said I know Josh wants to phone you so I'll get off the phone now. She sounded calm and that's when I put the phone down and I felt sick and very numb and just sat there I also remember looking up and coming in here and just picking up things	Initial shock Disbelief Calmness of daughter in conveying the news. Physical symptoms of shock	Jennifer's discussion with her daughter in law seemed to have been one that discussed the practicalities of who would contact who. Jackie seemed to have been the one who allocated tasks and therefore may have been much more in control of her emotions than Jennifer. Jennifer describes Jackie as being very calm which seemed in stark contrast to how Jennifer responded to the conversation with her son. Jennifer's inability to understand her son caused her to associate this with a level of facial injuries that in fact did not exist. She seemed to have panicked immediately after putting the phone down and between talking to her daughter again. This seems like a contradiction. On the one hand Jennifer recalls being very calm with her daughter in law and on the other hand that she felt like she was jumping around. Jennifer's use of the word calm might be describing a sense of numbness or disbelief and the jumping around might be referring to a heightened state of arousal and anxiety and therefore the precursor to distress. Jennifer's concern that she couldn't be on her own seems to support the above description of how she had responded to the telephone conversation with her son. That she was in a sense of panic or anxiety and felt a sense or need for comfort and reassurance from her close friend. At a conceptual level this calling out for help is explained by social support theory. Jennifer's need to have the company of a friend was perhaps because she was also unclear about how to make sense of her own behaviour and feelings and felt the need to be comforted by someone who she could trust.

randomly and putting them down in odd places, no idea what I was doing,….I don't know what it was it was as if my brain had cracked and I would pick up a cup in the kitchen and leave it in the dining room, pick up an ornament and put it down somewhere else and rushed up stairs and that in fact happened after Josh had rang me. She did tell me that he had an injury that he was alive and all we've been told is that he has a broken arm and some facial injuries. I then had the phone call from Josh who I couldn't understand I think the predominant thing that was going through my mind was that I hadn't understood anything that he had said. There were facial wounds and they were just facial wounds and all around the face and I started to imagine all sorts of things. Then Jackie phoned me again and told me that the welfare officer was with her and that she would probably visit Saturday	Moving objects erratically around the house Unable to understand what son had said A sense of calmness but also arousal and anxiety Irrational movement of objects around the house Delegation of tasks Need for calm	Jennifer's inability to understand her son caused her to associate this with a level of facial injuries that in fact did not exist. She panicked immediately after putting the phone down and between talking to her daughter again. This need to calm herself down reinforces Jennifer's description of how she was probably in a state of heightened arousal and anxiety which seemed to have originated from her inability to understand what her son was saying and in doing so magnify the extent of his injuries. This suggests that Jennifer felt she was being all these things and may have been using her mother to be critical of the way in which she responded to the news of her sons TCI. This reference to her friend providing her with support refers to the relationship between telling a friend of the news knowing that in return the friend will give their support. For other mothers the more friends and family they told the more support they felt, that the problem was shared. Telling as many as possible was perhaps a way of sharing the burden of the news. A way of diluting the anxiety or uncertainty of the situation. Jennifer refers to how she anticipated her mother's reaction would be to her hearing how out of control she felt. This seems such a harsh appraisal by Jennifer of how her mother would respond to her daughter feeling anxious and distressed by the news of her son's injuries. This description of what Jennifer believes had happened is of course retrospective and sounds like it was very calculated and rationally thought out Jennifer uses a clumsy analogy to describe how she was able to regain her composure before speaking to her other sons. She suggests that she was suddenly able to put all her distorted and distressful thoughts to one side before talking to her sons. This describes behaviour which would have seemed very difficult for her to achieve given how she describes her level of distress earlier in the narrative. It might be that in hindsight this is how Jennifer would prefer to remember how she behaved. It may be that Jennifer was in a state of emotional numbness rather than composed and cognisant of her thoughts and actions.

and at that point she asked me whether I would go up and help her. I said yes, I would come up the next day. I remember being very calm with her, it wasn't how I was feeling and remember feeling like I was jumping around and then I thought I can't be on my own and it was just before 3 o'clock so I phoned a friend of mine and she said that she would come right over I carried on picking things up and putting them down. And then I remember thinking I've got to phone the boys.

Q: So from the moment you receive the news from Jackie to the moment you spoke to the boys was it long?

Jackie phoned me again about half an hour to 40 minutes and then I phoned my friend and then Jackie and I discussed who we were going to contact and Jackie said that Josh was going to call his Dad could you contact the boys and I said yes but thought I'm going to have to talk | Mother's disapproval of Jennifer's response

The effects of morphine

Lack of prior information from medical staff

True nature of son's injuries

Retrospective understanding of son's injuries and Jennifer's response

A calming presence would have helped | his response to the question in fact answers more accurately a question asked earlier in the interview regarding how Jennifer had felt after talking to her son. In fact, Jennifer answered the earlier question by saying how she felt but it is not until Jennifer answers this question that we are given an explanation for first of all why Jennifer perceived her son's injuries to be far worse and who had contributed to the poor way in which Jennifer was told about her son's injuries. Jennifer was unaware of the effects of morphine combined with the mouth injury her son had sustained – together his pronunciation of words would have been distorted and perceived by Jennifer to infer permanent damage and disfigurement of his face. Secondly, it seems naïve of Josh to think that his less than cognisant self and his mouth injuries would have not created a distorted perception by his mother and particularly when her sons acknowledged her propensity to worry. There also seems a lack of judgement by whoever allowed

This answer to the question points to the difference between perception on the one hand and reality on the other. At the time Jennifer was unaware of the amount of morphine her son had been administered and so attributed his mumbling to the result of severe facial injuries. Consequently, in the absence of a true understanding of her son's facial injuries she visualised something much more serious and permanent. It was this artificial representation of his injures that may have caused Jennifer's heightened state of arousal and anxiety leading to her distress and irrational movement of ornaments and crockery around the house.

This seems like an acknowledgement by Jennifer that she had created a picture and perception in her mind about her son's injuries that was 'false'.

This suggests that Jennifer had created several different versions of the nature and extent of her sons combat injuries. Initially because of the effect of morphine and injury to the mouth she imagined that her son had sustained extensive injuries to his face and had also imagined that these would be permanent and that it would change her son's facial appearance. Next after visiting her son in hospital she was able to compare perception with the reality of his injuries which were minor to his face and at that time it seemed that he had only broken ankles which wold heal relatively quickly with no permanent damage. The open fracture of the elbow was the major concern |

to my friend first and calm myself down before trying to speak to the boys.		because of the possibility of infection but this seemed to have been overlooked by Jennifer.
Q: So at that point were you making some sort of sense about how you were feeling?	Avoidance of parent's rebuke	The conceptual element of this suggests that the way in which Julia cognitively appraised the information she had been given was distorted and as a result her stress response was elevated beyond a point at which she was comfortable with or had control over. Once this had happened there was no way of switching it off until she saw her son in the ward. At this point she was able to compare her version of his injuries with the real version.
I knew I was hysterical.	Admission of not being stoic	While there was a lack of information about the nature and extend of her sons injuries caused by in the main by her son electing to talk to his mother while experiencing the effects of morphine and perhaps poor judgement by the military to allow the conversation Jennifer, by her own admission created an artificial perception of her sons injuries particularly his facial injuries which seemed to have far greater significance than the injuries to his ankles and the open fracture to his elbow. This over-reaction or false picture in her mind seems to have been the cause of her heightened arousal and anxiety and the distressful behaviour she describes earlier in her narrative. This might be explained conceptually by emotional coping strategies or how Jennifer regulates her emotions. This in some ways is alluded to Jennifer's response to the next question.
Q: Can you remember what actions accompanied how you felt at the time? Were you planning what to do in a rationale way?	Self-critical of response to son's telephone call	
No, I felt out of control. And mumbling in the background was a feeling that mum wouldn't like the way I was behaving with a very sort of critical parental voice going on about don't be so wet don't be so pathetic get a grip and I thought the only way I'm going to be able to do that is to get my friend to come round and help and support me. And once I'd put that logical thought into my head and I'd phoned my friend in a way it had put a spoke into the spinning out of control feeling and I'd taken control of myself and then now I need to phone the children.	Being stoic is false The support of someone else would have provided me with control Irrational thoughts and judgements	The presence of a friend would have perhaps provided the emotional regulation and objective appraisal Jennifer in retrospect felt she would have benefited from. This statement by Jennifer seems to suggest that she acknowledges that her emotional response to the telephone call with her son was 'hysterical'.

Q: So at that point when you were able to make that phone call you were more in control of your thoughts and feelings? ==Yes, I'd put everything into a jiffy bag and had pulled it tight and put it to the back.==	Concealment of information about her son's injuries	
Q: So would you say you contained the situation because you realised that there was a certain role to perform again in the role of mum for the other three sons? Yes.	Sons change in appearance was a concern	
Q: Can we briefly go back to the conversation with Anthony. Was it brief? Yes.	Dealing with something imagined	
Q But despite knowing he was alive and having spoken to him you don't seem to have been reassured that everything was okay? ==It was because I couldn't understand him, he was so high on morphine we later discovered, that I couldn't understand him ....now if a nurse had phoned me and said that Josh wants to talk to you he has a lot of morphine on board==	Dealing with perception rather than reality	

but he's fine but it may be difficult for you to understand him if someone had just said that first that would have actually brought my levels of anxiety down but because we didn't actually know what his injuries were we had been told and really had very little information. I think the MOD did get better at that em, and the facial wounds to me….. and I couldn't understand him I thought maybe that he had the whole of his mouth blasted away sort of thing… what am I going to have to cope with ….my imagination run riot when he phoned		

Appendix 9: Write up of theme 1

The table represents stage 4 of the analysis followed by a write up of theme 1 'Response to stress'.

Meaningful extracts	Conceptual interpretation
"She did tell me that he had an injury that he was alive and all we've been told is that he has a broken arm and some facial injuries." "I felt sick and very numb and just sat there I also remember looking up and coming in here [conservatory] and just picking up things randomly and putting them down in odd places, no idea what I was doing." "……the predominant thing that was going through my mind was that I hadn't understood anything that he had said…there were facial wounds and they were just facial wounds and all around the face and I started to imagine all sorts of things." "……mumbling in the background was a feeling that mum wouldn't like the way I was behaving with a very sort of	Jennifer responded to the schedule of questions and those questions which arose within the interview by discussing a number of critical events. For the majority of the interview these events centred around the moment she received the news from her daughter-in-law, her reaction to the news, her reaction after speaking to her son, how she regained her sense of self-control, her self-criticism of how she behaved, her fear of her son's facial injuries and how seeing her son informed her that she had imagined her son's facial injuries to be much worse than they actually were. While the initial level of distress Jennifer describes seems to have been significant it may in fact point to how Jennifer may have a propensity to adopt a narrow choice of options when processing information which has the potential to cause a heightened level of arousal and anxiety. In the context of this sub-theme Jennifer seems to have experienced at a conceptual level 'the stress response' which seems to have lasted for many hours from immediately after the conversation with her son until the next day when she visited him in hospital and was able to acknowledge that his facial injuries were minor cuts and grazes.

critical parental voice going on about don't be so wet don't be so pathetic get a grip."

"I thought the only way I'm going to be able to do that is to get my friend to come round and help and support me."

"And once I'd put that logical thought into my head and I'd phoned my friend in a way it had put a spoke into the spinning out of control feeling."

"Yes I'd put everything into a jiffy bag and had pulled it tight and put it to the back."

"My beautiful baby and every time I looked at him I would be reminded I would see it and you know I think facial injuries are probably just about the worst living injury… you can't cover it up."

Creating images of her son's facial injuries caused Jennifer to become distressed about how she would cope with not being able to recognise her son and how this might change their relationship. It is also important to highlight Jennifer's use of words and analogies to

describe several key moments in her interview. It is possible that Jennifer is calling upon descriptions and explanations as a result of how she has made sense of events and her responses and her subsequent experience in the role of counsellor. In doing so it is possible that Jennifer might be applying her own interpretation of what happened rather than recalling accurately her feelings, responses and actions at the time. A second significant factor in Jennifer's first interview is how she called upon a hypothetical conversation between her parents and herself to describe how she was behaving in response to the conversation with her son and at the same time enable her to be self-critical of how she behaved. This may have been an intentional strategy adopted by Jennifer to garner the author's empathy and to lessen any expected criticism by him of her actions. At the same time while Jennifer apportions some responsibility for her distress to the lack of information from medical staff, she avoids apportioning any responsibility for her distress to her son and how he could have shown better judgment by not talking to his mother, knowing the nature of his injuries, the effects of morphine on speech, and the propensity for his mother to sometimes worry unduly.

"Yes that's what I dealt with to begin with, what am I going to see, how am I going to deal with this how am I going to let him know that I still love him."

"……on the Saturday when we saw him in hospital and saw that he didn't have facial injuries or wounds well he did but they were cuts and grazes."

"It was because I couldn't understand him he was so high on morphine we later discovered that I couldn't understand him…I think the fact that they had said facial injuries and the fact that I had been so shocked by Jackie's phone call I very quickly added 2 and 2 together and came out with 62."

The following write up represents the progression of the stages of analysis in Jennifer's first interview, represented in the table above and how this later gave context to descriptions Jennifer gave about how she had dealt with previous stressful events in her life. This part of Jennifer's write up also demonstrates the 'part' and the 'whole' in that the sub-theme 'strategies for coping' when viewed within the remainder of Jennifer's narrative provided meaning to the cause of Jennifer's encounters with stress and the measures she took to mitigate its effect. Jennifer: Theme 1 'response to stress'.

In her first interview Jennifer is unwilling to talk explicitly about her strategies for coping, preferring instead to focus on the distress she experienced. In talking about her son's decision to elect for surgical amputation, Jennifer unknowingly provides insight into how her insecure relationship with Josh and her hyperactivating strategies for dealing with distress depleted her self-esteem in the role of mother to her family members. It is not until her second interview that Jennifer talks about the stressful events she has experienced earlier in her life and how she was prescribed anti-depressants to mitigate her levels of anxiety "I was diagnosed with cancer back in 1987 and my marriage fell apart" (Jennifer2: p. line) and the consequences on her physical and mental wellbeing "the way I handled it I became anorexic, my marriage fell apart, and I was given anti-depressants" (Jennifer2: p. line). Jennifer also experienced several concurrent stressful events and was prescribed anti-depressants again "The second time around was when, after Josh was injured, mum had died, dad had died, and I went to the GP because I wasn't coping too well" (jennifer2: p. line). Jennifer marks these events in time and a measure of the debilitating effect they have had on her wellbeing when she states "that was 2011, and then they did give me some anti-depressants about a year ago because I had cancer again and they said I needed it, so I took them for about 3 months and then I said I don't need this, I just need to talk to some-body" (Jennifer2: p. line). Line). In talking about her previous stressful events Jennifer provides a history and context to the catastrophic way in which she responded to learning of Josh's injuries and how attachment insecurity is associated with depressive symptomology (e.g., Bifulco et al., 2002; Roberts, Gotlib, and Kassel, 1996; Scharfe, 2007). Additionally, how according to (Mikulincer, Ein-Dor, Solomon and Shaver, 2015) persistent and pervasive trauma can heighten attachment insecurities, especially among individuals who entered a period of trauma with already existing attachment-related doubts and

insecurities " having had the previous 6 years at that sort of worry level, as one of the son's had said, mum if you didn't have something to worry about you would find something"(Jennifer1: p. line).

Although Jennifer is willing to disclose the level of stress she had experienced in the past, Jennifer is unable to articulate the way in which she appraises the characteristics of her stressful encounters or how she controls her levels of distress, other than the anti-depressants prescribed by her GP. The only indication Jennifer gives to her strategy for coping is when in her first interview she talks about how she telephoned her friend "once I'd put that logical thought into my head and I'd phoned my friend in a way it had put a spoke into the spinning out of control feeling and I'd taken control of myself" (Jennifer1: p. line), more commonly associated with calling upon social resources (Holahan, Moos and Shafer, 1996; Pierce, Sarason and Sarason, 1996).

Appendix 10: Table of family pseudonyms

Pseudonym	Family member
Jennifer	Mother
Josh	Son 1 (amputee)
Jeremy	Son 2
Jacob	Son 3
Joseph	Grandson
Julie	Grandaughter
Jack	Husband
Jackie	Daughter-in-law

Pseudonym	Family member
Sarah	Mother
Steven	Son
Sandra	Daughter
Shaun	Husband

Pseudonym	Participant
Felicity	Mother
Fredrick	Son (amputee)
Ferguson	Alex Son 2
Flynn	Tom Son 3
Floyd	John Husband
Francis	Merlin - Welfare officer

Pseudonym	Participant
Mary	Mother
Michael	Son 1 Simon (amputee)
Melvin	Son 2
Maurice	Husband
Margaret	Welfare officer
Melony	Marisa - Daughter-in-law
Pseudonym	Participant

Lance	Son
Leonard	Husband
Laura	Daughter
Linda	Work colleague 1
Lucy	Work colleague 2
Lorraine	Work colleague 3
Pseudonym	Family member
Patricia	Mother
Peter	Husband
Paul	Son 1 (amputee)
Patrick	Older brother (estranged)
Phillip	Son 2
Petula	Daughter 1
Patrice	Suicide friend
Paula	Attempted adoption