Northumbria Research Link

Citation: Watson, Paul Gareth (2022) Understanding the emotional response of being a young carer of a combat veteran with PTSD: a narrative inquiry. Doctoral thesis, Northumbria University.

Understanding the emotional response of being a young carer of a combat veteran with PTSD: A Narrative Inquiry

By

Paul Gareth Watson

Thesis submitted to the Faculty of Health and Life Science
Northumbria University in fulfilment of the requirements for the degree of Doctor of Philosophy
2022

Supervised By:
Professor Matthew Kiernan
Dr Sharon Vincent

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to Northumbria University's Ethics System in October 2017, and a second amendment was granted to include mothers in June 2018.

I declare that the Word Count of this Thesis is 85,936 words

Name: Paul Gareth Watson

Date: 20.05.2022

Acknowledgement

It is difficult for me to fully articulate my immense gratitude I have for all of those who have supported me throughout this PhD journey. It has really taken the efforts and continued support of many friends, peers, and my family.

To Professor Matthew Kiernan, I am truly grateful for the opportunity you have afforded me. You gave me an open door which I never knew I could walk through. You have provided continued support, guidance, and the opportunity to learn from you, to observe your research practice and to mentor me in my own research endeavours. These practical experiences have been more valuable to my learning and my application to research than any textbook. All I can say is I am thankful for these opportunities and the faith you put in me to be more than I thought I could be. I cannot fully express how you have changed my life, you continually inspire my application to support the military community.

To Dr Sharon Vincent. You came into my PhD halfway through and have been invaluable. You have been so patient, compassionate, and supportive. You have given me so much of your time when this was just too big for me, when I could not see the woods from the trees, you were there. I am grateful for all your suggestions, corrections, and the extended time you took to help me polish my writing. I have gained so much confidence from your guidance, enthusiasm and you being involved with my project with military young carers of veterans with PTSD. I admire your dedication to supporting children and young people and you have inspired me to be more for this population.

To the families, the young carers, and their mothers, you are the heartbeat of this study. I am eternally grateful that you trusted me to hear and retell your stories as young carers of veterans with PTSD. I am grateful for your continued service and sacrifice and admire your strength to carry on and ‘step up’. As a military child myself it has not gone unnoticed how much the military has been part of your life’s journey and helped shape the people you are today. Thank you.

To my many colleagues, with special thanks to Elaine, Maggie, Alison, and Gill. I thank you all for sharing your time, your shoulder, and an ear when I was struggling, when I was finding moments in time to catch my breath and when I knew what I was doing. Many of you have

been here for me from the start and have seen my many faces. You have stood fast and provided a secure base for me to grow. I am grateful for your encouragement and examples as you all work to balance your own personal and professional lives. Thank you. I could not have achieved this without you.

To my family, you know what we have been through, but you have always given me the strength to move forward. Auntie Pauline, you have always protected me and loved me, and for that I am truly grateful. To Ellie, thank you for being a guiding star, and giving me those encouraging words when I desperately needed them. To my brother Craig, thank you. I know there are times where we do not speak for months and are on a different path, but I know you are there for me. Knowing I have you in my corner whenever I need you is more than I have ever given you. I am grateful and I love you.

To my nan and grandad. You are no longer here, but you have always been here. Not a day goes by without me thinking of you both. When the chips are down, the picture on my desk keeps me going and makes me smile. I love you.

To my parents, I can never repay you for all the support you have afforded me. Not just throughout the PhD process but throughout my whole life. Mum, you have always been there for me, always had my back when we collectively went through hell. We have lived this study together and have come out the other side. Your love and support never wavered, I was always put first above all else, and at times above you. I know that will always be the case. I love you so much. To Cindy and Bernard, it is hard to put into words what you have enabled me to do by giving me one opportunity. You gave me the opportunity to go to university, this was a door a never thought I could open for a young lad, born in a council estate who left school with no qualifications. You believed in me. Your belief was unwavering, so much so, you paid our mortgage whilst I studied for my BSc, something I had doubts to even undertake. You supported us with childcare, with words of encouragement and most importantly with love. I took all my opportunities knowing you were there walking beside me, to pick me up and to carry me forward. I love you.

To my children, Joseph, and Izzy. You are my world. You gave me space when I needed it, gave me hugs when I needed them and continued to tell me to hurry up and write. You have taught me the importance of being a good dad, setting an example, and to be honest with my feelings. Because of you, I have pushed myself to be more than I thought I could be, in the hope you both do the same – be the people you never thought you could be. I love you.

To Charlotte, my favourite person. You have been everything and more. You have stepped in when I have needed to step out, you have stepped up, when I have needed to step down. You have encouraged me, cried with me, and shared the laughs with me. This journey has been our journey and I could not have even contemplated stepping on to this path if I didn’t have you beside me. I love you.

Abstract

Title: Understanding the emotional response of being a young carer of a combat veteran with PTSD: A Narrative Inquiry

Due to extended military commitments and deployments to Iraq and Afghanistan over the last 20 years, the ferocity of combat has led to some serving members of the military returning home with physical and mental health issues including Post Traumatic Stress Disorder (PTSD). Many of these individuals are parents and their PTSD diagnosis is likely to have a significant impact on their children. Much of the research which has been undertaken in relation to military families points to a lack of supportive structures post combat operations and highlights poor family integration and functioning leaving many children within the military community at risk of presenting with behavioural, emotional and mental health issues.

Young carers are a group of children and young people who provide a vital role within their families and their communities by providing unpaid care to a family member over prolonged periods of time. It is not known how many children and young people within the military community undertake caring responsibilities and to date no studies have explored the emotional impact of being a young carer to a veteran parent with PTSD or investigated the impact that providing care has on child/parent relationships.

This study sought to identify the lived experience of young carers of veterans with combat related PTSD by investigating their own perspectives as well as the perspectives of their mothers. Narrative inquiry was used to capture the narratives of the young carers in order to understand the emotional impact that caring had on them and how it impacted on their relationship with the parent with PTSD. The narratives of the young carers’ mothers were also captured. This enabled the researcher to produce stories of how young carers who were caring for a veteran parent with PTSD were able to renegotiate family life and family relationships and manage their emotions post diagnosis.

The theoretical lens of this study is situated in Symbolic Interactionism (Bulmer, 1969), an ontological assumption based on the belief that reality is ‘socially constructed’, and an emic epistemological foundation built on subjective lived experience. The study investigated how

the young carers orientated their thoughts, feelings and emotions based on their activities of daily living and their interactions with their families, friends, and their community, whilst providing care for a veteran parent with combat related PTSD.

Interviews were used to capture and explore the participants’ narratives. Using Narrative Inquiry as a qualitative method and subsequently inquiring into the meaning of the narratives furthered understanding of family relationships and roles undertaken within the family environment. It also furthered understanding of what it is like to care for a parent with PTSD by capturing the emotional costs for the child by considering their lives pre-PTSD presentation as well as post-PTSD diagnosis.

Qualitative interviews with 4 young carers from 3 families and their mothers were used to address the aims of the study. The young carers, two girls and two boys who were aged between 12 and 16 years of age were all providing care to a veteran father or stepfather, but they did not necessarily identify as ‘young carers’.

The findings of this study suggest there may be common experiences amongst young carers who care for a veteran with PTSD. All of the participants’ emotional health was adversely affected by being a young carer to a father/stepfather with a PTSD diagnosis as was their social connectedness and the functionality of their family. However, whilst the young carers within this study all shared similar experiences in terms of providing care for a father with a diagnosis of PTSD due to military combat exposure, each family, and each young carers’ experience was unique.

The findings suggest there is a need for policy makers and service providers to devise a universal definition of ‘what’ a young carer is in order to aid identification of young carers in military families. There is also a need to provide specific service provision for young carers from the military community so we can better meet their unique needs. This should be co-constructed with young carers themselves and their views should inform future policy developments. The findings suggest those who provide support to young carers and their families may also benefit from military awareness training.

Table of Contents

1 Chapter 1: Introduction

Research exploring young carers globally has advanced the understanding of care being provided to parents and significant others by children and young people (Aldridge and Becker 1993, Becker and Becker 2008). Young carers balance a number of different roles (including physical, psychological, practical, financial and emotional support) whilst also attending school and living a childhood.

As children and young people navigate what it means to be a young carer and understand what this role entails, the need for research to focus on young carers' emotional health and well-being has come to the forefront. Joseph, Sempik et al., (2019) suggest there is a need to understand and address the practical approach to supporting young carers' emotional health and well-being through policy. Moreover, they justify this statement by indicating that approximately 2-8% of children and young people are carers and stating that their caring role has an impact on their education, health, well-being, social opportunities, and employment prospects. It is, therefore, important to understand as young carers' roles develop, how this role affects their long-term health outcomes. There is a plethora of research which has explored the circumstances of caring and its effects. This research has concluded that some young carers experience poor emotional health (Becker 2000, Cree 2003, McAndrew, Warne et al., 2012, Robison, Egan et al., 2017) and feelings of isolation and loneliness (Dearden and Becker 2005, Stamatopoulos 2018, Siva 2020).

Another notable group of children and young people are those who are from military families. The influence of military conflict both in Iraq and Afghanistan has seen British Armed Forces at war for over 20 years. The extreme length of combat operations has led to a growth in both governmental and public support for the 'troops on the ground'. Initially, there was a distinctive escalation in government and private funding specifically to address the needs of military personnel and their families, through both long-standing organisations including the Royal British Legion and newly formed charities including Help 4 Heroes and Combat Stress (Gribble, Wessley et al., 2015). Importantly there have also been some key policy changes within the United Kingdom (UK), namely the Armed Forces Covenant to support the men and women returning from combat with both physical and psychological injuries and their reintegration back into the civilian population. Whilst there has been some American based research on the emotional effects war has on children and young people (Cozza, Chun et al., 2005, Lincoln, Swift et al., 2008, Swedean, Gonzales et al., 2013), there has been no research on the emotional effects conflict has on young carers of veterans with a medical diagnosis of combat related PTSD.

Military academics from around the globe and more recently the UK have begun to explore in greater detail the impact combative operations have on military personnel and the potential effects they may experience when returning home. There is a wealth of research which looks at the effects combat has on health. This research covers conditions such as post-traumatic stress disorder (***PTSD)*** (Jones & Wessely, 2005, Sundin et al., 2010), traumatic brain injuries (***TBI),*** pre-deployment stress (Sharpley 2008), poor mental health (Forbes et al., 2011; Preez, et al., 2012; MacManus, et al., 2014) re-integration and the military family (***spouse/partner)*** (Buchanan, Kemppainen et al., 2011, Yambo, Johnson et al., 2016). This suggests that there is a great deal of effort going on to acquire a greater knowledge to develop an evidence base to inform understanding of the effects combat has on military personnel and their families.

A small but developing body of research regarding children and young people from military families suggests children and young people also suffer the psychological effects of parental/sibling deployment (Huebner, et al., 2007; Bradshaw, et al., 2010; Werner, 2012; Cederbaum, et al., 2013). Additionally, there is evidence to suggest children and young people present with a change in behaviour, both internally (Chartrand, et al., 2008; Lester, et al., 2012) and externally, suggesting the need for continual positive family support and social connectivity (Iversen, Fear et al., 2007, Mmari, Bradshaw et al., 2010, O'Neil 2013). Moreover, the Iversen, Fear et al (2007) study presents an insight into the personal struggles many children and young people face in terms of reintegration and mental health when a parent or sibling returns. Harvey, et al., (2011) support many of Iversen et al’s (2007) findings regarding how the deployment cycle affects the family (McFarlane 2009, Mansfield, Kaufman et al., 2011, Bello-Utu and DeSocio 2015, Meadows, Tanielian et al., 2017). Importantly, both Flittner O'Grady, Whiteman et al., (2018) and DeVoe, Ross et al., (2020) argue that poor family integration and lack of supportive structures puts many children at risk of presenting with secondary emotional and mental health issues.

1.1 The Rationale of the study

A reported national increase of poor mental health in children and young people (Baker, 2020) means it is vital to understand the emotional aspects being a young carer of a veteran with PTSD has.

Deployment, reunification and transitioning out of the military due to poor mental health are major events that can become stressors for the family unit; often reunification is reported to be the most difficult process to navigate within the home environment (Meadows, Tanielian et al., 2017; Flittner O'Grady, Whiteman et al., 2018). Transitioning from the military can be a stressful event for some military families (Ray and Heaslip 2011; Verey and Smith 2012; Hatch, Harvey et al., 2013; McGill, Wilson et al., 2020; Smith-MacDonald, Raffin-Bouchal et al., 2020) depending on the family's needs and preparation for leaving the forces.

The focus of this research is to understand the lived experience of young carers of veterans with mental health issues. Importantly, there is a large body of research on the effects military life has on children and young people (Cozza, Chun et al., 2005; Chandra, Burns et al., 2008; Cozza and Lerner 2013; Easterbrooks, Ginsburg et al., 2013; Bello-Utu and DeSocio 2015). Moreover, there is a growing amount of research focusing on how combat related PTSD impacts on children and young people from military and veteran families (Banneyer, Koenig et al., 2017; Creech and Misca 2017; Foran, Eckford et al., 2017; Parsons, Knopp et al., 2018; Huebner 2019; Sullivan, Cozza et al., 2019; Watson and Osborne 2020). However, what is apparent within the United Kingdom (UK) is that research undertaken by military academics has tended to focus on examining the detrimental effects of war and failed to explore, in any depth, the effects a combat veteran's PTSD has on their children. Moreover, the very real and emerging roles of family members who become caregivers to a spouse (Murphy, Palmer et al., 2017, Finnegan, Di Lemma et al., 2021) or parent (Watson 2016) requires additional research within the UK. As outlined above, there is ample evidence to demonstrate the long-term effects caring has on children and young people's health and well-being and academic attainment (Dearden and Becker 2003; Robison, Egan et al., 2017; Warren and Edwards 2017). However, acknowledging the military *'can do attitude'*, that is, that military families carry on regardless of their experiences (Braun-Lewensohn and Bar 2017) researchers are yet to establish if children within veteran homes identify themselves as care providers, neither do we yet know how caring affects young people's emotional responses or what impact it has on their daily life. Without such understanding of this unique population, it can be argued we are creating the potential for ill-informed policies and wasted service provision. Importantly, the previous mentioned research negates any focus on children and young people who are providing a caring role for a parent with PTSD and its effects on their emotional health.

The study had two main aims:

- To explore the impact that parental Post Traumatic Stress Disorder, which is associated with combat, has on children within the home environment.
- To explore the impact on parental and child relationships when a child assumes the role of ‘young carer’ for the parent with combat attributable Post Traumatic Stress Disorder.

1.2 Outline of the thesis

1.2.1 Chapter 2: A review of the literature

Chapter 2 seeks to understand the emotional response that caring for a veteran parent with PTSD has on the child and what impact this has on child/parent relationships. It starts with a discussion of the various ways in which young carers are defined in legislation and policy. It then reviews the literature regarding young carers, focusing specifically on children and young people who become carers for a parent or close relative who suffers from a mental health illness, including Post Traumatic Stress Disorder (PTSD), in order to understand how children and young people cope emotionally with caring for a parent or close relative with PTSD. The chapter then navigates through appropriate literature to identify what is already known about children and young people from the military community, including veterans.

1.2.2 Chapter 3: Methodology

Chapter 3 presents the research design which was used to answer the research questions in this study. It starts by clarifying the aims and purpose of the study. It then moves on to provide a deeper understanding of the ontological and epistemological theoretical framework of the study, which is underpinned by the theoretical framework of Symbolic Interactionism (Bulmer, 1969), an ontological assumption based on the belief that reality is ‘socially constructed’, and an emic epistemological foundation built on subjective lived experience. This enabled me to understand the lived experience of young carers of veterans with PTSD. The methods of data collection and the process of narrative inquiry analysis are also explored and the ethical implications of involving children and young people in research are discussed.

1.2.3 Chapter 4: Constructing an Interpretive Story ‘within family’

Chapter 4 seeks to understand the emotional response that caring for a veteran parent with PTSD had on each child in the study and what impact it had on relationships. The Chapter explains how the data was analysed through multiple lenses (language, context, moments, and symbolic interactionism) which enabled the construction of interpretive stories for each case family. Six interpretive stories relating to the three case families included in this study are presented in Chapter 4.

1.2.4 Chapter 5: Cross-Case Findings ‘between Families’

While Chapter 4 presents individual case findings, Chapter 5 builds on chapter 4 by outlining cross-case findings. While it was important to present each family’s story it is also important to consider cross-case themes. After producing the six interpretive stories I therefore analysed the entire data set as a whole to enable me to search for consistent/conflicting themes across families/cases. This process allowed the stories and the experiences of each military connected family to be shared as a collective, allowing me to represent multiple voices. The chapter explores the key themes of presentation of PTSD within the home, relationships, Young Carer identity and the effects of caring for a parent with PTSD.

1.2.5 Chapter 6: Discussion

Chapter 6 is the discussion chapter. It explores the meaning of the findings outlined in chapters 4 and 5 by applying the theoretical concept of symbolic interaction. This chapter ends by considers the implications of the findings by proposing a number of recommendations which are designed to support the emotional and relational needs of young carers of veterans with PTSD and their families.

1.2.6 Chapter 7: Final Thoughts and Conclusions

In Chapter 7 I provide my final thoughts and offer an overall conclusion to this study. I start by offering my reflections and a critical appraisal of the chosen research design. I then move on to discuss the limitations of this study before considering the contribution to knowledge this study has afforded. Finally, I will present the implications, where I identify the need to recognise the impact caring has on children and young people within the military and veteran community; the need to improve recognition and identification of young carers within the military community and to develop dedicated service provision for this population of young carers.

2 Chapter 2: A Review of the literature

2.1 Introduction

The overall aim of the literature review was to understand the emotional response that caring for a veteran with PTSD has on the parent – child dyad and their interactions. The chapter begins by critiquing the various definitions of a young carer which are rooted in legislation and policy. It then moves on to review the broad spectrum of young carer's literature, with a specific focus on young carers caring for parents with mental health illness, including PTSD, before moving on to review what we already know about the children of military veterans and importantly, to highlight any gaps in knowledge in relation to this potentially ever-growing population of young carers.

2.1.1 Definition of a Young Carer

Most children and young people will undertake chores within the family home, such as domestic tasks, household management and looking after younger siblings (Becker, 2007). However, the presence of severe physical or mental health illness in the family, specifically the parent, often increases the nature of caring activities children and young people undertake (Stamatopoulos, 2015; Kavanaugh, Stamatopoulos et al., 2016).

More than 25 years ago two academics Aldridge and Becker (1993) introduced the concept of 'young carer' by identifying the role some children and young people under the age of 18 years assume when they provide care to family members. The term 'young carer', which is now globally utilised within academia and national policy, is widely attached to children or young people under the age of 18, who provide care for a member of their family who have an illness or a disability. However, there is a strong argument for young people to be considered young carers up to the age of 25 years of age (Stamatopoulos, 2015). Importantly, this upper age bracket is recognised in the UK within social policy and practice. However, those carers within the age range of 18 years to 24 years are classed as 'young adult' carers (Becker and Becker, 2008). There are often slight differences in classification depending on the organisation which works with young carers. They have different definitions of what a young carer is and what their remit of support is. Aldridge (2018) noted that the ‘under 18’ distinction is important, due to the recognition of child status within the context of legislation, namely the Children Act (2004), thus making it clear where the duty of care and responsibility lies with regards to identifying, recognising and supporting ‘young carers’.

The definition of a young carer needs to incorporate key dimensions of young caring that are important in academic discourse and in health and social care policy and practice. Despite the recent increase and interest in young carers over the last 25 years, and the pertaining issues surrounding the role of providing care, there remains a lack of consistency from governmental stakeholders and researchers in defining what a young carer is.

2.1.2 Legislative definitions

The Children Act (1989) postulates that children are best cared for within their own families and that external intervention should occur only, if necessary, to safeguard the child. The Act emphasises ‘parental responsibility’, and the combination of rights, powers and responsibilities parents have. Moreover, the Act highlights the ‘welfare principle’ making the child’s welfare paramount.

Section 17 of the Children Act (1989) states local authorities have a duty to ‘safeguard and promote the welfare of children within their locality who are in need and promote the upbringing of such children by their families’. The Act defines a child as being in need if the following criteria are met:

- Is likely to achieve or maintain or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for the child by services provided by their local authority;
- The child’s health or development is likely to be significantly impaired, or further impaired, without the intervention of services from the local authority;
- The child is disabled.

Importantly, the Act negates from specifying what constitutes a ‘reasonable’ standard of health or development. As Dearden & Becker, (2005) stress, there is some debate as to whether a young carer should be considered as a child in need of services and as a child who may not have (due to caring responsibilities) an equal opportunity of achieving a reasonable standard of health in relation to their non-caring peers.

Young carers have the potential to be assessed as children under the Children Act (1989) if they meet the criteria of their local authority. However, as Becker (2002) alludes, their needs as ‘young carers’ may be overlooked, referring to family members who have care needs, who are assessed under the NHS and Community Care Act (1990), and the child who is providing care not being identified and supported. As a consequence of the potential of young carers being ‘missed’ within the system. The Carers Act (Act 1995) closed some of the loopholes facing young carers regarding assessment, as it encompasses all carers, regardless of age. This legislative act paved the way for children and young people providing care to be assessed as carers.

The Carers Act (1995) is concerned with all carers who are providing, or intend to provide, a substantial amount of care on a regular basis, therefore entitling them to an assessment of their specific needs, when the person they are providing care for is assessed or re-assessed. One of the major benefits of the Carers Act (1995) is that it gives formal recognition to a specific group of children and young people who are providing care and specifies that an assessment of their individual needs is required as care providers. Furthermore, the Act enables a wider definition of a young carer, thus not limiting accessibility for an assessment. Whilst this demonstrates a breakthrough within legislation, the terms within the document do not clarify or define ‘a substantial amount of care on a regular basis’, which by default, has the potential to mitigate some young carers who provide intermittent care provision for a family member.

When supporting young carers, the Department of Health’s (DH 1996c) *practice guide* offers clarification around the definition of a young carer. It acknowledges that some children may not be providing a substantial amount of care, therefore a young carer should not be defined by how regularly they provide care. The guidelines state: ‘*there may be some young carers who* *do not provide substantial and regular care, but their development is impaired as a result of their caring responsibilities*" (DH, 1996c, p.11). Therefore, young carers identified under this piece of legislation should be supported via local authorities under section 17 of the Children Act 1989, i.e., they will be identified as children in need. Moreover, this will also be the case for those children and young people who do not provide substantial amounts of care on a regular basis, but who are considered to be in need of services, which will promote their overall health and development.

Importantly, young carers who provide a substantial amount of care and those who care intermittently, but whose care is impaired as a result of providing care, can both be defined as children in need and can be supported by the Children Act 1989, even in the absence of the Carers Act. However, children over the age of 16 years are also entitled to a Carers Assessment from children's services under the Carers and Disabilities Act (Great Britain 2000).

The Care Act (2014) places a duty on local authorities to identify young carers within their locality. Moreover, both the Care Act and the Children and Families Act, (2014) (which amended the Children Act 1989) make specific reference to young carers regarding the importance of assessment, their transitional support (from children's services to adult service's) and their wider needs.

The Care Act (2014) includes a section on assessment of young carers and refers to the Children Act (1989), which also provides a broad definition that a

> *'young carer' means a person under 18 who provides or intends to provide care for another person.' (1989, p.96)*

The Children and Family Act (2014), which requires local authorities to actively identify young carers and assess their needs, defines a young carer as

> *'a person under 18 who provides or intends to provide practical or emotional support to another person.' (2014, p.63)*

Both definitions mentioned above raise ambiguities, as they do not clarify the meaning or nature of 'care'. The Children and Families Act (2014) also employs language such as 'intends to' which is difficult to determine as there is no clarification of when in the child's lifetime, they may become a young carer. The above definitions at best are very general in terms of the language and structure used. Becker (2005) explains that the simplicity of the definitions offered within legislation, contribute to the difficulties faced by professionals when identifying and referring young carers, as the identification and referral process could be considered to be reliant on subjective opinion and judgements.

2.1.3 Practice definitions

The Children's Society, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Children's Services (ADCS) in their memorandum of understanding state that:

> *'The term young carer should be taken to include children and young people under 18 who provide regular or ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances…A young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child risking impacting on his or her emotional or physical well-being or educational achievement and life chances.' (2012, p.4)*

The definition provided by ADASS, ADCS and the Children's Society offers inclusive criteria with regards to specifics, for example, substance misuse and disability. Additionally, the above definition incorporates the extent and the duration of care provision and refers to the impact caring has on children; however, it does not define what is meant by 'vulnerable', 'excessive' or 'inappropriate'.

In professional guidance on assessing the needs of young carers, Dearden & Becker, (2005) refer to young carers as,

> *'Children and young people, under the age of 18, who provide care or support to a relative in the home. That relative is usually a parent but may be a sibling, grand parent or other family member.'(p.252)*

The guidance goes on to explain in greater depth the context of caring and the appropriate and necessary assessment procedures required to identify children and young people as carers.

2.1.4 Understanding the complexity of a definitive definition

Becker (2000) has described young carers as:

> *'Children and young persons under 18 who provide or intend to provide care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility that would usually be associated with an adult. The person receiving care often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with the need for care, support or supervision'. (p.387)*

Whilst the definition offered by Becker provides an age limit of a young carer, along with detailed descriptions of the tasks undertaken by a young carer, the definition has a hint of a statement of role, for the young carer. As a pattern of ambiguous descriptions begins to emerge, it could be argued that the definitions are moving away from being a succinct and simplistic term, to becoming definitions based on the number of 'tasks' a young carer is undertaking, as in the examples provided above. However, a very pertinent point is raised within Becker's definition which explicitly notes a young carer carries out, on a regular basis, substantial caring tasks usually associated with that of a responsible adult.

The UK is not the only country that identifies that children and young people may have responsibilities for caring. As we can see from the definition provided by Becker (2000), international definitions are becoming extended, based predominantly on the nature of the child or young person's caring responsibilities. For example, Diaz, Siskowski et al., (2007) identified young carers as:

> *'Children and adolescents who are 18 years of age and younger and who provide significant or substantial assistance, often on a regular basis, to relatives or household members who need help because of physical or mental illness, disability, frailty associated with aging, substance misuse, or other condition. This assistance may include one or more of the following: personal care, medical care, household management, supervision, translation in medical settings, and emotional support. Young caregivers may provide care directly to the recipient or indirectly by taking over the care recipient's responsibilities, such as parenting younger children. They perform tasks that go beyond chores and require a level of responsibility more appropriate for an adult'. (p.133)*

Due to the number of variants within the definition of what a young carer is, for the purpose of this research I will define a young carer as a child or young person, under the age of 18 years, who provides a form of care to a relative who has a condition such as a disability, illness, mental health condition, or a drug or alcohol problem. Specifically for this research their relative must hold veteran status and have a mental health condition.

2.1.5 Parentification

Throughout the world there are discourses regarding young carers who potentially become parentified. In Europe young carers are seen as needing support in coping with extraordinary family responsibilities (Charles, Stainton et al., 2009). However, in North America, if they are acknowledged at all, young carers tend to be referred to negatively with labels such as 'parentified children'; because they provide caring responsibilities to a family member, they are seen to take on the role of a parent (Charles, Stainton et al., 2009). The 'parentified child' as coined by Montalvo, Guerney et al., (1967) is a concept which refers to children who are expected to carry out the role of a parent within the dynamic of the child or young person's family, often acting as a parent to siblings or their parents (Earley and Cushway 2002). As Becker, (2000) argues, by labelling children and young people who provide care to a close family member, under the term 'parentification', we are at risk of pathologising young people's holistic situations and potentially putting them at risk of being removed from their home due to potential safeguarding concerns or concerns about the impact of the amount of care they provide on their health and well-being; alternatively they may be assessed as needing therapy. In essence this is medicalising the role of caring and subjecting the young carer to a multitude of tests, which may have a detrimental effect on their development and safety, if they are deemed at risk due to the potential amount of care they provide.

Much of the parentification literature is borne out of psychology and provides additional evidence of the social and emotional impacts that performing caring roles may have on a child or young person (Montalvo, Guerney et al., 1967). A vast array of literature regarding parentification suggests this can occur in families who present with or experience substance abuse, sexual abuse, marital conflict, and divorce (Barnett and Parker 1998). However, parentification as a concept evolved through the works of Nagy and Spark (1973), who illustrated how all relationships, including positive healthy relationships, contain certain components of caregiving which are underlined by continual patterns of relating that only become problematic once there is a presentation of excessive burden to the child or young person. Critically, as Stamatopoulos (2018) eloquently discussed, the possibilities of parentification (like caring) may have either positive, negative, a combination of positive and negative, or no effects at all to the child or young person's base or the child's position on a care continuum from normal to maximum, based on the child's own age related emotional and physical abilities.

2.1.6 Estimating the prevalence of Young Carers

Children and young people who have a high level of caring responsibilities have been identified globally across a number of European countries, the United States, Canada, Australia, New Zealand and the Middle East (Leu and Becker 2017). As Becker and Beker (2008) highlight one of the first sources of information on the prevalence of young carers within the UK was the UK Census in 2001 which estimated that approximately 2 percent of children and young people between the ages of 5 and 17 had a caring role. Estimates on the prevalence of young carers varies from between 2 and 8% of all children and young people under the age of 18 years in advanced societies providing some form of care, dependent on the methods utilised in identification and the rigour of data collection (Leu, Frech et al., 2019). To date the exact number of young carers in the UK is largely unknown. However, the most recent Census (2011) by the Office of National Statistics (2021) identified 177,918 young carers aged 5-17 in England.

A British Broadcasting Cooperation (BBC) survey of school children claimed there were ‘about 700,000’ young carers in the UK (Howard 2010). However, the methodology used by the BBC was criticised by Aldridge (2018), who stated that the survey was based on studies which were flawed or used incompatible instruments. The BBC’s estimates were based on one in 12 young carers identified from 4,029 school children who took part in the survey. The findings were based on a questionnaire which was sent to only 10 schools across the UK. One of the major flaws of the study was that the survey did not attempt to screen any of the young people to identify caring roles. Furthermore, the questionnaire assumed a level of understanding by the children and young people that they could differentiate between caring *about* and caring *for* a family member (Joseph, Sempik et al., 2019).

Aldridge (2018) critically appraised the methods by which data on young carers are collected. She notes that a problem with prevalence data on young carers is the lack of clarity in ascertaining whether the child or young person is providing care or not, thus she suggests that those collecting data should also measure the qualitative narratives of the children and young people who are providing care along with the narratives of their parents to support the quantitative data. Clay, Connors et al., (2017) support the above statement, explaining that parents and children will often have different perspectives and experiences on what care provision is within the family home, depending on the illness or disability. Importantly, some parents may not describe their children as ‘carers’. Moreover, both the child and the parent may even reject the carer identity entirely, which will make the recording of young carer status difficult.

Aldridge’s statement underpins the importance of undertaking this research as it would add the voice and perspectives of young carers and their parent to a growing knowledge base, and importantly fill a gap in knowledge by adding the voice of young carers and mothers of the military veteran community.

2.1.7 The Role of a Young Carer

A multitude of studies have identified the wide range of caring roles and additional responsibilities children and young people undertake as young carers (Aldridge and Becker 1993; Newman 2002; Becker 2005; Dearden and Becker 2005; Kavanaugh, Stamatopoulos et al., 2016; Aldridge 2018). The abundance of research regarding the role of young carers identifies that caring roles vary from practical help around the family home or close family homes (if a relative lives close by), undertaking personal or nursing type care, emotional and psychological support, and financial support, for example, budgeting (Clay, Connors et al., 2017).

A plethora of evidence identifies there are multiple complexities as to why children and young people provide care, which are often related to the notable absence of formal care provisions, a lack of available networks and social isolation (Dearden and Becker 2005; Gray, Robinson et al., 2008). Importantly, Joseph et al (2019) suggest children and young people provide care through the love of the family member and not because it is a role given to them. Importantly Becker (2007) highlights the importance of differentiating between *caring about* a family member and *caring for* a family member. Caring about a family member reflects the role of carrying out daily chores in accordance with the child or young person's age, for example, making sure their room is clean, or the washing up is done after an evening meal. The notion of caring for a family member highlights children and young people going above and beyond what is expected of them, based on their age. Young carers tend to provide an increased level of care by spending more time carrying out domestic chores and taking on intimate care provisions. Therefore, their position continually changes from 'caring about' to caring for'. Research demonstrates that by caring for a family member, there is an increased burden on the young carer (Clay, Connors et al., 2017), and increased commitment to the family member along with greater responsibility, due to the time taken up by caring (Aldridge 2006).

2.1.8 Health Outcomes for Young Carers

According to a growing body of research, most young carers who care for a parent with an illness and/or a disability are more at risk of mental health issues which persist into adulthood (Fraser and Pakenham 2009; Chikhradze, Knecht et al., 2017; Chen and Panebianco 2020). Importantly, research from a number of academics has highlighted that having a parent with a chronic illness is associated with a significantly higher risk of internalising behaviours (for example, depression, anxiety and somatic symptoms) and externalising problems (for example, aggressive and delinquent behaviours) (Fraser and Pakenham 2009; Chen and Panebianco 2020; Landi, Boccolini et al., 2020). Young carers also report lower life satisfaction and poorer quality of life and often express feelings of guilt, shame, and loneliness (Chikhradze, Knecht et al., 2017). Of note, compared to their peers, young carers of parents with chronic illness have also been found to be at risk of stress related disorders, affective dysregulation and weakened immune response systems (Morley and Jenkinson 2016; Chikhradze, Knecht et al., 2017). Kallander, Weimand et al., (2018) found that 10% of the 246 young carers who participated in their study reported feelings of intense sadness and frequently thought their lives were not worth living. To meet the aims of this study and to understand the emotional aspects of being a young carer the following section provides a detailed review of the emotional aspects of being a young carer of a parent with a mental health illness.

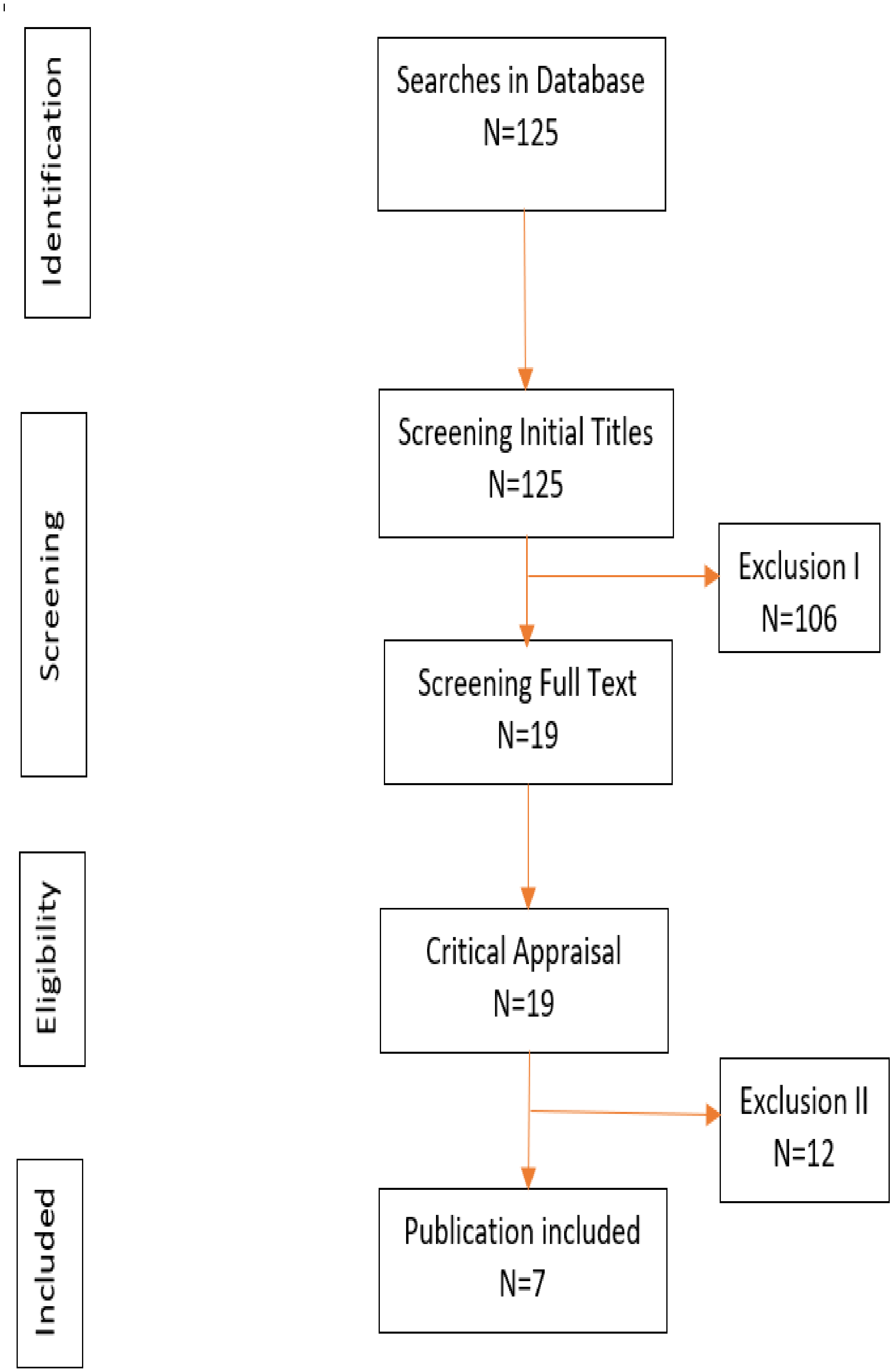
To summarise, the key characteristics of a young carer as identified within this section of the literature review are children or young people who:

- Are under 18.
- Provide some form of unpaid care – physical, emotional, psychological, financial or practical - to a parent or sibling for a non-specific amount of time.
- Undertake the role with little or no knowledge they are caring for a family member.
- May experience economic and educational disadvantage.
- Potentially experience poor emotional and physical health.

2.2 Understanding the emotional health of Young Carers

A Children's Society (2013) report notes 'young carers are more than one and a half times more likely than their peers to have special educational needs or a disability'. Whilst caring and the responsibility of caring can have benefits including building self-esteem and self-compassion the nature and intensity of caring can also have a detrimental effect on the young person (Leu, Frech et al., 2019; Berardini, Chalmers et al., 2021). This has been coined by Stamatopoulos (2018) as the 'young carer penalty' (p.191). The carer penalty focuses on the detrimental effect caring has on the young person; that is their emotional health and well-being, reduced social activity, poor educational attainment, and overall life chances (McDougall, O'Connor et al., 2018; McGibbon, Spratt et al., 2019). Therefore, this section will scope the qualitative literature and discourse surrounding young carers within families who have a mental health issue to allow further understanding of their lived experience.

The PRISMA guidelines (Arya, Kaji et al., 2021) were followed to search two databases (CINHAL full text and PsychArticles). The search covered 2017-2022 using the terms ‘Young Carer’ and ‘Qualitative’. Boolean operations and truncations were used to allow for alternative endings in key words. The search was limited to the past five years in order to focus on the most current literature within the field of young carer research. It was limited to qualitative research studies only as it aimed to further understanding of young carers’ lived experience to enable the aims of this study to be met. The initial search yielded one hundred and twenty-five articles.


Identification
Screening
Eligibility
Included
Searches in Database N=125
Screening Initial Titles N=125
Exclusion I N=106
Screening Full Text N=19
Critical Appraisal N=19
Exclusion II N=12
Publication included N=7

Studies were included if they met the following criteria: (1) had a qualitative or mixed method; (2) were written in English; (3) participants were below the age of 18 years; (4) explored 'lived' experience of care provision; (5) the participant was caring for at least one parent; (6) were published in peer reviewed journals; and (7) included the emotional aspects of being a young carer. Studies were excluded if (1) They were quantitative, (2) they were exclusively from the perspective of a parent or health or social care profession; (3) exclusively used retrospective accounts; (4) were not empirical studies.

After the inclusion and exclusion criteria were applied, seven papers remained which investigated the emotional and mental health of children and young people who provide care to a parent with chronic illnesses, including a mental health illness (Appendix 9).

2.2.1 Perspective of Young Carers living with parental mental health illness

McGibbon, Spratt et al., (2019) noted within their study of 22 young carers that caring for a parent with mental health issues had a huge impact on the emotional health of the young carer. 16 of the 22 young carers who took part in the study confirmed they were living with varying degrees of parental mental illness. Of note, the participants recalled being more intuitive to parental outbursts with regards to identifying behaviours, body language, and a change in atmosphere within the family home. In anticipation of their parents' behaviour, the participants explained they either retreated to their bedrooms, went out of the home for a walk or to see friends. It became apparent within the study that the fluctuating capacity of the parent affected the reciprocal support to their children, especially when the young carer required support for their emotional health. Several young carers noted how they found they could not share their feelings, emotions or struggles with their parent, at the risk of the parent also breaking down. However, the young carers within the study explained they knew that some of their parents had childhood trauma which attributed to their current mental health issues, demonstrating compassion and empathy to their parents' current presentation, similar to the young carers in the Berardini, Chalmers et al., (2021) study. The McGibbon, Spratt et al., (2019) study noted that the nature of caring relationships is complex, with the psychological impact appearing to be the most challenging aspect of a young carer's role. The participants within this study who provided care for a parent with mental health illness, whether subjected to unpredictable behaviour or parental withdrawal, had little to no emotional support and a tenuous attachment to their parents' psychological needs.

Järkestig-Berggren, Bergman et al's. (2019) mixed methods Swedish study measured sociodemographic factors, for example, age, gender and living arrangements. Moreover, the study appraised the context of caring activities, the psychological well-being of the children and the views and descriptions of caring by the child. The authors noted that children who had taken on the most caring activities were either the eldest child or an only child. Moreover, all participants expressed their lives were unpredictable due to living with a parent who misused alcohol or experienced mental health issues. It is clear within this study that a supervision role was undertaken by the participants, as their parent was unable to care for themselves. The participants had varying perceptions towards caring. They were more positive regarding domestic chores, financial support, doing tasks together with a parent, taking a break, recognition and appreciation. On the contrary, they felt more negative about providing emotional care, a high level of responsibility, being taken for granted and conflicts within the family home due to caring. The Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) was used to measure psychological well-being within this study and participants recorded values above the clinical cut off for total difficulties score, emotional symptoms, hyperactivity and peer problems. Whilst the study does offer a comparison to non-carers within Sweden using a population-based sample by Göran Svedin and Priebe (2008) it acknowledges the comparison is not completely comparable, but there is some indication that the participants within their study perceived more mental health symptoms, and thus had a lower degree of psychological well-being.

Gowen, Sarojini Hart et al's (2021) qualitative pilot study measured the five caring responsibilities identified by the Care Act (2014). The study highlighted seven caring activities were being carried out by young carers, and young carers normalised these activities. Whilst the findings demonstrated that participants were undertaking what the Care Act (2014) regards as 'identified' caring responsibilities: personal care, physical care, emotional support, financial and practical support, the study also identified two additional responsibilities, 'global parenting' which referred to significant parenting responsibilities; and 'global self-care', referring to the responsibility the participants undertook to manage their own health and well-being, along with self-management of emotions and mental distress. The authors used 'global' to refer to the scale and scope of responsibilities. They noted participants provided a caring role for much of the day and in some cases overnight as well. The young carers within this study found night-time particularly difficult, they were constantly worrying, checking in on and making sure the person they cared for was safe and secure. This had a huge impact on their sleep and overall well-being. The findings from this study highlight children and young people who are providing care require an appropriate assessment that does not just ask about the role of the young carer, but looks at the ‘global’ nature, scale and impact caring has on that child or young person. That is, it should involve listening to the young carers, identifying when and where a young carer is undertaking inappropriate and excessive care and implementing a family centred approach within both child and adult health and social care services.

Stamatopoulos (2018) research offered a contribution to the qualitative field of research of young carers by conducting first-hand accounts of the experiences of being a young carer in Canada. A focus group method was applied, with a sample size of 15 young carers from two regions of Canada. Of note, Stamatopoulos’s use of focus groups was to both offer shared power between the researcher and the participants and importantly, connect young carers to each other. The participants within this study comprised of young people between the ages of 15 and 19 years of age who provided a minimum of five hours of care (on average) and were already affiliated to a young carers service. The participants were made up of three males and 12 females. Of the care provided by the young carers the main condition which required support was for substance abuse. Like the findings from McGibbon, Spratt et al., (2019) and Järkestig-Berggren, Bergman et al., (2019) providing care was found to affect their joint familial, social, and emotional well-being. Of importance, it was emphasised by the participants within this study, that strained family bonds often linked to a real or perceived inequality in the provision of care, and limited opportunities for socialisation outside the family home. Stamatopoulos (2015) coined the term ‘young carer penalty’ referring to the penalty of providing care as a child or young person. The emphasis of the ‘young carer penalty’ was highlighted throughout this research with its severity being associated with two key factors: family size and type of condition requiring care; specifically, if the family was a single parent family with a mental health condition. Whilst the author acknowledged the limitations of their study due to sample size, they offered detailed and in-depth accounts of life as a young carer and the ‘penalty’ of being a young carer.

McDougall, O'Connor et al., (2018) research used a phenomenological approach to understand the lived experience of young carers in Australia. The sample size within this research was 13 young carers between the ages of 14 and 25. The participants were either currently providing carer or were formally an informal and unpaid caring role and identified as a young carer. The study was conducted through in-depth semi-structured interviews, which were subsequently themed using Braun and Clarke’s (2006) systematic procedure. Four themes emerged from the data of this study with three themes highlighting some of the negative aspects of being a young carer. These were navigating competing demands; desire for normalcy; and being lost in the system. These themes are also highlighted within the works of Stamatopoulos (2018), McGibbon, Spratt et al., (2019), Margaret Gowen, Sarojini Hart et al., (2021) and Järkestig-Berggren, Bergman et al., (2019). However, the authors of this research also highlight within their findings the narrated benefits of being a young carer. The participants within this study highlighted the positives of being a young carer. They derived personal meaning from their caring role, and felt they were improving the quality of life of the person they cared for. In addition to improving the life of the person they cared for, the participants also added that being able to put things into perspective was another benefit of being a young carer. Such positives are not a common presentation within the young carer literature.

Matzka and Nagl-Cupal’s (2020) study of young carers in Austria used a qualitative approach to understand the lived experience of being a young carer, with resilience being a guiding concept of the study. This study offered a different aspect to the perceptions of being a young carer compared to the other reviewed studies, in that, the authors wanted to identify psychosocial resources available to the young carers taking part. The methods of the study also differed to other studies. The authors used a method called “photo novella”. Photo novella is a technique of gathering narrative data using photographs taken by the participants which are used as stimuli during the interview process. This process is also called “photo elicitation interviews” or “photo interviews” (Close 2007). The study used a purposeful sample of young carers under the age of 18 years who lived with a family member who was chronically ill or disabled. Access to the young carers was through a healthcare and state-funded service which acted as a gatekeeper. As Stamatopoulos (2018) implies within her research, globally, a higher percentage of young carers are female, and this is supported by Becker (2007), Aldridge (2018) and Leu, Frech et al., (2019). In contrast, Matzka and Nagl-Cupal’s (2020) study included more male participants (six boys and 4 girls). The findings of this study offer a different perspective of the emotional effects of providing care for a family member compared to the aforementioned studies. The participants within this study reported that they needed to distract or distance themselves from the everyday stresses and strains of providing care to reflect and regenerate. Being able to spend time alone in their room or in nature enabled the young carers to cope with their caring responsibilities.

Berardini, Chalmers et al’s. (2021) study on what self-compassion means in young carers lives offers an insightful picture into the lives of young carers and how they feel about themselves and those they care for. This study used a qualitative focus group approach, utilising a purposeful sample of young people who self-identified as young carers. Of the 33 recruited participants between the ages of 12 and 18 years, eight participants were boys. Although girls dominated, like Matzka and Nagl-Cupal (2020), this study included enough males to offer a male, in contrast to the studies conducted by Stamatopoulos (2018), McGibbon, Spratt et al., (2019), Järkestig-Berggren, Bergman et al., (2019) and McDougall, O'Connor et al., (2018), which had only one or no male participants. Like Stamatopoulos (2018) a focus group was used, and the findings thematically analysed, using a hybrid approach which included deductive and inductive thematic analysis. The findings within this study were based on two characteristics of compassion; the first, task-oriented compassion which included behaviours that were intended to problem solve, such as helping others with shopping or speech. The second, affect-oriented compassion comprised of `behaviours specific to showing emotional care, which included giving someone a hug, emotionally checking in and showing empathy. Like McDougall, O'Connor et al’s. (2018) study, Berardini, Chalmers et al’s. (2021) study highlighted the positive emotional effects of being a young carer. All the participants within this study provided an adjective to describe how helping others made them feel. Participants described feeling ‘happy, excited, good and amazing’. Moreover, it was interesting to see that the caregiving actions undertaken by participants in this study enhanced a positive view of self and others’ regard. These findings are congruent with the Berardini, Chalmers et al., (2021) and McDougall, O'Connor et al., (2018) studies which also reported that providing care as a young person contributed to some young carers feeling happier and becoming emotionally stronger, as well as more considerate, mature, compassionate, and proud.

In summary, the qualitative literature which was reviewed demonstrated that being a young carer for a parent, sibling or other family member has an emotional effect on the young carer. Much of the literature which was reviewed came from the perspective of female young carers, however, three studies provided insight into the lived experiences of males who are providing care. It is clear from the literature that the emotional effects of providing care are subjective to the individual and their personal circumstances. Importantly, the reviewed literature also demonstrates that there are positive aspects of being a young carer and being a care provider can enhance young carers’ lives, their relationships and their emotional health and well-being. That said, the literature which was reviewed also highlights that if a young carer is providing care for a parent with a mental health issue, they often present with increased poor emotional health compared to those who are supporting a parent, sibling, or family member with a physical health issue.

2.3 Research with Military and Veteran Children and Young People

Academics, military establishments, and leading military charities from around the globe, in the UK and elsewhere, continue to explore the impact combative operations have on military personnel and the potential effects they may experience when returning home to their families. There is a growing wealth of research looking at the effects combat has on both the physical and emotional health of returning military personnel (Rivera, Krueger et al., 2015, McDonald, Liang et al., 2018, Rafferty, Cawkill et al., 2018).

There is also a growth of research focussed on the psychological aspects of combat covering a multitude of conditions such as post-traumatic stress disorder (***PTSD***) (Jones & Wessely, 2005; Sundin et al., 2010; Philips et al., 2018; Solomon et al., 2021), traumatic brain injuries (***TBI pre-deployment stress*** (Sharpley 2008; Loignon, Ouellet et al., 2020; Reger et al., 2022), poor mental health (Forbes 2011; MacManus, Jones et al., 2014; Britt, Sipos et al., 2019; Hynes et al., 2021) re-integration and the military family (***spouse/partner***) (Burgh 2011, Harvey, Hatch et al., 2011; Yambo, Johnson et al., 2016; McKinzie 2022). Most importantly for this study, the expansion of military research in recent years suggests a great deal of effort is going into acquiring knowledge and evidence to understand the continually changing landscape of the effects combat exposure has on military personnel's psychological wellbeing and the effects on their families.

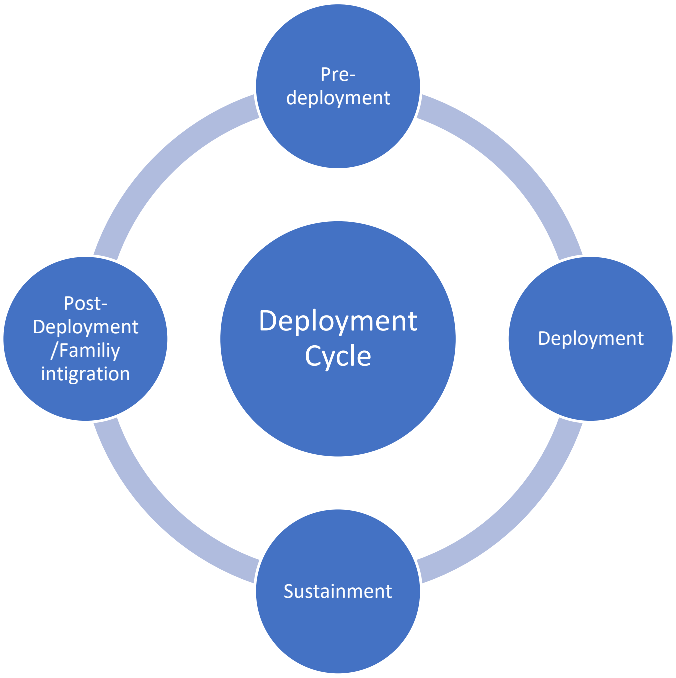
2.3.1 Understanding the deployment cycle and its effects on children and young people

Constant and repetitive deployments of serving personnel to both Iraq and Afghanistan over a consistent period have seen some of the 170,000 military children and young people become separated for enduring anxiety provoking periods of time from their parents (O'Neil 2013). The deployment cycle is a catalyst for change within the military family's day to day structure, their functioning as a unit and the emotional turmoil separation may present.

To understand the process of the military, it is important to understand the deployment cycle and how this cycle effects the military family. Moreover, there is a need to understand how the deployment cycle affects children and young people and why it can potentially have a detrimental effect on military families.

The deployment cycle has been conceptualised in a number of ways, with the number of phases in the cycle ranging from three (Horton 2005) to seven. Pincus, House et al., (2001), propose a five-phase cycle comprising Pre-deployment, Deployment, Sustainment, Re-deployment, and Post-deployment but due to deployment differences between the United States and United Kingdom military it is more appropriate to use a four-stage process in the UK: Pre-deployment, Deployment, Sustainment – Rest & Recovery (R&R) - Re-deployment and Post-deployment. Each phase of the deployment cycle is explored outlining evidence about its effects on military families below.

Figure 1: The 4 stage cycle:



Each stage of parental deployment effects children differently as Table 1 illustrates below:

Table1: The Deployment Cycle.

Pre-Deployment	Anticipation of loss, emotional detachment, withdrawal, anxiety, guilt, frustration, worry, sadness, hard to understand, impatient.
Deployment	Anxiety, loss, irritable, sadness, fear, insecurity.
Sustainment	Calm, new routines, independence.
Post-Deployment	Anxiety, happiness, role changes, re-negotiations of roles, irritability, loss of independence,

(Lincoln, Swift et al., 2008; Fitzsimons and Krause-Parello, 2009; Waliski, Bokony et al., 2012; Swedean, Gonzales et al., 2013).

Pre-Deployment:

The pre-deployment phase begins when the service member is given notice that they will be deployed. As such, the length of this phase is difficult to define due to operational need. In the main the service member will begin pre-deployment training up to 6 months prior to deployment. This phase is, for many families, filled with excitement, pride, fear, anxiety and uncertainty as family members begin to contend with the inevitability of separation (Bello-Utu and DeSocio 2015).

It is not uncommon for the service member to become detached from their family during periods of pre-deployment training, leaving the care of the family to the remaining parent, potentially tending to the majority of home based tasks, thus creating a one parent family (Meadows, Tanielian et al., 2017).

Whilst Pre-deployment effects children and young people differently, it is important to note that many researchers have found contrasting differences in emotional and physical responses to parental deployment, based on age, sex and the mental health of the stay at home parent (O'Grady, Wadsworth et al., 2015; Meadows, Tanielian et al., 2017; Veri, Muthoni et al., 2021).

Pre-deployment is typically a time when children and young people begin to understand that their parent will be away for a period of time, potentially increasing their anxieties of conflict, a change in behavioural presentation, frustration and fear (Swedean, Gonzales et al., 2013). It is not uncommon for children and young people to regress and display behaviours more commonly presented by younger children. This can include frequent crying and tantrums for what appears to be no reason (Foran, Eckford et al., 2017). Children and young people may also become clingy, not allowing space for the stay-at-home parent, when previously they were confident being alone when playing or watching TV (Bello-Utu and DeSocio 2015; Stepka and Callahan 2016). Additionally, some children and young people will have night terrors and may even wet their beds (Stepka and Callahan 2016). Such behaviours can have a significant impact on the family and its functioning dynamic.

Deployment:

The deployment phase begins when the service member departs, lasting in theory, for around one month due to the settling in period when the service person exchanges roles with their predecessor, whose deployment has ended, will be returning. During this time the service member and their families will potentially be in a state of disorientation. Children and young people may especially feel confused, angry and upset at being separated from their parent. A child or young person's difficulties may present in a number of forms, including poor self-esteem, lack of emotional and physical control, low mood and crying (Waliski, Bokony et al., 2012).

During this phase, families will begin to restructure and the older children within the family will inevitably take on additional chores around the home, which were previously divided between both parents (Flittner O'Grady, Whiteman et al., 2018). Research has shown that this shift in role can have both a positive and negative effect on children and young people (Chandra, Lara-Cinisomo et al., 2010). For many children and young people being given additional responsibility gives them a sense of pride, making them feel grown-up and trusted. For other children and young people, it can leave them unsure of their role within the family, in that they are not looked on as a child. This is especially pertinent for older children who may take on additional jobs around the home or look after younger siblings, when they would rather as young teens want to be exploring life outside the family home with friends (Esposito-Smythers, Wolff et al., 2011; O'Grady, Wadsworth et al., 2015), partaking in normal exploratory teenage risk taking behaviours (Evans and Watson 2015).

For some children and young people there is a sense of loss. Pauline and Boss (2009) describe ambiguous loss as something which is "uncertain, vague, unclear and intermediate"; which can have a detrimental effect on a child or young persons' emotional health. The child is unable to provide validation of when a parent will return (Bowlby 1982) or know if they will return at all (Holmes, Rauch et al., 2013).

Sustainment, R&R and Re-deployment:

The sustainment phase is generally the longest of the deployment cycle and is defined as the time between the end of the first month of deployment and the period leading up to rest and recuperation (R&R) – the period where a service member will return home for two weeks, then return to combat/deployment.

During this phase service members and their families settle into their new roles and routines, with many children and young people thriving and taking on additional roles within the family home due to there only being one parent (Cozza, Chun et al., 2005; Lincoln, Swift et al., 2008).

This phase can be fraught with difficulties for the stay-at-home parent; not only are they taking on additional responsibility for the running of the family home they are, in the main, the only person caring for the children. Due to this additional responsibility, the stay at home parent may find that children and young people are at risk of acting out emotional behaviours during this time, creating increased stress for the stay at home parent (Lester, Peterson et al., 2012).

Deployment related stress on the part of the stay at home parent may occasionally manifest as child maltreatment (e.g., physical, sexual, emotional, or other abuse or neglect). Rentz, Marshall et al., (2007) conducted an analysis of child maltreatment data in Texas in order to assess reported incidents of child maltreatment amongst military and non-military children. The analysis showed very similar rates between 2000 and 2003. However, there was a significant increase in maltreatment reports of military children towards the end of 2002, and at the beginning of 2003, which corresponds with intense combat operations in the Middle East.

Further research by Rentz, Marshall et al., (2007) showed that during the sustainment phase, where a spouse was deployed in an ongoing combative operation, there was a significant increase in child maltreatment. These findings could suggest that deployment, especially during intense combat, has a potentially significant impact on the safety of the child under the care of the stay-at-home parent.

In addition to the above, pertinent research has shown that there is an 11% increase of military dependent children and young people accessing mental health services when one or both parents are deployed to combat due to poor emotional stability and increase in risk taking behaviours (Johnson and Ling 2013). Hisle-Gorman, Eide et al., (2014) examined the use of health care services for children with pre-existing diagnoses of Attention Deficit/Hyperactivity Disorder (ADHD) and found that the youngest children presented with increased symptoms of ADHD, an increased utilisation of mental health services and used more medication during the deployment period. This research also found that when the deployed service member was a married male, children had significantly more visits to mental health services in comparison with single-parent homes or when the deployed service member was a married woman.

During the period of R&R the service member and their family will have time together. This short period of reintegration is time which is usually positive to the family. Many children and young people settle into new routines and find a new independence within this phase of deployment, generating positive emotional and social development (Baptist, Barros et al., 2015).

However, due to this period being such a short time this can have negative effects on some families. Some service personnel may find it difficult to fit back into their role within the family due to the dynamics of the family changing to survive (Bello-Utu and DeSocio 2015). This can equally be difficult for older children as their role as support for the stay at home parent changes, and they return to being the child, potentially promoting unrest and confusion (Huebner, Mancini et al., 2007).

Once R&R has finished the service member will return to their location of deployment, promoting the thoughts, feelings and emotions of the pre-deployment stage, for the period leading to deployment extraction. Moreover, this phase can further promote role ambiguity in relation to children and young people taking up their supportive roles within the family (Waliski, Bokony et al., 2012).

Post-Deployment & Family Integration

Post-deployment refers to the end of the deployment phase when the service member returns home. Much like the pre-deployment phase, the length of time service personnel and their families remain in this stage is dictated by the deployment and remains extremely variable. Reintegration for some can be difficult, unsettling, and emotionally challenging, depending on a number of factors such as deployment role, length of deployment, family dynamics and deployment outcomes (for example, injuries – physical and psychological) (Cozza, Chun et al., 2005; Cozza, Holmes et al., 2013; Bello-Utu and DeSocio 2015).

Importantly, many leading researchers of military children demonstrate that poor family integration and lack of supportive structures put many children at risk of presenting with secondary emotional and mental health issues (Maholmes 2012; Fear 2017; Watson and Osborne 2020). In particular, Glenn, Beckham et al., (2002) report parental depression, anxiety, PTSD and substance misuse problems have been associated with older military children's behavioural and emotional problems, which is also supported by Wooten, Brittingham et al., (2019).

As discussed, there are designated stages of the deployment cycle that promote specific emotional challenges for children and young people that need to be considered. As the research gathered previously within this section highlighted children and young people can also suffer the psychological effects of parental deployment (Huebner, et al., 2007; Bradshaw, et al., 2010; Werner, 2012; Cederbaum, et al., 2013). Moreover, children and young people may present with a change in behaviours, both internally (Chartrand, et al., 2008; Lester, et al., 2012) and externally (Iversen, Fear et al., 2007; Chartrand, Frank et al., 2008; Chandra, Martin et al., 2010), suggesting the need for continual positive family support and social connectivity (Mmari, et al., 2010; O'Neil, 2013).

The literature which has been reviewed, indicates that while important research in relation to how the deployment of a parent is affecting children and young people is being conducted, there remains little research from the child's point of view on how deployment has affected them. All deployment phases can be confusing for family members, especially children. Families not only experience the physical separation from a deployed loved one but also boundary ambiguity throughout the different phases of the deployment cycle due to role changes within the family dynamic, for example, more responsibilities to the 'lone' parent, children and young people stepping up to provide support for the stay-at-home parent, and potentially caring roles will change within the family. Moreover, there is a reported ambiguous presence when the family member physically returns from deployment but is psychologically absent (Faber, Willerton et al., 2008).

2.3.2 Transition and the veteran family

Søndergaard, Robertson et al's (2016) systematic review regarding transition and the military family came to the stark conclusion that there is little research relating to the military dependent child or young persons' experiences of the transition (Cramm, Norris et al., 2020). Therefore, this section of the literature review will provide a brief extract of general transition from the military to the civilian population with regards to the service member.

Approximately 12,700 personnel left the Armed Forces in 2020 (Defence Analytical Services Agency. 2021). Most UK veterans make a successful transition into civilian life. The vast majority of service personnel leaving the Armed Forces are not injured during their service and have no long lasting health problems so the majority of veterans and their families will transition with no major issues (Cozza and Lerner 2013; Ashcroft 2014). However, a minority either leave with or develop mental health difficulties. Mental health issues within the Armed Forces continue to raise concerns relating to both the potential short and long-term effects of enduring combat operations. Like the civilian population, military personnel are not exempt from presenting with common mental health issues, such as anxiety, depression, and behavioural disorders (MacManus, Jones et al., 2014; Finnegan et al., 2014), and alcohol abuse (Fear, Jones et al., 2010). In contrast, PTSD is depicted in the eyes of the mainstream media and the general public as the mental illness of conflict (Leightley, Williamson et al., 2019); enabling PTSD to become socially acceptable, potentially enabling those with PTSD to seek support.

However, due to recent conflicts, and the change in combat roles, military personnel, veterans, and their families face different physical and psychological issues. Due to improved weaponry, combat safety equipment and advances in medical care and rehabilitation, service personnel are surviving serious injuries, which they may not have had in the past. However, whilst there has been a significant reduction in combat fatalities, this reduction is accompanied by a rise in the number of amputees and those effected by blast and psychological injuries (Holmes, Rauch et al., 2013; Melcer, Sechriest et al., 2013; Kelley, Kenny et al., 2015; McGill, Wilson et al., 2020; Hynes et al., 2021).

Since Vietnam and the Falklands war, the military has paid significant attention to the psychological aspects of war, that is, Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI), which have both short and long term health consequences for veterans and their families. Tanielian, Haycox et al., (2008) concluded that military personnel serving in Iraq, had a marked reported increase in the presentation of depression, anxiety, and PTSD symptoms, between three and 12 months after returning from deployment. Therefore, for many veterans of combat, the invisible wounds may not surface until months or years after they have returned home from combat and/or left the Armed Forces.

The stressors that service personnel face during deployment may influence their overall experience of the family, both during the deployment and on their return. During deployment service personnel experience a number of difficult challenges, obstacles and pressures. For example, service personnel endure strenuous physical and psychological training, long working hours and an intense working pace, infrequent breaks and little time off; not to mention uncertainty and exposure to danger whilst being separated from their families (Hosek, Kavanagh et al., 2006). Furthermore, many service personnel who deploy to a combat zone are exposed to severe trauma, such as witnessing injury or the death of friends and colleagues, hand to hand combat, explosions and blast injuries (Chandra, Burns et al., 2008). In addition to the previous mentioned, combat exposure has also been linked to substance use, high-risk drinking and reckless driving (Renshaw, Rodebaugh et al., 2010). Moreover, anger, excessive drinking, lack of sexual intimacy, and wanting to return to the combat zone were identified by McNulty (2010) as barriers to reintegration into the family dynamic and society.

2.3.3 PTSD Studies

PTSD is a diagnosis under the DSM-5 characterised by a cluster of symptoms including intrusion symptoms, avoidance, negative alteration in cognitions and mood, and alterations in arousal and reactivity (APA 2013). A UK cohort study on military personnel within the UK who deployed to Iraq (Rona, Hooper et al., 2006) and, in a second study, to Afghanistan (Fear, Jones et al., 2010), indicated low rates of reported PTSD diagnosis. Rona et al's (2006) research was unable to find any significant demise in mental health outcomes for soldiers because of combat exposure in Iraq. Importantly, the results from this study revealed a probable PTSD prevalence rate of around 4%, which did not show a rise on returning to the UK within the first 6 months. Coincidently, the second cohort study (phase 2) conducted by Fear et al., (2010) revealed that mental health disorders among UK military personnel remained remarkably stable during the reporting period of 2003 and 2009 (Fear, Jones et al., 2010), indicating a slight rise in prevalence of PTSD to 4.2% for deployed regular military personnel.

The findings from King's (Phase 3) PTSD study generally depict much lower rates of PTSD presentation than their US counterparts. To add context to PTSD and its national prevalence, research findings of military personnel who served in combat operations show a modest but important change in the overall mental health of UK Armed Forces personnel throughout the period of 2004-2016. This research shows there has been a moderate increase in PTSD, largely due to a larger veteran cohort. For those still serving within a combat role, PTSD increased from 6% in 2004-2006 to 7% in 2007-2009 and remained stable up to 2016. This is comparable to a rate of 4.4% within the civilian population. For serving personnel in non-combat roles, PTSD rose from 3% to 4% in the same reporting period. In contrast, in those who have left the forces (overall 7%), especially those who had deployed to combat (17%), PTSD does appear to be elevated. In summary, the prevalence of PTSD is not a blanket finding across both serving and non-serving personnel. In still serving regular personnel the overall rate of PTSD is 4.8%, with a statistically higher rate in the veteran population at 7%.

2.3.4 Understanding the military child

The UK has approximately 170,000 children and young people living within military families (O'Neill 2017). A number of authors explain this population of children and young people are often portrayed as a stereotyped group, rather than a multi-layered complex and heterogeneous population (Cozza, Chun et al., 2005). Lagrone (1978) coined the term 'military family syndrome'. He used the term to describe a certain set of traits presenting within military families. These traits included, an authoritarian father, depressed mother and out of control children. LaGrone's study of 792 children and young people, seen within a military medical centre over a two-year period, resulted in several traits being established. This data suggested that rates of disorders were higher in the military clinic compared to the civilian population attending mental health clinics. The author suggested that the behavioural problems of the group of children and young people studied represented a process of acting out in the rigid, autocratic system of the military.

Taking account of LaGrone's (1978) description of children and young people from military families, over the preceding years, military children and young people have also been identified and labelled as the 'military brat'. The term "brat" [a ragamuffin; an ill-mannered annoying child (Webster's dictionary)], denotes "rubbish". Current use, however, is believed to have originated from England in the 1920's where Lord Trenchard initiated aircraft training for people as young as 15. Some of these 15 year olds were knowledgeable beyond their years, resulting in adults on the same course labelling them “Trenchard brats” (Tams 2000). It was then, that military children became the brats of military personnel. However, in today’s military communities, the term military or service brat is not considered to be a description of a spoilt child, but rather connotes affection and respect (Wertsch 2006). Children of a serving military person have been associated as having a unique subculture and cultural identity. Musil (2005) commented that military brats do not know what belonging is about and that many children who are born within the military environment do not realise there are potential differences associated with being a military child *versus* being a civilian child. The strict, organisational discipline may not seem appealing to the population but, to military children, young people, and their families this is all they know.

Military culture involves many unique experiences that the civilian population do not experience.

> *“Culture can be defined as a ‘group of people who have a set of values and beliefs which embody ideals and are transmitted to members of the group”* (Matthews 1992, p.54)

Military culture is shaped by rank and file branches of service (e.g. Army, Royal Airforce and Royal Navy) military units and location of the family home, in relation to the rank of the serving person, both inside the wire (houses located on the military base) and within the local proximity of the military base. All of this could affect the identity of a child growing up within that environment. This is supported by Williams and Mariglia (2002) who note within their work the military rank caste system is visible everywhere through symbols (e.g. rank identification), and as a result, status is most visible and manifested in the military community through segregation of family housing.

Whilst this may sound negative, the foundation of, it is a ‘forever’ community (Easterbrooks, Ginsburg et al., 2013) provides an insight into the connectedness of military life. Ender (2002) describes the military community as those “culturally rooted in a society that values individuality, family, community and nationality” (p.93). As stated by Williams and Mariglia (2002) “the highly structured society of the military requires that all members of the military family be accountable for their actions….and the military community requires soldiers and their families to follow certain patterns of conduct” (p.71). By following a pattern of conduct it presents as an unwritten law on how to act within the military community, allowing a sense of “we know what is expected of us, so let’s get on with it!” This provides a commonality amongst strangers.

Military children and young people tend to bond quickly due to their shared experiences, the difficulties they collectively face and loyalty to the service family (Easterbrooks, Ginsburg et al., 2013, Watson and Osborne 2020). The military community could say that it is not defined by geographical location, but that of a shared set of morals and values, based strongly on pride.

Much of the literature and research surrounding military children and young people examines stressful experiences (such as parental deployment, moving home or school, or maltreatment) (Waliski, Bokony et al., 2012; Bello-Utu and DeSocio 2015) or the negative aspects of the presenting stressor (for example, poor academic attainment, depression, anxiety, or behavioural problems) (Drummet, Coleman et al., 2003; Huebner 2019). However, there are also many positives. For example, military children and young people tend to show more adaptability to their civilian counterparts, a higher ability to make friends quickly, share a sense of travel and experience new beginnings, in what are often multi-cultural communities in which they reside (Blamey, Phillips et al., 2019). Many military children and young people tend to accept that they live in a transitional population, accepting that home is where the family lives, where they live, or where they have lived the longest. Importantly, growing up in a military environment can affect a child’s sense of place without negatively impacting on their physical and psychological development (Sullivan, Cozza et al., 2019).

Keller and Decoteau (2000) are in no doubt that the most common feature which shapes military children and young people is mobility, of their family unit and in particular, their parents. This is an unusual stressor not usually faced by the general population. For military children and young people, frequent moves can disrupt their educational attainment and bring periods of stressful acclimation to a new environment where they may not have many friends and may be disconnected from school and community activities. Due to military locations, schools may be at different stages of the curriculum, children and young people may find that they miss parts of the curriculum, or they are at a stage where it is repetitive, having a detrimental effect on their learning (Keller and Decoteau 2000; Cozza and Lerner 2013).

2.3.5 Military PTSD and dependent children and young people

Research by McFarlane (2009), which is strongly supported by a number of academics within the field of military children and young people (Cozza, Holmes et al., 2013; Holmes, Rauch et al., 2013; Kaplow, Layne et al., 2013), notes that a parent with PTSD tends to cope by withdrawing from social contact and presenting with emotional numbing. They can become irritable and lack any empathy for their children. As noted within section 2.4.2 the presenting symptomology of PTSD such as irritability and anxiety are related to limited problem solving skills and conflict management (Dekel and Monson 2010), and poor partnership/spousal connectedness with regards to parenting (Gewirtz, Polusny et al., 2010; Parsons, Knopp et al., 2018; Waddell, Lawn et al., 2020) which are the foundations of promoting positive outcomes for all children to grow (Williamson, Stevelink et al., 2018). Vital to the emotional and physical growth of any child or young person is the development of resilience, facilitated by the surrounding of stable, loving parents who provide a safe, consistent, nurturing environment, that actively encourages learning and positive interactions (Smith, Perou et al., 2002; Le Menestrel and Kizer 2019).

King and Smith's (2016) qualitative literature review support many of the issues of parental re-integration, PTSD and military children mentioned previously within this chapter. The aim of King and Smith's review was to explore and gain a greater understanding of the lived experiences of children within a veteran family, where the veteran had PTSD. This review showcased the importance of understanding the child *versus* parent relationship and the complicated relationship intricacies with regards to parental PTSD, within a military context.

Collins (2018) scoping review on military parents' PTSD and child mental health supported the findings of King and Smith (2016). In all twenty-one studies reviewed PTSD had a negative impact on family functioning and on the mental health of children and young people within the family home. Furthermore, Collins noted that there is a substantial need for further research on the impact parental combat related PTSD has on children and young people under the age of 18 from military families. Moreover, Collins highlighted that the literature within her scoping review related to adult children rather than children, and the effect that parental trauma had on them. Finally, Collins concluded, there was a gap with regards to children and young people's personal perspectives of living with parental PTSD due to combat.

2.4 Conclusion

In summary, all the above studies concluded that PTSD had a negative impact on family functioning and on the mental health and well-being of children and young people. It is therefore apparent that PTSD not only impacts the person with PTSD but also impacts those around them. Based on the literature reviewed within this section on military children and parental PTSD, it can be concluded that there is a need for further research on the emotional impact living with parental combat related PTSD has on a child or young person under the age of 18. Of note, there is a paucity of research on the emotional well-being of children and young people whose parents are in, or have been in the Armed Forces, who have a diagnosis of PTSD. Therefore, this study aimed to help fill this gap within the literature to understand the lived experience of children and young people who are living with and caring for a parent with combat related PTSD who have become young carers.

3 Chapter 3: Methodology

In this chapter I present the research design which was used to answer the research questions in this study. I start by clarifying the aims and purpose of the study. I then move on to provide a deeper understanding of the ontological and epistemological theoretical framework of the study, which is underpinned by the theoretical framework of Symbolic Interactionism (Bulmer, 1969), an ontological assumption based on the belief that reality is 'socially constructed', and an emic epistemological foundation built on subjective lived experience. This theoretical framework enabled me to understand the lived experience of young carers of veterans with PTSD. The methods of data collection and the process of narrative inquiry analysis are also explored and the ethical implications of involving children and young people in research discussed.

3.1 Aims of the research

The study had two main aims:

- To explore the impact that parental Post Traumatic Stress Disorder, which is associated with combat, has on children and young people within the home environment.
- To explore the impact on parental and child or young person's relationships when a child or young person assumes the role of 'young carer' for a parent with combat attributable Post Traumatic Stress Disorder.

3.1.1 Positioning myself as a researcher

As a child growing up in a military community, I have first-hand experience of being a hidden young carer, something I did not recognise until adulthood. At times, as a child growing up in a military home, I provided practical support in caring for my sibling whilst my mother was working, and my stepfather was deployed. On returning from Iraq my stepfather developed mental health issues, leading him to self-medicate with alcohol. This toxic environment led to domestic violence within the family home. I would become the negotiator, providing emotional support to both my parents, taking care of my younger brother, distorting my role within the family home (DuMont, Widom et al., 2007; Williamson and Price 2009).

As a cultural insider, I had to represent a space in which objectivism and subjectivism met. Whilst conducting this study I was aware I needed to strive towards objectivism but must remain reflexive regarding my subjectivism (i.e. social, emotional and educational stand point). It was important to acknowledge who 'we' both were (researcher and young people/carers) as individuals, and to be mindful of the fact that we were members of a similar group but held our own positions within our lived experience.

The need for ongoing reflection throughout the research study provided a number of challenges. Whilst the possibility of subjectivity was recognised, there was a potential for researcher bias, which may have adversely affected the reliability of the data. In order to minimise this, it was important to reflect on my positionality, using my field notes and when transcribing, to determine the relevance of my subjective lived experience, bias, prejudices and assumptions. Ultimately, I was aware of my potential in 'clouding or distorting the perceptions of others' experiences' (Anzul, Ely et al., 2003).

To minimise subjectivity, a number of steps were taken using McCormack's (2002a; 2002b) framework. McCormack's framework requires the researcher to consistently reflect on the transcripts they are re-storying by sharing those stories with the participant, to make sure this newly constructed story is a correct representation of their told story. Once the researcher has received feedback, they are then required to act on the participants' comments and then return the transcript for further scrutiny until the participant is happy with the constructed story.

3.1.2 Epistemological and Ontological stance

This study is underpinned by the theoretical framework of Symbolic Interactionism (SI) (Bulmer, 1969), an ontological assumption based on the belief that reality is 'socially constructed', and an emic epistemological foundation built on subjective lived experience. This enabled me to understand the lived experience of young carers of veterans with PTSD.

Symbolic interactionism can be framed as a micro-level theoretical framework and perspective in sociology that addresses how society is created and maintained through repeated interactions among individuals (Carter and Fuller 2015). Moreover, Symbolic Interactionism has been regarded both as a general framework for the analysis of society (Blumer 1986), and as a specialised theory in social psychological theory, which primarily addresses problems in socialisation (Stryker 1964). By utilising the theoretical lens of symbolic interactionism within this study, it was important to put young carers of veterans and their interpretation of life as a young carer under the microscope to determine how the dynamic of a veteran family is created through the eyes of a young carer. It was also important to understand young carers' perceptions of their interactions with a parent from the point of being a carer and to capture their life story.

Using Symbolic Interactionism as an ontological approach to understand the perception of one's 'truth', as described by Blumer (1986), is built on what we believe to be true, and based on how we and others communicate what we believe are truths. Therefore, one could argue, 'reality' is constructed by observations, interpretations, perceptions and our conclusions, which are established by shared narratives.

As this study was situated within 'Symbolic Interactionist' traditions, the approach was founded on the concepts of human society being viewed as 'actors' or 'societal performers' and there being an 'interconnection' between individuals and their surroundings (Blumer 1962). With regard to the young carers within this study, the researcher looked at how the young carers orientated their thoughts, feelings and emotions based on their activities of daily living and their interactions with their families, friends and community.

There are a number of approaches to Symbolic Interactionism, with three main schools of thought, Chicago (Mead, 1934; Blumer, 1937; Goffman, 1971 and Denzin, 1992) the Iowa (Khun & McPartland, 1954; Couch, 1958 & Kuhn, 1964) and Indiana (Stryker 1980) which are associated with qualitative research, quantitative research and mixed methods respectively. For the purpose of this study, the Chicago school of thought was used, as it was considered to be the best fit to Bulmer's work (based on Mead's work) and his development of symbolic interactionism which sits well within Narrative Inquiry. Bulmer explains that Symbolic interactionism works on three premises. They are:

- Humans act towards things on the basis of the meanings they have given them.

- The meaning of such things is derived from, or arises out of, the social interaction.
- The meanings are handled in, are modified through, an interpretative process used by the person (Blumer 1986).

For this study to truly make a difference, it was important to articulate the voice of those taking part in the research and to share their interpretation of how they moved from having a child and parent relationship pre-PTSD presentation to having a young carer and parent relationship post-PTSD diagnosis. Importantly, this journey of role change was expected to create new relationships and behaviours within the family home and with communities.

Importantly, meanings are modified based on any given individual's interpretation of their world (Blumer 1962). For example, the term 'young carer', as outlined in the previous chapter, is a socially constructed 'label' which is rooted in legislation and policy and based on a given 'role' being assumed within the family dynamic. Although these official definitions may be used by health and social care professionals, the term 'young carer' may hold a different meaning to individual young carers, and some may not even recognise that they are a 'young carer'. This may go some way wards explaining why it was difficult to recruit young people to this study because they did not always know they were a young carer.

3.1.3 A Qualitative Approach

This study adopted a qualitative approach, using the research framework of Narrative Inquiry. Creswell (2009) explains that qualitative research is an enquiry process of understanding, built on distinct methodological traditions that explore a social or human problem. That being, the researcher builds on a holistic, whole life picture, analysing spoken and unspoken words, which report the expressed views of those participating.

Narrative inquiry permits a combination of understanding the nature of research, the nature of knowledge, the purpose of research, research design and research processes. Moreover, narrative research is based on the assumption that an individual constructs their reality, that is, they seek to explore meaning via interpretation and the use of in-depth and thorough reflective cognitive investigation (Gall, Gall et al., 1999).

Fundamentally, qualitative research methodology aims to answer the questions of where, what, who and when of any given phenomenon (Silverman 2000). Using narrative inquiry allowed the participant and the researcher to collectively shape the dialogue of the told stories over the young carer's life course (Clandining & Connelly, 2009). This approach to generating knowledge, which was constructed through the process of 'storying stories, allowed the recognition of the story to be situated, transient, partial and provisional; thus, characterised by the collective voices of both participants and researcher, generating multiple perspectives, of our own truths, which in turn created meaning.

In practice, using a combination of analytical methods is common amongst narrative researchers as this can be a tool to analyse the multiple aspects of data. Appropriate consideration was taken to choose the best way to present the participants' stories. There are several qualitative approaches to research with children and young people and it is well known that data collection and analysis methods directly affect the outcome of the study. For example, grounded theory, is a way of interpreting research data to provide new insights within the analysed data and generating new theory. However, as Strauss & Corbin (1990) explain the theory is developed while creating data through discussions in focus groups (Saunders et al., 2009), something I did not want to use as a method of data collection, due to the potential sensitivity of what was being discussed during the interview stage, and the potential for causing psychological destress. Since my priority was to safeguard the confidentiality and emotional health of the participants the rationale for analytical synthesis, that is, using a mixture of Narrative Inquiry, Symbolic Interaction and Thematic Analysis as a method of data analysis was chosen firstly because of its appropriateness in understanding the language used to analyse narrative content within-family. I was then able to widen the analytical process to understand content narratives between-families. Moreover, utilising thematic analysis enabled the development of shared moments being present in time, place and societal context. Using this mixed method of analysis also enabled qualitative data sets to be represented in a methodical and meaningful form (Narendorf, Munson et al., 2015) to systematically understand the emotions of what it is like to be a young person who, due to the effects of a parent returning from combat, becomes a young carer of a veteran with PTSD over a life course (Floersch, Longhofer et al., 2010).

3.1.4 Narrative Inquiry

In narrative inquiry, people are viewed as embodiments of lived stories. Narrative inquiry is defined by Bleakley (2005) as a qualitative research tool which places story, or narratives, at the centre of the research process. Bleakley, goes on to explain that stories, or narratives can be utilised in two ways within the research strategy; as raw data, which are systematically analysed, or as a final product of the analytical synthesis and construction of the collected data.

However, the methodological approach of narrative enquiry, according to Phoenix, Smith et al., (2010), is difficult to singularly define, therefore, it becomes difficult to place boundaries around the meanings given by participants.

Clandinin and Connelly (2000) postulate this complexity by suggesting narrative research can have, and produce, different meanings. Therefore, as a research method it can be applied to a multitude of disciplines, but narrative cannot be interpreted as meaning anything and everything, as it is considered a jumble of qualitative research (Randall 1999). Within the context of this study narrative inquiry provided concept, analytical standing and validation of the participants' lived experience within the context of the real world (Phoenix, Smith et al., 2010).

As Clandinin & Connelly (2000) highlight, people need life stories to make sense of the confusion within the context of their individual psycho-social environment. In other words, by empowering young carers to share their stories, the social researcher can, through appropriate use of research methods, support the discovery of the real individual who is present in the world and able, in some form, to articulate and validate their experiences (Denzin and Lincoln 2011).

The use of narrative, storying, or story telling (these terms will be used interchangeably within this study) is a long-accepted exercise of a qualitative research method (Connelly and Clandinin 1990). As a research 'insider' it was imperative to acknowledge my life's narrative, not only from an ethical standpoint, but to give the study rigour and transparency. The point presented by Phoenix, Smith et al., (2010) highlights, that the child/young person/ researcher relationship offers further complexity to an already multi-layered set of relationships for a young carer. Moreover, the collaboration of the research process arises from the relationship between the researcher and the participant. Hall (1990) explains there is no enunciation without positionality. You have to position yourself somewhere in order to say something at all. As forementioned the young carers within this study had a very similar life experience to me. Therefore, I continually had to be reflexive and position myself as a researcher with lived experience.

A narrative inquiry research framework sees narrative as both a way of knowing and a way of re-presenting knowledge. Narrative inquiry focuses on personal description and interpretation regarding lived experience (Geertz 1973). When researching complex and or multi-layered relationships such as pre and post combat child and parent relationships, it raises the issue in relation to whether the child consciously recognises that they have become a carer for their parent (Montgomery 2008).

> *"narratives are the form of representation that describes human experience as it unfolds through time" (Clandinin and Rosiek 2007, p.39)*

Thick description of an individual's story allowed for social meaning and structure (Phoenix, Smith et al., 2010) to be developed in constructing the young carers' lives. The previous point is supported by Clandinin & Rosiek (2007), who explain that the stories people live and tell are the result of *"a confluence of social influences on a person's inner life, social influences on their environment, and their unique personal history"* (p.41). Clandinin & Connelly (2000) describe that living, telling, re-telling, and reliving mark the qualities of one's life. They note in their previous works, people live stories, and in them reaffirm them, modify them and create new ones…stories…educate the self and others, including the young and those, such as researchers, who are new to their communities (Connelly and Clandinin 1990).

When using narrative inquiry, stories are what the inquirer collects, retells, and writes. This study raised a valid point, that when we truly understand how being a young carer of a veteran with a PTSD feels, thinks and behaves, we will be able to address their specific and collective needs in relation to their caring responsibilities and how this affects both their emotional response and external behaviour.

Morris (2001) describes a distinct difference between thinking *about* stories and thinking *with* stories, which helped sharpen my ontological approach to this study. Morris writes, "The concept of writing with stories is meant to oppose and modify (not replace) the institutionalised Western practice of thinking about stories. Thinking about stories conceives of narratives as object. Thinking with stories is a process in which we as thinkers do not so much work on narrative, but more of allowing narrative to work on us" (Morris 2001, p.61). This promotes the idea that the stories being researched are the experience of both the participant and the researcher.

> *"we live stories that either give our lives meaning or negate it with meaninglessness."*
> *(Okri 2014, p.46)*

Okri's (2014) quote provides validation in relation to the rationale for using narrative inquiry with children and young people. We use their stories and inquire narratively to provide meaning, or the meaning will be lost by not actively engaging in their narrative. Clandinin & Connelly, (2001) explain that Narrative Inquiry allows for the co-construction of story-telling and re-telling in collaboration, promoting autonomy and reflexivity. Moreover, the use of narrative inquiry with children and young people allows the child or young person to work at their own pace and communicate in a way that fits their narrating style (Wilson, et al., 2007). Importantly, due to my own life narrative (mentioned above), Life Story narrative inquiry underpinned the importance of collaboration and relationship building, based on a shared experience. That meant taking into account the individual's lived experiences (Heidegger 1996), and in turn, accepting and valuing both the participants' and the researcher's familiarities as cultural insiders within a military environment and being young carers of veterans with PTSD.

Clandinin & Connelly (2006) explain that narrative inquirers attend both to personal conditions and, simultaneously, to social conditions. Personal conditions are described as; feelings, hopes, desires, aesthetic reactions and moral dispositions of the inquirer and participants. Social conditions refer to outward factors, to the milieu, the conditions within which people's experiences and events unfold (p.480).

The above explanation directly reflects the aims of this study and supports the rationale for using Narrative Inquiry (NI) as a research method, in conjunction with Symbolic Interactionism (SI). As an ontological approach the use of narrative inquiry and symbolic interactionism both encapsulate a person’s interactions; that is, that a person is always in interaction with their mind, self and society, constantly creating symbolic meaning to objects, other people and assigned groups. The use of symbolic meaning allowed young carers to navigate and understand their lived experience.

3.1.5 The rationale for Life Story Narrative Inquiry

Life Story narrative inquiry was used in this study to produce an understanding of young carers’ life courses. Life course narrative inquiry is a “method of looking at life as a whole and carrying out in depth study of an individual’s life” (Atkinson 2012, p.187). According to Atkinson (2012), it is the main genre of narrative research to truly understand a life in detail, noting the importance of the individual’s various roles within society. Importantly, Life Story narrative research enabled me to explore the lived experiences of young carers and their perspectives of activities undertaken in daily life, including their past, present and their future, focusing on how this made sense to them and provided meaning to the stories they told (Denzin 1989).

In this study, Life Story narrative underscored how young carers of veterans interpret their social environments where the experience of being a young carer is experienced. The use of Life Story narrative inquiry within this research was orientated towards producing an understanding of a young carer’s experiences of living with a parent with PTSD, who is also a military veteran. I explored if their experiences affected their emotional health and how caring affected their activities and daily living. Importantly, this approach emphasised the personal story itself and enabled me to stay away from the assumption that if we understand one young carer’s life, we will gain access to the values and norms of the young carer population (Kim 2015).

3.1.6 Society, place and temporality

This study was informed by Clandinin & Connelly’s (1994) collective beginnings of narrative inquirers, born from the influence of John Dewey’s (1938) three dimensions of inquiry – society, place and temporality.

Society:

Dewey's two criteria of experience, interaction, and continuity enacted situations enabled a narrative concept of experience to be built. Clandinin & Connelly (2000) linked Dewey's criterion of interaction, that is that a person is continually in interaction with their physical world, to the dimension of sociality. Narrative inquirers attend both to personal conditions, and social conditions simultaneously. Moreover, social conditions refer to the milieu of life and the conditions within which lived experiences or events are unfolding.

Place:

Within the three dimensions mentioned above, place is defined as "…the specific concrete, physical, and topological boundaries of place or sequences of places where the inquiry and events take place" (Clandinin and Connelly 2006, p.480). Therefore, a specific situation allows us to draw attention to the specific place or places in which we live a specific experience or event.

Temporality:

Clandinin & Connelly (2006) demonstrated a link between Dewey's criterion of experience and continuity. That is, how a person's experience moves forward from past experiences to future and present experiences in the context of temporality or "events under study are in temporal transition" (Clandinin and Connelly 2006). The process of temporal transition means temporality draws on ways in which the past, present and future of people, places, objects and events are interrelated with the experience. Therefore, their experience is always in a temporal transition, always on the way, and therefore always in the making.

As the stories of the young carers of veterans unfolded, they utilised the fore mentioned three levels of symbolic interactional analysis. That is, the culture, its meaning and its connection with the lived experience. Subsequently, placing the above substructure into the framework of Society, Place and Temporality (Clandinin and Connelly (2006), enabled discussions specific to the individuals' experiences in terms of the following: how it felt in any place and time; what their day to day lives looked like; and how the experience of caring had affected who they were today, and who they might become in the future.

Documenting young carers’ narratives within a specific time in their lives, also offers a place (Narrative Inquiry) or situation (Symbolic Interactionism) explanation. The use of narrative explanations enabled young carers to discuss in detail their thoughts, feelings and emotions at a specific time and place within their developing timelines (Dewey 1989; Clandinin and Connelly 2006; Wilson, Cunningham-Burley et al., 2007). Moreover, the exploration of thoughts, feelings and emotions allowed young carers to ‘tell their stories’ (SI&NI) and narrate how they previously and currently interacted (SI) within their changing family environment (Denzin 2008).

3.2 Developing the Research Method

3.2.1 The Research Design

Narrative inquiries are lives which have been lived and the stories of those lives (Clandinin and Connelly (2000). This study was a collaborative investigation between young carers of veterans, their mother and the researcher. We collectively explored experiences, struggles and triumphs in the day to day lives of the young carers. We shared stories of our individual and collective experiences of human endeavour, motivation and human spirit. By doing so, a tapestry of the young carers’ life experiences evolved.

Collectively we examined and confirmed past and present life experiences, in order to provide meaning (McCormack 2000). Clandinin & Connelly (2000) speak of being in the midst of an experience as a necessity of narrative inquiry. Thus, retelling specific lived experiences was a way of making sense of the life journeys of young carers of a veteran with PTSD.

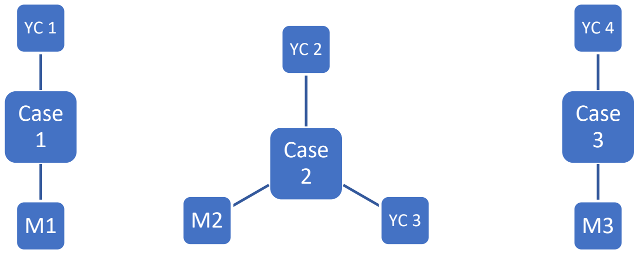
Within research there are three methods of gaining knowledge, there is deductive and inductive reasoning or a mixture of both. Deductive Reasoning is concerned with developing a hypothesis based on existing theory, and then designing a research strategy to test the hypothesis (Wilson 2014). Alternatively, Inductive Reasoning begins with observations, and theories are proposed towards the end of the research process as a result of those observations (Goddard and Melville 2004). One of the aims of this study was to recognise and articulate emotional responses, whilst understanding the complexity of a role change that was shifting from a child versus parent relationship to that of a young carer versus parent relationship. To do this a reflexive and lineal inductive approach to analysis was used to form meaning within the narrative data (Braun and Clarke 2006; Bernard 2017).

3.2.2 Case Study

As a research method, case study has been used in both qualitative and quantitative research (Yin 1994; Rowley 2002) to optimise understanding when perusing research questions, triangulating descriptions and interpretations continuously through a period of study (Stake 2008). Yin (1984) defined a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p.23). A case study can be any bound unit such as an individual, group, place, organisation or interaction (Casey and Houghton 2010). In this study each family unit was treated as a unique case study. For each case I conducted interviews with the young carer and with the parent who did not have PTSD. This enabled triangulation and allowed me to understand the dynamics more fully within the homes of the participants. I analysed the data from each case separately to enable me to understand individual home environments. I then looked for similarities and differences across the whole dataset. Using a case study approach allowed me to construct the collected narratives in the form of life history's ensuring individual stories were not lost (Creswell 2009). As Yin (1984) stated "the real business of case studies is particularisation, not generalisation…there is a uniqueness which we emphasise its meaning" (p.8).

The study included three case families including the young carer (YC) and their mother (M) as outlined in Figure 1 below:

Figure 2: The case families



3.2.3 Study sample: Young Carers and Mothers

Holloway & Wheeler, (2010) explain the defining principle of recruiting for a specific study is that all participants have experienced the phenomenon and are willing to share their experience with the researcher and potentially, the general public. It was acknowledged that young carers are a potentially vulnerable population, therefore, careful due consideration was given to sampling strategies such as snowball and convenience. These sampling strategies are useful when trying to recruit participants such as young carers, who are classed as vulnerable and hard to reach. A convenience sample is a non-probability sample which involves a group of participants who are easily accessible to the researcher (Lunneborg 2007). Snowballing using its simplest description, is recruiting by word of mouth (Sadler, Lee et al., 2010), which allows the development of trust, therefore, maximising recruitment from hard to reach and vulnerable populations such as young carers of veterans with PTSD.

Purposive sampling was used to recruit participants for this study due to wanting to study a specific group. Speziale, Streubert et al., (2011) state purposive sampling requires the researcher to identify the specific group of participants they want to study, who have first-hand lived experiences of the chosen research question, therein providing a representative viewpoint on that topic. Purposeful sampling is widely used in qualitative research for the identification and selection of information-rich participants relating to the phenomenon being investigated (Suri, 2011). This involves identifying and selecting individuals that are especially knowledgeable about the investigated phenomenon (Creswell, Klassen et al., 2011). To meet the aim of the study participants were required to meet the following criteria: they needed to be between the age of 11-18 and be providing a caring role for a veteran with PTSD. The inclusion criteria stipulated participants must be between the ages of 11 years and 18 years as it was felt young people over the age of 11 would be better able to articulate their experiences, about living with at least one parent who was a veteran with PTSD.

3.2.4 Recruitment

The sample was recruited from England, predominantly from the South-West and the North-West. These locations were used as they are areas known to have significant populations of veterans residing within them (Royal British Legion, 2014).

I used the connections I have within the military sector to identify and gain introductions to potential participants who met the inclusion criteria. I contacted Combat Stress, Ripple Pond and Combat Angels. Combat Stress are a military charity who support veterans with mental health issues. Ripple Pond are a peer support charity who provide peer support to family members of the veteran community who are struggling with mental health issues. Combat Angels are a group of spouses who offer peer support due to partner military related PTSD. These organisations were identified as appropriate organisations to support recruitment due to them already supporting veterans with mental health issues and their families throughout the UK.

These organisations advertised the study on my behalf using my recruitment posters (see appendix 1) and sharing this through their internal communication channels and social media. A total of six mothers contacted me via email to gain more information about the research. In all cases this was not the parent with PTSD. At this point I had a telephone discussion with the mother to establish whether the father held veteran status and had a diagnosis of PTSD.

It was anticipated that up to 10 young carers would be recruited. However, as Denzin (2011) highlight, having an estimation of participants required will allow for those who meet the criteria to (i) not reply, (ii) drop out after consent and (iii) change their minds to re-engage. Recruiting such a small number of participants is justified by Ellis (2011), who suggests, qualitative research requires time for participants to articulate their story and time for the researcher to be able to analyse the story and formulate its data.

Whilst the study aimed to recruit 10 young carers it became clear that this was going to be difficult due to the difficulties previously discussed with regards to young people identifying as being a young carer. As discussed previously, identifying young carers is extremely difficult due to the fact that they rarely acknowledge or consider that they are living in that role. It could be argued that they are a hidden population, and by the nature of being a young carer they do not realise they are actually providing a caring role. Initially eight young people made contact via their mothers, but two young people decided not to be part of the study and two did not return their consent documentation or reply to any email correspondence. After seven months I, therefore, only succeeded in recruiting 4 young carers between the age of 11 and 18 years, two males and two females from 3 families.

3.2.5 Study Sample: Mothers

I had not originally intended to include parents in the study. However, the number of young carers was lower than I had hoped and having already made contact with the mothers to obtain their permission to interview their child, I decided to include them in the study. Thus, my final sample included mothers of young carers of veterans with a PTSD as well as young carers themselves.

The purpose of interviewing the mothers was to understand how PTSD had affected the family unit, but to also understand in more detail their perceptions of how their child become a young carer for a parent with PTSD. This approach assisted with the triangulation of narrative data and supported fact checking. Interviewing mothers not only added to the narrative data in generating their own stories of the perception of being a mother of a young carer, but also helped map the context of their child/rens life history by providing dates, locations, number of moves, number of schools and how they perceived caring to take place within their home.

In addition, little is known about how mothers feel being a young carer of a veteran with PTSD impacts their child/ren. While there has been interest amongst academics on the impact that military PTSD has on a spouse (Ahmadi, Azampoor-Afshar et al., 2011; Buchanan, Kemppainen et al., 2011; Yambo, Johnson et al., 2016; McGaw, Reupert et al., 2020) or spouse carers (Cobos 2020; Shepherd-Banigan, Sherman et al., 2020; Waddell, Lawn et al., 2020), there is no recent literature regarding the perspectives of mothers whose child/ren care for a veteran with PTSD. Mothers' perspectives were, therefore, important in terms of contributing new knowledge about the issue under investigation.

3.2.6 Information

Participation was on an opt-in basis once full information about the study had been given to families. Each young carer received an information leaflet via their mother about the proposed study (Appendix 2). This was sent to the mother's email account. The participants' mothers also received an information leaflet via email (Appendix 3) clearly explaining the aims of the study and what participation would involve. The leaflet provided details of how to contact the researcher if participants had any additional questions. This information enabled the parent to understand the study and make an informed decision on whether they wanted their child/ren to take part. If the young person did not want to participate, then there was no further contact. Young people who did not want to participate either explained via their mother they did not want to take part, or they did not return their consent documentation.

When undertaking research with children, researchers must gain the co-operation of a multitude of gatekeepers; for example, parents, legal guardians and schools (Cree, Brooks et al., 2015). Gatekeepers are individuals who have the power or influence to grant or refuse access to the participant or research field (McFadyen and Rankin 2016). Within this study, the parent without PTSD, in all cases the mother, acted as gatekeeper. Gatekeepers are an essential part of the research process, presenting positives and negatives to the researcher. For example, a positive may be that they allow the participant to take part, they support and have responsibility to protect potential participants. The negative side of a gatekeeper would be if they deny access to potential participants, potentially limiting access to data (McFadyen and Rankin 2016). For example, Cocks (2006) argues that the use of parental consent, may exclude some children from various types of research. It is not known how many young people were prevented from taking part in this study because their mother's decided participation was not in their best interest.

Once I made the decision to include mothers in the study a second participatory information leaflet was sent to ascertain if they would also like to participate (Appendix 4).

3.2.7 Consent

Informed consent was sought from the mothers who contacted me. I wanted to gain consent from the parent/guardian without a mental health issue, due to potential issues with mental capacity and giving consent (2005). It was imperative to obtain written proof that informed consent had been obtained – the mother was required to sign and date the consent form before the young person could take part in the research if they were under 16 (Appendix 5). If the young person was over 16, in line with best practice, information was passed through their mother to disseminate the information and consent documentation.

Article 12 of the UNCRC (1989) stipulates that a child who is capable of forming their own views has rights to express those views freely in all matters which affect them. This means empowering children to consent to take part in research; freely, without coercion, threat or persuasion, even if a gatekeeper has provided consent. This acknowledges the child as both an expert in their own life and promotes autonomy. As such I also wanted to gain written consent from the child. In line with Northumbria University's ethical guidance, young carers were asked to sign their own consent forms, which were disseminated to parents' email accounts, signed and sent back via post or by email. (Appendix 5).

When including children in research, the researcher has a responsibility to ensure capacity. Capacity was assessed using the Gillick Competency Framework (1984), which is viewed as best practice for assessing capacity with children under the age of 16 years on matters concerning their health and well-being. It considers various levels of child development and cognitive abilities, to assess whether young people are able to make informed, conscious decisions about themselves. The Capacity guidelines were adhered to when assessing the young carers' abilities to understand what they were consenting to. Potential participants were required to articulate their understanding of the study and its purpose. Furthermore, the participants were asked if they understood who was carrying out the study and whether they understood they had a right to take part and withdraw at any time. At each contact point an assessment of the participant's capacity to understand the study was conducted to ascertain if they understood what was being asked of them and to establish, they still wanted to take part.

Importantly for full participation in this study the concept of ***'assent'*** was used as a sensitive and appropriate option for the study to be fully inclusive. Assent is regarded as an "affirmation to participate in research" and described as a "cooperative process between the child and the researcher's involving disclosure and discussion of the research" that "indicates that researchers respect children's rights and responsibilities in the research process" (Lindeke, Hauck et al., 2000). Using a child or young person's assent allows research to be carried out on issues that affect children, promoting an argument that the notion of 'assent' 'removes the reliance on the child, demonstrating adult-centric attributes such as maturity' (Cocks, 2006: p.257).

3.2.8 Confidentiality

All young carers and their mothers were, at every contact, given a verbal and written explanation of confidentiality and what this meant for them in the context of the research. However, due to ethical requirements and in view of safeguarding concerns, should a child disclose or allude that they or others were at risk of harm I understood that I had a responsibility and duty of care to share this with Children's Social Care or the Police. This clause of confidentiality was discussed prior to any data collection with participants and should the parent or child not have agreed then the interview would have been terminated and suitable support offered or the family signposted to appropriate agencies, for example, the child may have needed to be referred to the local children's safeguarding team. Additionally, I understood I had a duty of care to follow up on any referrals to maintain the safety of the participants, their families, myself and Northumbria University, in line with Northumbria University ethical guidelines, NMC (2015) guidelines and Child Protection guidance (2018).

3.2.9 Safeguarding the young carer

Due to the nature of this study, participants were likely to have an emotional response to the story they told. Additionally, they were asked to recount difficult or traumatic events in their life. I was mindful that the children and young people taking part in the research had been brought up in a military environment and their personal accounts might include experiences of how conflict and war affected them and their family. Participants debrief information was given after each interview (Appendix 6)

As a children's mental health professional and a qualified School Nurse (NMC pin - 13E1873E), who held a caseload of 1600 children in a Military Garrison, I have extensive experience of interviewing children and young people, about their lives at challenging times. I possess the appropriate skills needed to recognise when a child or young person was becoming distressed. However, I am acutely aware that whilst I have some basic CBT knowledge, ***I am not*** a trained therapist, and this was not my role within this research project. Nevertheless, this did not relinquish my responsibilities as a health professional to signpost the child or young person to appropriate help and support, if they or their families required this. Of note none of the participants required signposting for additional support (Appendix 7).

3.2.10 Safeguarding the mother

Due to the nature of this research and the information sought from the mothers, I was mindful of the potential emotional response from the mothers taking part in this research. When interviewing the mothers, I was mindful of the questions I asked, and aware that some of the questions, based on their narratives, would be difficult questions to ask, for example “how do you think caring has impacted on the emotional health of your child?”. Importantly, I was mindful these types of questions were potentially difficult to answer. If there was an emotional response from the mother, I took the time to be quiet for a short period of time, ask if they were okay, ask if they wanted to continue and importantly ask if they needed additional support from an external organisation (Appendix 7). Debrief information was given after each interview (Appendix 6)

3.2.11 Safeguarding the researcher

Prior to any face-to-face interviews taking place and to maintain the safety of the researcher, a risk assessment was completed in line with Northumbria University’s ‘lone working’ policy, in addition to a current dynamic risk assessment. This risk assessment was undertaken over the telephone with both the mother and the young person, prior to all interviews, to ascertain if there had been, or there was a likelihood of being any incidents which may put myself or the participant at harm. All the mothers and young people spoke to me when their partner or parent (father) was not in the family home. This approach was established by email prior to the call. Moreover, a ‘safe and well’ system was also put in place. The ‘safe and well’ system requires the researcher to provide their location and postcode; the length of time the interview is expected to take and contact telephone number to their supervisor, prior to any fieldwork taking place. Additionally, post interview, the researcher made telephone contact with their supervisor to acknowledge interviews had concluded and they were safe and well. Importantly, if the interview did run over the allocated time, a call was made to communicate what was happening, and a new finishing time was provided.

It was imperative to carry out the above protocol and vitally important for data protection, that the location of the interview was only to be shared with the supervisory team, who were ethically bound to maintain confidentiality (unless there was a serious incident), if confidentiality had to be broken for the safety of the researcher or the participants. At all times, I conducted myself in a professional manner in line with the expectations of Northumbria University and the NMC code of conduct.

3.2.12 Ethical Approval

Prior to conducting the research, the researcher considered the key ethical challenges within the study. Ethical documentation was required by Northumbria University's ethics committee, to enable me to carry out social research with young carers of veterans with mental health issues and their mothers. This written documentation explored the main ethical challenges when undertaking research with children and young people, whilst providing the necessary safeguards to protect the participant, the researcher and Northumbria University. Ethical approval was received in October 2017 and an ethical amendment submitted and approved in June 2018 to include mothers (Appendix 11).

3.2.13 Involving Young People within research.

Research where children and young people are involved and recognised as vital participants is a relatively new concept (Einarsdóttir, 2007). Historically, researchers conducted research *on* children and young people, for example, by observing and testing their developmental growth, both physically and psychologically. Now, conversely, researchers try to do research *with* children and young people, by seeking their opinions (Mayall, 2000). Previously, doubt was cast as to the competency of children and young people to express their opinions within a research setting (Einarsdóttir, 2007). However, qualitative research methodology and the introduction of more diverse methods to gather data have given researchers the opportunity to seek children's' perspectives. Using diverse methods of data collection from and by children and young people has revealed that children and young people are reliable informants, able to give valuable and informative information (Sheridan and Samuelsson 2001).

Freeman (1998) explains within his writings that the contemporary children's rights movement accentuates taking children's rights to express their own opinions and beliefs seriously. As outlined above, it is vital to recognise that children and young people have a right to participate in decisions affecting their lives and should be able to communicate their own views. Article

12 of the United Nations Convention on the Rights of the Child (UNCRC) states that “a child who is capable of forming his or her own view should have the right to express these views freely on all matters affecting the child, and those views should be given weight in accordance with age and maturity” (1989). However, continually reflecting on the ‘power imbalance’ in the process of research is both ethically and morally important when conducting research with children and young people (Smith, 2011).

As England (1994, p.82) states “research is a process and not a product”, therefore, throughout this process I remained reflexive in my approach to this study and mindful of whether the research presented the participants with disadvantages. For example, non-inclusion, based on fears the research may cause psychological harm and not forsaking the advantages of participatory research methods for the children and young people taking part, which have already been outlined. To meet the aims of this research it was vital for young people to share their narratives.

3.3 Collecting and Recording Young Carer and Mother Narratives

3.3.1 Textual data collection.

Face to face or skype interviews were deemed to be crucial to gain an understanding of the young carers’ lived experience as they navigated their lives. Interviews are conducted or negotiated between two or more people in an effort to gain an understanding of the how’s, where’s and what’s of people’s lives (Corbin, Strauss et al., 2014; Clandinin 2016). Collecting young carer’s stories was vital in making this study purposeful and meaningful. The word ‘collecting’, in the context of this research is used loosely. Clandinin and Connelly (2000) allude to the fact that the loose term of ‘collection’ refers to the manner in which narratives are developed, gathered and obtained from the field. Each young carer was interviewed twice, both interviews lasted between 60 and 90 minutes. Mothers were interviewed once, and the interviews lasted approximately 60 minutes.

When completing the interviews with young carers a life story approach was used. This approach enabled the participants to narrate their life from as far back as they could remember to the current time. This approach is supported by Fielding and Thomas (2008). Using a life story approach to interviewing appeared to enable the young carer to relax and begin the story of their life. The researcher-participant relationship was negotiated continually and reflexively during the entire interview process, to maintain awareness of the power balance when interviewing young people (Smith 2011). Moreover, this approach enabled the young carer to have what appeared to me to be a reciprocal and balanced relationship with myself as the researcher in the context of their environment.

"The tenants of symbolic interactionism are based on the belief that humans should be regarded in the context of their environment" (Benzies and Allen 2001, p.543)

3.3.2 Unstructured Interviews

As described above, my rationale for undertaking unstructured interviews gave me the ability to formulate some rough themes within the narrative scripts when I had finished the interview with the young carer and to prepare for future interviews, on concepts or themes which had emerged in light of the research question, supporting the growth of evolving theory or narrative data (Corbin, Strauss et al., 2014). This approach is supported by Corbin and Morse (2003) in their earlier work, which postulates that unstructured interviews (those not conducted according to a pre-structured interview guide) provide the richest source of data, for building theory. Using unstructured interviews, especially with children and young people, enabled the participants to take more control over the course of the interview, and in this study allowed young carers to negotiate the pace, order and length of the interview (Corbin, Strauss et al., 2014).

3.3.3 Anonymity

The Research Governance Framework for Health and Social Care (DoH 2005) states that 'protecting the integrity and confidentiality of…. data generated by the research, covers all health research conducted within any given location' (p.30), clearly highlighting the researcher's responsibility to respect confidentiality. It is made abundantly clear within this framework that confidentiality is of ethical importance, therefore, interviews were coded by number and no names were used to identify participants. Participants were identified throughout the research by their code or pseudonym and only the researcher had access to the code identifying the participant.

Following the Research Governance Framework enabled the researcher to reduce harm and minimise confidentiality breaches, allowing him to create and uphold safeguarding anonymity and confidentiality in the development of an open, transparent, and united relationship between the participant and the researcher (Farrimond, 2012).

Any audio clip used in dissemination will be checked for appropriateness to the required purpose. For example, if I used an audio clip at a conference that included significant military and or veteran groups, there is the potential that someone may recognise a participant’s voice. Should audio clip content be used, voices will be put through voice changing software. This was continually explained prior to all interviews.

Due to the nature of the research, it was deemed permissible to acknowledge where the participant’s parent/carer served in combat. This is not location specific i.e., Kabul, Kuwait, but was generalised i.e., Afghanistan, Iraq. Moreover, specific military units referred to by the participant have been referred to by type of unit, for example, combat unit, engineering, logistical.

3.3.4 Data Storage

To maintain participant anonymity, all audio data collected within this study, using audio equipment, were stored on a password protected device and downloaded to an external secure hard drive (Northumbria University U Drive) as soon as possible after recording had taken place.

The university’s cloud storage was chosen as the most appropriate storage method, as the service is managed centrally by the university IT department, and the system is regularly backed up. The data storage systems within the university are secure, therefore, minimising the risk of unauthorised usage, loss or theft of information, offering protection to the participant, the researcher and the university.

3.4 Data Analysis

3.4.1 Narrative Inquiry Analysis: Storying Stories

Using life stories as an approach provided a rich ground for the theoretical orientation of symbolic interactionism, as using this lens enabled me to reveal the constraining effects of structural relationships. Moreover, during the process of analysis I was mindful that this process met my ontological stance, that is, truth is subjective, numerous and created, and I was mindful of my own truth as a cultural insider. Additionally, the epistemological perspective of developing knowledge about young carers and their lives must be acquired by interacting with young carers. Therefore, the objective of this phase of the analysis was to turn the narrative data from the transcripts in to discourse composition within each of the three case studies. It was this discourse which drew together the mother's perceptions of life events leading up to and becoming a young carer of a veteran with PTSD. It was important to understand the effects that being a young carer of a veteran had on young carers day to day lives. Furthermore, it was important to understand if the experience of being a young carer or mother of a young carer altered individual's thoughts, feelings and emotions (Polkinghorne 1995; McCormack 2004).

3.4.2 Analytical Synthesis

While mapping out contemporary models of narrative analysis, Riesman (2005) in (Kelly, Horrocks et al., 2005) underlines the considerable variation in the definitions of narratives methods. Therefore, these methods are often shaped by the discipline of the researcher. Whilst it is possible to identify some models, according to Riesman, 'in practice, different approaches can be combined; they are not mutually exclusive and, as with all typologies, boundaries are fuzzy' (2005: p.2). In practice, using a combination of analytical methods is common amongst narrative researchers as this can be a tool to analyse the multiple aspects of data. Moreover, this approach aims to explore the multiple layers of meaning which are constructed and presented in the narratives. Importantly for this study various analytical models offered the exploration of linguistics, and contextual aspects of the young carers and mothers' narratives, creating an enriched multi-layered analysis. Drawing on the strengths of each analytical model is argued to make the findings grounded and as a result, they are more likely to be valid (Mello 2002).

Appropriate consideration was taken to choose the best way to present the participants' stories. The rationale for analytical synthesis, that is, using both a Narrative Inquiry and Thematic Analysis as a method of data analysis was chosen as its appropriateness between understanding the language used to analyse narrative content within-family; and to then widen the analytical process to understand content narratives between-families. Moreover, utilising thematic analysis enabled the development of shared moments being present in time, place and societal context. Using this mixed method of analysis also enabled qualitative data sets to be represented in a methodical and meaningful form (Narendorf, Munson et al., 2015) to systematically understand the emotions of what it is like to be a young person who, due to the effects of a parent returning from combat, becomes a young carer of a veteran with PTSD over a life course (Floersch, Longhofer et al., 2010).

3.4.3 The Narrative Inquiry within family

The narrative data were analysed within each of the three case studies in a five-phase process using a combination of McCormack (2000), McCormack (2000) (adjusted from Labov's, 1973 model) and the narrative works of Polkinghorne (1995); Riessman (1993) and Clandinin and Connelly (1994). Whilst the work of McCormack is fundamental to the field of narrative analysis, I also wanted to incorporate Clandinin and Connelly's (2000) three-dimensional model to assist me in the analytical process.

McCormack (2005) describes how she used Polkinghorne's (1998) distinction between narrative analysis and analysis of narratives and suggested locating a story in the data which encompasses Labov's model of the six components. It was through the work of McCormack that I was able to compose an interpretive story after each interview. It was these interpretive stories which where "nested" (p.13) within the young carers and their mothers' personal experiences, enabling "the process of storying stories" (p. 13) as outlined in Table 2 below.

Table 2: McCormack's (2000a, 2000b) Research Framework

Stage	Steps	Tasks
Construct an interpretive story (Stage 1)	Step 1. Compose the story middle	Re-connect with the conversation through listening. Locate the narrative in the transcript. Return enriched and constructed stories to participants for feedback. Form the first draft of interpretive story middle. List agreed titles Temporal ordering Add text of each story Redraft story middle. View the transcript through multiple lenses: language Context Moments Take into account the views highlighted through those lenses.
	Step 2. Complete the story – add a beginning and ending	Compose orientation and choose a title. Add coda Share stories with participants. Reflect on the story in the light of the participant's feedback. Compose epilogue.
Compose a personal experience narrative	Step 1. Construct a personal experience narrative	Temporally order the interpretive stories in a single document – forming personal narrative. Share the personal experience with the participants. Respond to comments.
	Step 2. Construct an epilogue to close the narrative.	Reflect on personal experience narrative in light of the research question. Add an epilogue to summarise these reflections and close the narrative.

McCormack's (2000, 2000b) Research Framework: Summary of the process of storying stories.

McCormack's (2002a, 2002b) work is supported by Clandinin & Connelly, (2000) who note, individuals cannot be understood only as individuals, and that their historic experiences and future experiences will contribute to that individual's life perspective, their truths and ultimately their subjective realities. Moreover, it is these realities which will enable the young carer to grow out of their experiences and therefore live in and with other future experiences. Therefore, this phase of narrative analysis drew upon Clandinin & Connelly's (2000) concepts of the human experience. That is, it sought to understand the lived experience of a young carer based on Clandinin and Connelly's (2000) three axes: Interaction, Continuity and Situation, which was developed from the works of Dewey (1989) as outlined in Table 3 below.

Table 3: 3D Analytical Framework

INTERACTIONS			CONTINUITY		SITUATION
PERSONAL	SOCIAL	PAST	PRESENT	FUTURE	PLACE/CONTEXT
Inner state of affairs; For example: Feelings, emotions	Interactions with others within the context of their environment.	Backward: remembering previous experiences, feelings and relationships	Now: Current experiences, feelings and relationships	Forward: Hopes for their future relationships	Context, time and place: Placing the lived experience within the concept of locality, its intention and purpose.

Clandinin & Connelly's 3D Analytical Framework (Clandinin and Connelly 2000)

Clandinin and Connelly (2000) argue that individual lives cannot be understood in silos, and that past experiences and future experiences within people's lives will ultimately contribute to their perspectives, their truths and their realities (McCormack 2004; Kim 2015). For example, one young carer explained that they had experienced their father's PTSD in such a way it scared them. This of course was a historic presentation. However, importantly, because this was a frequent presentation, when the house went quiet the young carer knew what the future could hold based on previous experiences and tried to act in such a way that they could avoid the presentation or prepare to confront the presentation.

3.4.4 The Narrative process: Interpreting Stories

For each interview I began the process of storying stories by constructing an interpretive story composed of a beginning, middle and an end.

Phase One: Transcription.

Composing a story middle

This first step was to compose the story middle (McCormack 2000a; McCormack 2000b). I began this step by immersing myself in the collected transcripts, and actively listened to what was being said several times. During this process I located the stories being told by the storyteller, whilst identifying argumentations, augmentations, theorizing and looking at description to enable me to construct additional stories.

Once completed, all stories were returned to each participant for comment. Once member checking was completed by each participant and returned, I noted any comments and made amendments, returning them back to the participant for further comment. At this point there were no additional comments. This process provided temporal ordering of the stories, which formed the first draft of the interpretive story middle. Once temporal order was completed, I reflected on, and redrafted the text according to comments, being mindful of the people within the conversation, the main events, the context of the event, my position with regards to the participant, and how I responded emotionally and intellectually to each participant.

When locating the narrative process, I was able to provide a description of how the storyteller constructs and gives meaning to their life. When locating the stories, as suggested by William Labov (1972) in (McCormack 2004) stories are constructed from the surrounding text from recognisable boundaries; a beginning (orientation – who, what, where and when) and an end (a coda -story ending). Included within the boundaries is an abstract, an evaluation and a series of linked events which are organised chronologically or thematically in response to the question, leading to the evaluation. It is the evaluation of the story which represents for the listener 'how they (the teller) want to be understood' (Riessman 1993).

Phase 2: Member Checking

It was at this point within the process that I returned my constructed stories of narratives to the participants asking them the following questions:

Does what I have written make sense?

How does this text compare to your experiences?

Do you want to remove any part of the text?

Out of the seven participants only Charlotte made any comments. They asked to change one part of their story as they said the timeline and some context was wrong. The other six participants did not reply.

Phase 3: Coding

From the feedback I was able to form a first draft of the story middle by listing the titles of the constructed stories which were agreed on by myself and the participants via NVivo and filed notes and this helped identify potential codes. From the participant profiles I created lists enabling me to construct titles for the stories, which enabled me to link to the plot. The plot of my stories configured around the thoughts, feelings, and behaviours of being a young carer of a veteran with PTSD.

Phase 4: Open Coding

This phase consisted of redrafting the interpretive story middle whilst continually reviewing the transcripts. However, in contrast to the previous phase of immersing myself in the narratives, I approached this phase with the use of lenses. These lenses consisted of language, context and moments (McCormack, 2004), as well as annotating ideas of symbolic interactionism and meaning.

Phase 5: Completing the interpretive story

I found completing the interpretive story quite a challenge due to my own experience of being a young carer of a veteran with PTSD, and how my own story started and ended. However, through reflexive writing within my research diary I was able to construct the participants beginning (the orientation) and an ending (a coda). I again sent my reconstructed interpretive story for review however I had no comments returned from the participants, which made the epilogue quite straight forward to write, as I had no external comments. Writing the epilogue concluded the construction of the participants' interpretive story over the period of two years (Appendix 10).

3.4.5 Positionality within the write up

The resulting narratives were written in the third person. By using this approach to narration, I was able to outline the thoughts and actions of the young carers and their mothers from the perspective of the narrator. The reason for not writing in the first person was to protect myself from my childhood experiences of being a young carer for a veteran. Moreover, the young carers and their mothers' stories are not reproductions of the exact spoken word, rather they are 'assemblages' which are comprised from a number of mediums; my observations and interpretation of the young carers and their mothers during the interviews, the data from the transcripts (written in first person) and the interactions between myself and the participants. Thus, the stories from start to finish were co-constructed.

3.4.6 Validity of the Transcribed Narratives

The narratives collected throughout the interview process consisted of a number of conversations, which were recorded on an electronic recording device. Within this study, I made the decision to include stutters and repetitive leading words to support the analytical process (Corbin, Strauss et al., 2014). With symbolic interactionism, textual analysis of meanings requires the implementation of a number of reading strategies, which examine how a text constitutes an individual as subject in a particular moment or site (Althusser 1971) and therefore it is imperative that clear understanding of the text is available. Clandinin and Connelly (1990) express the importance of re-telling the narrative to confirm its truth with individual participants. For example, prior to completion of each interview, together the participant and I reflected on their narratives, to ascertain whether the narrative data were correct, and to validate the participant's truth. By transcribing all of the narratives I was able to immerse myself within the data fully, thereby familiarising myself with the data. This enabled me to begin the process of identifying themes within the context of the psychological, behavioural and social aspects of being a young carer and loosely organising the data (Ritchie and Spencer 2002).

A number of participants were not able to remember specific dates, for example how many house moves they had had, which schools they went to at what age and when their veteran parent went to Afghanistan (first, second or third time) but mothers were able to clarify these important aspects of the young carers' life journeys. This process was completed with three of the young carers, prior to carrying out full interviews with their mother. By confirming these dates, I was able to start to systematically frame temporality, time and societal aspects of the interviews.

3.4.7 Bringing together the views highlighted by multiple lenses

The view from each lens represents a family who were working out how to live with combat related PTSD. Moreover, each lens highlighted the stark temporal change in child versus parent relationships due to presentation of combat related PTSD. I therefore needed to present a final draft of the collective stories, both visually and structurally to reflect this narrative. The interpreted stories did this by the following process:

- Alternating the free-flowing uninterrupted text of the families' short stories about their experience of living with PTSD enabled me to identify how PTSD had changed multiple relationships within the home and how this had affected them emotionally.
- Including two types of narrative process (stories and theorising). This process was different for each of the family members: Izzy's stories were short and concise, with very little theorising while Joseph provided more theorising than storytelling, and Pauline provided a balanced narrative of both storytelling and theorising.
- Alternating things each family member was certain about (for example, being a military connected family) to things each family member was not certain about (for example, how the day was going to be due to the presence of PTSD).

- Including wording ambiguity to highlight a frequency of words indicating uncertainty, such as “sometimes”, “erm”, “I don’t know”; theorising “I remember”, “I think” and reflective words like “we did”, “we used to”.
- Including pauses, silences and hesitations.
- Acknowledging the interaction between the family as story tellers and myself as listener and researcher. Acknowledging the interactions between the storyteller and the listener, enables the reader to understand the interchange of conversation by including long stretches of our collective dialogue to highlight the complexity of describing living with combat related PTSD and trying to understand the told story.
- Using a title which presented each family member’s storied story in their own words, highlighting their uncertainty of living with PTSD and how it affected their emotional health.

In summary, one lens alone would not have been sufficient in helping me interpret the families’ interview transcripts. The fact that I could look from different perspectives, using multiple lenses and bring together what I saw from each, allowed me to construct an interpretive story of living with PTSD, its effects on the young carer’s activities of daily living and how caring affected them emotionally. Multiple lenses enabled me to see more of each participant’s experience and piece together their collective experiences. By doing so it allowed the family’s experiences to choose the form of presentation (visual and structural). Following), McCormack’s (2000) narrative analytical process enabled the reader to hear more of the participants’ voices, as well as multiple voices, which would not have been possible through thematic analysis of their interview transcripts.

In re-presenting the lived experience of Joseph, Izzy and Pauline I have tried to produce a rigorous interpretive story rather than a casual story to attempt to unravel the complex way symbolic meaning affects the participants’ thoughts, feelings, and emotions. By adding the context of the presentation of PTSD and providing care we arrive at the lived experience. This understanding of lived experience is both rigorous and imaginative based on systematic analysis of our conversation, and on expressive insight.

3.4.8 Thematic Analysis Across Families

Thematic analysis was also used to assist the researcher to make sense of qualitative data by identifying, reporting and analysing the data to investigate meanings presented by the participating young carers with regards to their situation and life course events (Braun and Clarke 2006). Thematic analysis is a method for identifying, analysing and reporting patterns or themes. A theme within Thematic analysis is a '…patterned response or meaning within the data set' (Braun and Clarke 2006). Similarly, Riessman's (2008) model of thematic analysis focuses on the content of the analysis: 'what' is said more than how it is said, the 'told' story rather than the aspects of 'telling' (p.54). The content of the story is at the centre of thematic analysis within narrative inquiry. Esin (2011) notes, there is minimal attention to structures selected by the narrator when telling their story, its function, or contextual details of the story. Therefore, this thematic modelling can be used in a wide range of narrative text. Like Riessman (2008), Braun & Clarke's (2006) model of thematic analysis looks for patterns and meaning which have been produced in the data, labelling and grouping them in connection with the theoretical framework of the study, in this case symbolic interactionism.

This study employed Braun and Clarke's (2019) thematic narrative approach to examine the stories between-families to understand the shared life events, whilst also looking at elements within the life event. The early works of Braun and Clarke (2006) present a structured approach to performing thematic analysis based on a systematic and methodical system. This system had a six step process to carrying out thematic analysis:

- Familiarize yourself with your data.
- Assign preliminary codes to your data in order to describe the content.
- Search for patterns or themes in your codes across the different interviews.
- Review themes.
- Define and name themes.
- Produce your report.

Braun and Clarke's (2006) structured approach to data analysis appeared to me like Polkinghorn's (1995) descriptive approach to narrative analysis in that it appeared to lack a reflexive approach to analysing narrative data based on the lived experience of the young carers, their mothers and my position as a researcher but also as a ‘cultural insider’. This had the potential of guiding the analysis of the data in a less than balanced approach. Importantly, Braun and Clark’s (2019) model is about meaning and meaning making, and viewed as always being context-bound, positioned and situated within the ‘telling’ of the story. Moreover, Braun and Clarke (2019) also reflected on this structured method of thematic analysis and revisited their work and produced a more reflexive approach to thematic analysis. This reflexive approach allows the researcher to move freely between stages depending on their positionality within the research process.

The importance of reflexivity and optionality when answering the question of this study, was to recognise and articulate the emotional response whilst understanding the complexity of role change or shifting from a child versus parent relationship to that of young carer versus parent relationship. To do this I have to be reflexive and lineal in my approach to thematic analysis (Braun and Clarke, 2019). Therefore, I took an approach which was both deductive, that is to find nodes such as emotions, feelings, connectedness and change indicators within the presentation of thoughts, feelings and behaviours. However, and importantly, I also remained open minded to new information and formed meaning, which came from within the data, therefore I was also being inductive (Braun and Clarke, 2019). As Braun and Clarke (2019) note, their approach is sometimes presented as involving a rigid, linear series of stages. However, using a reflexive approach allowed me to be semantic, that is to highlight specific markers, for example, anxiety, but to also be latent, that is to understand or interpret what anxiety meant in the context of temporality (what was going on in a specific time and space), whilst also being mindful of the environmental factors linking to symbolic interactionism and ‘place’. Furthermore, adding depth to the theory of symbolic interactionism being mindful of engaging in societal aspects, that is, to understand and explore, who else is involved in this feeling of anxiety, if anyone. Therefore, I felt it imperative to begin data analysis from a deductive standpoint, with some semi-established characteristics or codes, for example: emotions, connectivity, and feelings to enable the research aims to be met, but to also be inductive, to introduce content and continually reflect on the content’s purpose and its worth.

With the fore mentioned, and in line with investing the emotional response of being a young carer of a veteran with PTSD and being a mental health nurse, I broke the initial narrative data into the emotional response pre and post the presentation of PTSD. Utilising this approach to data management and analysis helped develop sematic markers, which then supported latent contextual analysis to develop depth to understanding the complexities, the interplay of how relationships had changed and continued to change, within the dynamics of the whole family, and within the young carer and parent dyad.

3.5 Rigor

According to Corbin, Strauss et al., (2014) rigor is what makes research useful and successful, preventing the research becoming something of fiction. Within research validity and trustworthiness are the criteria with which rigor and credibility are measured. Importantly, however it is important to note validity and trustworthiness are used to measure quality, usually associated with quantitative research methodologies. Ritchie, Lewis et al., (2013) argues that reliability within qualitative research methods is concerned with uniformity across qualitative methods. However, this notion appears to be an unsuitable measure of quality within narrative inquiry, due to the pluralistic nature of narrative methodology (Clandinin and Connelly, 2006). As Mishler (2006) argues, the hallmark of narrative epistemology is multiplicity, noting that whilst diversity is not a bad thing, it poses challenges to the conventional notion of reliability. The reliability of qualitative research lies in the researcher's transparency in recording the processes they used at each stage of the study. Within this study, I have clearly documented the procedures I used in the research design stage, the recruitment stage, how I collected and analysed the data, how I interpretated the data and how I storied the stories of the participants. This does not negate the fact that another researcher could complete this study in the same way and come up with different findings.

Dependability is concerned with making sure the study in question is clear about how the conclusions are made so that others can see how the researcher has come to their conclusion (Creswell, 2009). As Creswell, Klassen et al., (2011) note an "external audit", the process of having a researcher who is not part of the study, critically explore the process and the outcomes of the study, as a method of confirming the study's dependability, is helpful. For the purpose of this study two independent observers examined my decision making and my findings: my supervisor and my second supervisor.

Credibility is concerned with my confidence in the 'truth' of the findings within this study and establishing whether the results of the study are plausible from the participants' perspectives. To ensure this study had 'credibility', member checking was offered to each of the participants, however, only one returned any feedback on their 'storied story'.

3.6 Reflections on the Methodology

> *"story makes the implicit explicit, the hidden seen, the unformed formed and the confusing clear" (Chou, Tu* et al., *2013, p.59)*

At the level of lived experiences, a central problem is the examination of how interacting individuals connect their lives to those ideological texts and make sense of their experiences in terms of texts' meaning (Denzin, 2008). I have had first-hand experience of this when trying to understand the content of my life when working through many issues regarding my childhood. As a distinctly qualitative approach to social research, interactionism attempts to make the world of lived experience directly accessible. Lived experiences according to Denzin (1989), are 'epiphanies', which radically alter and shape the meanings in which people assign themselves and their life projects. This is a pertinent point when capturing the lived experience of young carers of veterans with PTSD, as it is important to allow their narratives to shape the meaning of their life in the context of providing care for their parent.

These epiphanic moments leave a mark on a person's life. There are four forms of epiphany: a *Major upheaval*, which changes a life for ever (for example, a parent is diagnosed with combat related PTSD); the *cumulative*, referring to the final build-up of a crisis in a young carer's life (for example, witnessing a parent's mental breakdown); the *illuminative,* where the underlying existential structures of a relationship or situation are revealed (for example, a parent is emotionally unavailable) and the *relived moment*, where the person, after the event, comes to define it in consequential terms (for example a young carer gradually understands the presentation of the parent) (Denzin, 2008). A symbolic interactional study attempts to capture these moments, to give meaning to the narratives. Such a strategy presents three levels of cultural analysis: the contextual text, its meaning, and its connections to lived experience. Therefore, for young carers of veterans with a mental health issue, their narrative, with the use of symbolic interactionism, provided a useful method for exploring how they made sense of their everyday lives, how they made sense of the trauma of their parent's mental health issue and therein what effect this had on their own emotional health and wellbeing and how it affected the activities of daily living. Importantly, by defining the label or symbolic meaning of being a young carer, within symbolic interactionism traditions, the goal was to give understanding to the complex world of the lived experience of being a young carer of a veteran with mental health issues and unveil *'an insider's view on their reality'* (Given 2008). This statement is particularly fitting within the epistemology of this study, with its overarching aim being to understand the meaning of what it is like to care for a veteran parent with PTSD, and how young carers and their mothers themselves define their personal situation and experiences.

Emic epistemology *'an insider's view of reality'* (Given, 2008) is one of the principal concepts which guided this qualitative research. An emic perspective is fundamental to understanding how young carers of veterans with PTSD perceive the world around them. Moreover, adopting an emic perspective allowed for multiple realities and variations of knowledge, resulting in numerous interpretations of the lived experience which exist within a specific culture of the veteran community, and importantly, is determined by local custom, meaning and belief, which is best described by being a 'native' of the culture (Connelly and Clandinin, 1990).

In summary by using Narrative Inquiry (Connelly and Clandinin 1990; Polkinghorne 1995; McCormack 2000; McCormack 2000; Kim 2015) and its multiple lenses of language, context and moments (McCormack, 2004), and underpinning this research through the theoretical lens of Symbolic Interactionism (Blumer 1962; Dewey 1989; Denzin 2008) I have been able to explore the world of a young carer of a veteran with PTSD at a micro level; I have also been able to obtain the perspectives of their mothers. The use of narratives and its analysis allowed me to understand how young carers see themselves, and how their mothers perceive caring impacted on their child/ren. I was therefore able to obtain a holistic picture of young carers lives from within themselves (I), their primary group (family) and their reference group (community, civilian and/or military) (Blumer, 1962; Dewey, 1989; Denzin, 2008).

The completion of McCormack's (2000a, b) analytical process was characterised by the search for life events and the implications these life events had on the young carers' emotional health. The introduction of Braun and Clarke's (2019) thematic model enabled the captured narratives to look between-families in the search for common moments within life events and, to understand how these life events and the elements of the life event helped shaped their life story. The analytical process led to understanding of the participant's thoughts, feelings and subsequent behaviours, and how these life events were being storied. This section of the inquiry process allowed me to develop an understanding of the lived experience of young carers from their own and their mothers' perspectives, to intentionally "story stories" (McCormack, 2004) and therefore answer the research question - how caring for a veteran parent with PTSD effects the emotional response of a young carer.

3.7 Reflections on the ethics of this study

Throughout this study, a number of ethical issues relating to the participants' safety, my safety as the researcher arose. Some of the ethical issues which arose within this study included ammonising the participants and their narrative data. Being a closed community some of the narratives included regiments and locations, especially when discussing the number of moves the participant undertook, and the specific combat zones fathers fought in. I had to make the decision not to include towns named by the participants and only to refer to the combat zone as Afghanistan.

3.8 Reflexivity

Besides the above, as the researcher within this study I continually reflected on the process I used and adapted or changed my processes if they were not beneficial to the participants, the study aims or myself as a researcher. With regards to interviewing I found young carers, required a number of prompts when I began the interview. However, when I asked them to tell me about their life from as far back as they could, the conversation began to flow. It was important to allow young carers to narrate their life story. It was clear from the outset that this type of questioning would generate narrative data which would not answer my research questions, however, by using open interviews the narrative data offered temporality, which provided evidence of a change in relationship between fathers and young people. I was also mindful of my experience of being a young carer of a veteran with PTSD and tried not to seek answers based on my experience, although I did at times share moments of my life where there was synergy. Due to this I did attempt to continually check back to ensure authenticity.

I was the only researcher in this study; therefore, reflexivity was essential. I was open and honest throughout with regards to my values, morals, and assumptions and about my various experiences as a young carer of a veteran with PTSD, a military veteran, a children's mental health nurse, school nurse and lecturer at Northumbria University. Moreover, I was clear about my ontological and epistemological position, and how my knowledge and perceptions could influence the findings of this study, due to being a cultural insider.

4 Chapter 4: Constructing an Interpretive Story 'within-family'.

In chapter 3, I outlined the methods I used to analyse the data through multiple lenses. In this chapter I present interpretive stories for each of the 3 case families. This involved analysing the data through each lens and writing an interpretive story by bringing together the individual stories that each participant told into a single case story. I introduce each case by highlighting the use of story titles to demonstrate the outline of each family's story. The story plot is then developed using the lenses of language, context, moments, and symbolic interactionism. Finally, I demonstrate the completion of the story by presenting the orientation and coda, alongside the title choice. Using Denzin's (1989) epiphany stages enabled me to understand how the participants had become young carers of veterans with PTSD. It was only after following McCormack's (2000a; 2000b) analytical process and viewing the data through the lenses of language, context, moments and symbolic interactionism that I was able to locate the story within each case study and understand each participant's story within it.

Using each case's full data set (figure 2) enabled me to illustrate the process of conducting and developing an interpretive story within a household. All the cases within this study provided a significant moment in my thinking about how I would analyse and interpret the data. When reading each case for the first time I was initially confused as to how I was going to answer my original research question. I had a lot of narrative data which I knew would not answer the central question of this study, but I knew it was vital in terms of understanding where each member of the family sat within their home environment.

The lens of language requires the researcher to ask what features of the language of the data impact its interpretation. Three language features are considered at this stage: what is said, how it is said, and what remains unsaid. The lenses of context the researcher was interested in were the context of culture and the context of the situation. The lens of moments was signified by key words or phrases, descriptions of events or stories, or other forms of discourse. Finally, the lens of symbolic interaction sought to understand how the participants interacted with their primary (family) and reference groups (community), and how this interaction created meaning. Moreover, through this process I was also able to collate the participants' collective stories and identify their role transformation to becoming a young carer, as well as understand the emotional affects that this had on them.

4.1.1 Introduction to the Young Carers

To protect the participant's confidentiality and to remove the label of VYC 1, 2, 3 and 4, pseudonyms were used for all of the participants. The names of their parents and other family members have also been changed to prevent identification. The chosen pseudonyms for each young carer are Charlotte, Joseph, Izzy and Thomas. The pseudonyms for the young carer's mothers are Sandra (Charlotte), Pauline (Joseph and Izzy) and Cindy (Thomas). All the young people were initially interviewed separately. However, Izzy and Joseph were joined by their mother in their second interview. Further detail about this are discussed in the findings chapter 7.

Charlotte:

Charlotte is a 14-year-old young lady, who lives with her mother Sandra and two siblings in the North West of England. Charlotte is currently in school preparing for her GCSE's and really enjoys being at school. Charlotte's goal is to work in the theatre or become an actress as she is full of life, enthusiasm and enjoys performing.

Since being a young child Charlotte has played an active part in her family and has really close connections with her mother and her grandma, whilst also living within close proximity to a number of members of her extended family. This family closeness is evident within the narratives presented later within this chapter, for example, where she discusses the number of trips to the football to watch her local team and trips to Spain with her close family.

Unlike the other participants within this research, Charlotte was not born into the military community and did not grow up within the context of the military environment. Charlotte's mother began dating a veteran when Charlotte was 12 years old, and she gradually became part of a veteran family over a number of years. Prior to the presentation of mental health from her veteran stepfather, Charlotte did take care of her siblings and her mother, who presented with continuing back issues. Therefore, she provided some caring responsibilities prior to supporting her stepfather.

Joseph:

Joseph is a 15-year-old young man, who lives with his mother Pauline, father and sister Izzy (who was also included in the research) in the South West of England. Joseph is currently in school, which he at times enjoys and is preparing to take his GCSE’s in the hope he has the grades to work in horticulture, however, he stated that if he didn’t then he would join the Armed Forces, and follow in his father’s footsteps. Like a number of teenagers Joseph spends a lot of his time on his computer playing and interacting with his close friends. Joseph enjoys the outdoors and spending time with his family, but really enjoys time with his father in the woods or riding their bikes. When he can, Joseph often goes in to work with his father highlighting the closeness of their relationship.

Joseph was born into the military community and has spent a number of years living within a close military community on the ‘patch’ and has been educated within the local schools which are close to the family’s postings, where the majority of students attending have also been from a military family. Since the age of 2 , Joseph has had several moves throughout the South-West of England. These moves have all been in close proximity within the South-West of England, but over the years, Joseph has accumulated thirteen moves. These moves include moving schools six times, and therefore, having to leave friends and make new friends. Joseph’s father has been on a number of training details and has been on an active combat operation in Afghanistan three times throughout Joseph’s lifetime.

Izzy:

Izzy is a 12-year-old young lady who lives with her mother Pauline, father and brother Joseph in the South West of England. Izzy attends school, which she really enjoys and is thriving. During school Izzy likes to socialise with her friends and spends time outside of school with them. Izzy is not sure what she wants to do when she is older, but stated she has time to think about it. Izzy has a great sense of humour and is very level headed, tactile and states she can be quite shy with those she does not know , but when she does get to know a person, she really does make a good friend and likes to spend time with them. Izzy also likes to spend time as a family and her family are important to her, which is articulated later within her narratives. Her favourite thing to do with her family is having film nights, where the family get together on the sofa, get lots of sweets and popcorn and snuggle up together.

Izzy, like her brother, was born into the military community and spent a number of years living on the ‘patch’, where she also attended local schools with a high proportion of other military children and young people. Izzy has also spent her young years moving and has moved eleven times within her life course and attended four different schools. Izzy explained she loved living on the 'patch' as it made it easy to make new friends who understand what it is like to have a parent go away a lot. Izzy's father has been on a number of training details and has been on an active combat operation in Afghanistan twice throughout Izzy's lifetime.

Thomas:

Thomas is a 15-year old young man, who lives with his mother Cindy, stepfather and two younger brothers. Thomas lives in the South West of England. Thomas attends secondary school, where he is currently preparing for his GCSE's. Thomas was not born into a military family, but his mother began a relationship with a serviceman when Thomas was six years old. Prior to moving into the military community, Thomas lived with his mother and father in the South of England until their separation. Prior to marrying into the military, Thomas moved a total of five times due to his mother's job and needing support by family members to look after Thomas. After moving to the South West of England, Thomas's mother entered into a relationship with a serviceman and then married, moving on to the 'patch'. Thomas recounted that he enjoyed being part of the military community growing up as he was able to make friends with other children who were in the same situation as him, that is, a parent being away for a period of time every few months. Moreover, Thomas enjoyed the camp family days, where he would spend time with his family playing in military vehicles and having BBQ's.

Growing up in a military community was a positive experience for Thomas and he stated that he loved the military community vibe and the closeness of his stepfather, who he would spend a lot of time with playing outdoors. Thomas, like many of his peers, moved a total of four times due to his stepfather being posted to different regiments. Thomas's stepfather conducted several training operations and was away for long periods of time. Moreover, Thomas's stepfather, completed three tours of Afghanistan over a period of three years. Two of these operational tours were prior to Thomas knowing his stepfather.

4.2 Narrative Process

As part of the narrative process, I immersed myself back in the transcripts to locate the different narrative processes used by the participant: stories, descriptions, argumentations, and theorising. The narrative process also encompassed looking at the narrative data through the aforementioned lenses to interpret the stories. I began by listening to the story's titles. The story's titles offer a summary of each story's evaluation, offering a point within the story and providing the reason the story was being told (Riessman 1993; McCormack 2000). As McCormack (2000) notes, stories are self-contained, therefore, we do not have to interpret them as the teller has done this via the evaluation of the evaluation process. Moreover, temporal ordering of the titles provides the journey of the narrator. Therefore, continual development of the storied stories as drafts occurs as the researcher looks at the stories of the participants when using the other lenses for analysis.

4.3 Case One: Charlotte and Cindy

4.3.1 Constructing Interpretive stories:

List of Charlotte’s Storied Titles:

He just left [Army] not telling anyone.
I have to look after him.
More arguments, more shouting.
There is no way of escaping.
Rehab is not going to help.
We’ve had a fair share of drama.

List of Cindy’s Storied Titles:

The competition.

Better and worse times.

She saw more things.

Not a young carer as such.

When analysing this family in comparison to the other families the length of the stories told was significantly more, but the stories highlighted a level of disharmony between family members, as the stories did not always match, and perspectives were altered due in part to the position in which the storyteller experienced each episode. Moreover, this family, more than the other families, had a somewhat distorted temporal journey in retelling their story. The distortion of temporality made it difficult to plot the ‘life narratives’ to explore the lived experience of being a young person who provides a caring role for a veteran with PTSD. This distortion in part was due to Charlotte already providing care for her siblings and at times for her stepfather. However, it was also due to her not being brought up within the military environment which meant I did not have the pre-during and post Afghanistan context to help get an appreciation of the military context of her life. When I looked at the structure of the stories within this case, the stories told about living with PTSD and its effects on the young person, who was already providing caring responsibilities to her siblings, were long and filled with emotion, anger, fear, and compassion.

Like the other families within this study, this case offered a different perspective of living with PTSD. When breaking down the individual stories, both Charlotte's and Cindy's stories provide a breadth of narrative, which offered greater theorising and augmentation and again were filled with emotion. Charlottes stories offered a breadth and depth of detail not offered by her mother regarding providing care for her stepfather. The depth of theorising Charlotte provided on the context of her life enabled me to construct multiple stories. Cindy's accounts were dominated by theorising and augmentation. I suspect this was due to being asked specific questions and the need to reflect on the care Charlotte provided within the family home, and the effects this was having on Charlotte's emotional health and well-being, and the discourse between Charlotte and Cindy regarding the relationship with Charlotte's stepfather. To understand the discourse between both Charlotte and her mother and to explore its meaning, as with all the cases within this study, McCormack's (2000a, 2000b) multiple lenses were used.

4.3.2 Lens of Language:

Looking through the lens of language within this case I was able to assess features of the language used by the participants. Moreover, the assessment of language allowed me to note how words shaped and impacted the stories told within this case. By assessing this case I was able to consider what was said, how it was said and what the potential meaning of the language used was telling me as the story listener. As within the other cases the analysis of language highlighted word groupings, or phrases which indicated a relationship of self and? society. Additionally, I analysed the frequency of words, words which assumed a common understanding and words which gave opportunity for thought and importantly, words which would answer the research question.

Charlotte

The language used by each family member reflected their told story, each offering a different perspective and use of language when describing moments in time. When analysing Charlotte’s transcripts, she was articulate, reflective, and provided depth when sharing her life story. When reflecting Charlotte would use words like ‘well…’ I think’ and ‘it was’. Charlotte was quick when answering my questions on specifics, as if she knew what the question was going to be, especially when she used the word ‘well’ as this word was often followed by a short pause. The use of ‘well’ also had a distinct tone to it, as if she was making a statement or a point to make sure the listener was taking note of the start of something interesting about the situation and actively listening. There were moments within the interviews when Charlotte took her time to answer and used the words ‘let me think’ as if she was theorising on developing an answer due to sensitivity or recall of memory.

When describing care provision for her stepfather, Charlotte seemed to have taken on a parenting role and appeared to take pride in this responsibility, listing the tasks she undertook. However, there was a tone of resentment within her voice, especially when she used the word ‘I had to’ or ‘I have to’ when listing these specific tasks. The use of this language created a picture of her being the only person in the house to support her stepfather. Analysis of the data suggested that Charlotte did have some resentment towards her stepfather and his symptoms of PTSD due to the way it was breaking up the family dynamic. This was evident within the language Charlotte used in the constructed stories.

In Charlotte’s first storied title ‘He just left [Army] not telling anyone’ Charlotte shared the narrative of the build up to living with the presentation of PTSD. In this story the use of ‘I am unsure’, ‘I have been told’ and ‘I think’ were terms used to piece stories of her stepfather’s past together from the perspective of others. However, Charlotte was witness to the accumulation of the stories told by others and described the presentation of her stepfather. She said, “he gets stressed” and “he hadn’t had… [a smoke or a drink]” stating, “he’s an alcoholic and uses cannabis to self-medicate”. Charlotte was describing a common presentation of those with PTSD and the use of substance to self-medicate. Describing this episode Charlotte was empathetic and understood the reasons why her stepfather used substances to ease his memories of his friend being shot; but she was also angry as this presentation led to the escalation of disharmony within the family home and at times the severe presentation of aggression.

Charlotte spoke in the past tense, as if the story of her and her stepfather's life had changed. Charlotte used words like 'we would' and 'as a family' when describing the first six months of her relationship with her stepfather. Interestingly, due to the intermittent presentation of PTSD the language of connectivity changed over time and Charlotte moved to using words which demonstrated separation. For example, Charlotte went from using 'we would' to 'he would' and 'I would'. This was apparent within Charlotte's second storied title, 'More arguments, more shouting'. Charlotte removed the connectedness she had between herself and her stepfather by repeatedly using the words 'him' and 'he' which I have interpreted as separating her stepfather from her family unit. In the build up to an aggressive episode, Charlotte described her stepfather's presentation stating "'his eyes would focus", "his body would tense" and then "he would explode". Charlotte was describing some of the presenting symptoms of the fight or flight response accustomed to PTSD.

It was during this story that Charlotte appeared to be reflecting on the situation. This reflection was physically evident during the interview, and it was apparent Charlotte was able to identify the start of her poor emotional health using "it" to describe domestic abuse within the family home. The use of 'it' to describe domestic abuse within the family home was used more than any other word as Charlotte described the first six months of the new relationship between her mother and her stepfather. Interestingly, Charlotte was explaining domestic abuse without actually saying domestic abuse. Using 'it', to label domestic abuse, enabled Charlotte to describe the change within the home environment and that of her relationship with her stepfather. During this narrative episode Charlotte indicated she was upset and fearful about 'it' and how 'it' would present. For example, Charlotte stated "when 'it' was happening, I would sit there [in my room], I would cry…I didn't know what to do". From this extract alone, I could see that although Charlotte undertook a perceived parenting role within the family home, when under extreme stress and fear she wanted to be parented, protected, and cared for.

Cindy on Charlotte

The language Cindy used during the interview suggests that she was working out how the dynamics of her relationship with Charlotte's stepfather had impacted on the family. Moreover, Cindy was also trying to work out how her relationship with Charlotte had affected Charlotte. In addition, Cindy understood the role Charlotte undertook whilst supporting her siblings but was unable to identify with purpose Charlotte's role in supporting her stepfather due to the strain on their relationship. Cindy, was reflective, pausing at times after a question had been asked, but was also distracted due to one of her children needing attention at different times. This distraction at times caused Cindy to miss parts of her story out, saying “where were we?” and I would have to recap.

Cindy used positive descriptive words to affirm Charlotte’s early childhood and her relationship with her family and school. Cindy used the words ‘confident’, ‘outgoing’ when describing Charlotte as a child. As Charlotte grew into a teenager, Cindy explained Charlotte was a person who would ‘just do enough’, stating, “*She would rather not try so then it is almost not her fault. She can blame not having worked enough rather than just not being good enough at it”.* Cindy claimed Charlotte had the ability to do more but would just do what was needed. It is this description of Charlotte by Cindy that demonstrates Cindy could still see Charlotte’s ability to achieve more. However, within this extract there is a perceived notion that Charlotte did not believe in herself or have the confidence Cindy previously spoke of. The lack of confidence was not something I picked up on within the interviews I conducted with Charlotte when discussing her life narrative. Cindy provided a potential explanation for the loss of confidence within school suggesting it was in part due to the death of Charlotte’s nan. She also suggested the poor relationship with her biological father changed Charlotte’s emotional presentation and she changed as a young person.

4.3.3 Lens of Context:

As described in the data analysis section of this study, which was presented in Chapter 3, the lens of situational context refers to the participant being a young carer of a veteran with PTSD. Within the analysis process I wanted to think about both our personal context and our interactional context at two moments in time, at our first interview, and at the second interview. Within these two interviews I wanted to analyse our conversations and understand the revealed moments within the annotations of the analysed text, which helped to further clarify what was happening.

When reading my notes and supporting them with the annotations I made during the analytical process of Charlottes narratives, I noted that Charlotte had said she responded to my advert because she wanted to share her story of being a young carer of a veteran with PTSD. The most telling note was that Charlotte said she really wanted to help others who may be in the same situation by sharing her personal experience of providing care. Charlotte stated that she did not really see her stepfather as a veteran as she had not been part of the military community and knew nothing about the military until her stepfather became part of the family. This implied the term veteran was indeed a topic she had not thought much about before replying to my advert.

When looking through Charlotte's data I was able to extract that she was able to articulate her responses well with both depth and breadth, and with some reflective certainty. However, of note, Charlotte did not ask many questions regarding what I was asking her, she only answered what was asked. Moreover, with regards to her stepfather's military career Charlotte was very unsure of his service, his time spent in the military and what life was like for him. Charlotte did, however, no one episode of military life her stepfather was exposed to, which as Charlotte explained goes some way towards identifying a causal effect of PTSD.

Thinking it through without resolution

> *Paul: Was he [stepfather] still in the Army?*
>
> *Charlotte: Erm no…he went in when he was 16 and came out…* (not sure) *he just left not telling anyone. I don't know what happened, but I have been told that he saw his best mate get shot and that like really affected him obviously.*
>
> *Paul: Do you know where that was?*
>
> *Charlotte: erm no I am not sure, I didn't get told…yeah so, I think that was the thing that broke him really. I think he started drinking out of the Army and just carried on and carried on until a few months ago.*

The above extracts highlight Charlotte's limitation of knowledge regarding military life or at least her stepfather's military life. Moreover, to understand Charlottes thoughts from the above extract, I had to ascertain what her data was saying and importantly not saying to identify the emerging cultural concepts of her narratives.

Sure, of her position - The role of protector.

> *Charlotte: So, I have to look after the boys…it's likes his [Stepfather] behaviour…. you just never know!*
>
> *Paul: what is it about his behaviour?*
>
> *Charlotte: I was always constantly worried whether mum would be ok, weather she's going to be able to look after the boys. Whether he [stepfather] was going to do something or come back drunk or off his head or something. I would have to take the boys with me.*
>
> *Paul: Where would you take the boys?*
>
> *Charlotte: I would take the boys up to my room. I had a desk in my room, and we would put a chair under the door. My bedroom's over the living room. So, we would just sit on the floor and hear them screaming, hear mum crying, hear him screaming at her calling her names, everything…we just sit there, the boys would cry, and I would cry it was just like…I don't know what to do.*

From Charlotte's text there is a sense of taking on the role of protector with regards to keeping her siblings safe from a volatile environment, which was evidently affecting her own emotional health and well-being *"I have to carry on, but I can't cope with this. I don't want my life to be like this anymore, I don't want to…".* The above extracts support Qasir, Hassan et al's (2022) work, which postulates that if children and young people experience trauma and adversity this influences their home life and s the way their family interact, function and carry out their day to day lives due to the potential of conflict. This change of structure will often see the older sibling providing a protective role during parental conflict and it will shape that child's experience with regards to future interactions with members of their household, including the victim and the perpetrator.

Taking Charge with certainty

> *Charlotte: Me and my stepfather have been working together to eat and control our anxieties cos all we have been through. So, we have been working together a lot. We went to MacDonald's the other day, and he didn't want to eat at all but ordered something.*
>
> *Paul: So how did you get him to eat?*

> *Charlotte: I said I am not eating if you're not eating, and he obviously said that I had to eat.*
>
> *Paul: Did that work?*
>
> *Charlotte: So, he ate and that's the way I can control what he is doing. I have to call him to make sure he has taken his pills, like his medication and check that he is going to meetings.*

As discussed within the literature review of this study in Chapter 2, children and young people who are care providers are sometimes described as parentified (Hooper, Moore et al., 2014; Chen and Panebianco, 2020). This is a concept which refers to children or young people who are expected to carry out the role of a parent within the dynamic of the child or young person's family, often acting as a parent to siblings or their parents (Earley and Cushway, 2002). As Stamatopoulos (2018) explains, the possibilities of parentification (like caring) may have either a positive, negative, a combination of positive and negative, or no effects at all to the child or young person's base or the child's position on a care continuum from normal to maximum, based on the child's own age related emotional and physical abilities. Throughout Charlotte's narratives a contextual theme of parentification being a mix of positive and negative experiences was presented.

4.3.4 Lens of Moments:

Using the lens of moments when they emerged in the data, I was able to locate within the narrative text specific episodes of the four forms of epiphanies. It was these moments which highlighted the changes of behaviour, feelings, and relationships within the family due to the presence of PTSD. The focus of the next section is of 'moments' within the life experience of the participants. It was these life experiences or 'epiphanies' which radically altered and shaped the meanings which the participants assigned themselves and their life projects (Denzin, 2008). Therefore, it was important to plot and examine those moments within the text when the individual, in a variety of locations, came into contact with the changes to their lives.

Below are extracts from the narratives which highlight where I felt the effects of Charlottes stepfather's change of presentation due to PTSD had been mapped. These were shared by

Charlotte and Cindy and changed the emotional dynamic of the family. The chosen narratives pinpoint a major upheaval, the culminative, the illuminative and the relieved moment.

A major upheaval can be classed as a big change which can cause trouble, confusion or worry and can change a life forever (Denzin, 2008).

A major upheaval: Death changes a life forever

> *Charlotte: My life changed in 2012 when my nan died, she was my everything. A few years after my nan's death my mum met my stepfather. His [stepfather] dad lived across the road from us, so I would always play out at his house with my friends. Me and his [stepfather] dad have always been close. He died in 2016, 23rd December which is great timing [sighs].*
>
> *Paul: What was life like after the death of your stepfather's dad?*
>
> *Charlotte: I wouldn't eat, I was so low. I would go to school and my friends would offer to buy me food, but I refused. My mum said that I should eat, and I will be ok. I just didn't want to.*
>
> *Paul: and how was it for your stepfather? The loss of his dad.*
>
> *Charlotte: My stepfather's an alcoholic. He smokes cannabis and weed. At that point when he was being violent (domestic violence) we'd have to call the police because he would throw things and he would break things. I remember maybe a few months into their relationship… [mum and stepfather].*

Charlotte demonstrated an understanding of the loss of a number of loved ones and the accumulative stages of grief describing what happened within her family and how these moments can impact on an individual and the dynamic of the family home (Kübler-Ross and Kessler 2005). Charlotte narrated her lived experience of loss of her nan, then her step grandfather within a few years of each other. Moreover, Charlotte presents to the reader not only a temporal journey of loss and its effects on her, but also on her stepfather; and importantly demonstrates different presenting behaviours from her perspective and that of her stepfather.

The culminative refers to the final build-up of crisis within a person's life (Denzin, 2008).

The Culminative: Witnessing chaos

> *Paul: After these 6 months of perfect family life, what changed in yours and your stepfather's relationship?*
>
> *Charlotte: Him and mum had more arguments, more shouting, he would come home drunk. Throw stuff call mum names, it felt like he wasn't the person I met there was just someone else.*
>
> *Paul: So, what was the characteristics that changed?*
>
> *Charlotte: He got a lot more angry. His eyes, I always remember his eyes, like something just clicked and he was an entirely different person. But his pupils would shrink, he would tense a lot more, tense his fists, and he was more angry.*
>
> *Paul: How would he present when he was angry, what happened in the house?*
>
> *Charlotte: He would shout, he would call mum names and if mum even slightly stood her ground he would kick off and throw something. We've had two PS4s because he has either stamped on it or thrown it out of the back door, into the garden then went into the garden and stood on it.*
>
> *Paul: What would you and your brothers do when your mum was arguing with Darren?*
>
> *Charlotte: Run, just run upstairs.*
>
> *Paul: What did it feel like for you hiding away?*
>
> *Charlotte: Absolutely terrifying. I can't even describe it. It feels like you're under attack and there is no way of escaping. Like in the Army say if the other enemy came with a bomb, and you would be so scared that you couldn't move but you know you had to do something like that. I would be so scared that I couldn't move from that bed, but I so desperately wanted to help mum. I think that is the best way I can describe it.*

It is well documented that witnessing domestic abuse, including domestic abuse due to parental PTSD can have a negative effect on the health and emotional well-being and sense of security of children and young people (Felitti 2009; Williamson and Price 2009; Klostermann, Mignone et al., 2012; Williamson and Matolcsi 2019; Alves-Costa, Lane et al., 2021). In the above narrated episode, Charlotte described the presentational symptomology of PTSD. Moreover, not only did Charlotte describe the presentation of PTSD she also described what that presentation looked and felt like and outlined the impact this presentation had on her and her coping strategies. For example, in the language used in this extract "just run!", Charlotte is sharing a learnt behavioural aspect of survival, her fight or flight response (Bucci, Marques et al., 2016), a response used overtime to reduce the exposure to the escalation of presenting aggression from her stepfather and protect herself and her siblings.

Illuminative moments, as described by Denzin, (2008) are moments in which the underlying existential structures of a relationship or situation are revealed.

The illuminative: Just in case

> *Paul: So how are you finding supporting Darren now because he went on to rehab over Christmas, so how's that relationship changed?*
>
> *Charlotte: It's got better and different, because obviously he's not drinking anymore and doing any of what he was doing and so his attitude has changed, and we haven't had to call the police in a long time.*
>
> *Paul: So how does that feel?*
>
> *Charlotte: I am trying to get myself better make sure mum's ok, make sure Darren's getting better and us all working together it's been very difficult. He [stepfather] is not a part of me [biologically]. I am not going through what I went through, what we all went through last year and for the past five years. I am not doing that at all. I don't know…. he has proved himself differently… like if he messes up again…no absolutely no [relationship] I will go and live with my aunty.*

The above excerpts describe how the episodes of violence towards her mother changed the way Charlotte would interact with her stepfather and how the relationship changed when he came out of rehabilitation. Interestingly, Charlotte suggested above that she was willing to give her stepfather a chance, but she also acknowledged that this was the last chance and she reported that the last five years had had a significant effect on her emotional health and well-being, and she was willing to sever her relationship for the sake of her own emotional health and well-being. This extract highlighted how Charlotte's trauma response changed the dynamic of the family because of her clarity of the situation (Qasir, Hassan et al., 2022).

Relieved Moments: Reflections and Forward Forecasting

> *Paul: is that one of your worries that your stepfather could slip back?*
>
> *Charlotte: Yeah. I think with everyone who's been through that, it's always a worry that it's never going to change. You hear about people who have changed so much, and they've done everything and kept it up and then just one thing can change everything. I'm worried that one thing is going to happen I just don't know when and don't know what, I don't know if it's going to affect us, affect anything, it's just…it scares me a lot.*
>
> *Paul: Is it something that you are waiting for?*
>
> *Charlotte: I don't know, I feel like I am waiting for him to slip up. I feel like what's the point of him…like I know him, I think more than he knows himself. I see a lot of me in him…I hate it, I absolutely hate it but, I do, I used to throw stuff. After nan died, I used to throw stuff, there is still a hole in the wall from when I ripped a behaviour chart off the wall and the plaster came with it. That's actually what I did. Watching a lot of stuff with my stepfather I'm like that was me…not as bad.*

Charlotte demonstrated her ability to be reflective and theorise on the context of her narratives, which provided an understanding of her thought process in relation to her temporal journey with her stepfather and where this journey may end due to the consequences of her stepfather's future actions. Charlotte narrated several worries regarding the future and her relationship with her stepfather based on her previous experiences and reported how these experiences had not only affected their relationship, but also her emotional health and well-being. Within this extract Charlotte described the similarities between her trauma response when her nan died and her stepfather's trauma response, indicating her body was unconsciously keeping the score of previous trauma and how to respond (Van der Kolk, 2014).

4.3.5 Lens of Symbolic Interactionism:

A symbolic interactional study attempts to capture moments of lived experience and give meaning to the narratives. Such a strategy presents three levels of cultural analysis: the contextual text, its meaning, and its connections to lived experience. Reading the transcripts through the lens of symbolic interactionism enabled me to understand the family using these three levels of cultural analysis (LaRossa and Reitzes 1993; Denzin 2008). Moreover, this lens allowed me to appraise how discourse within the family had impacted on Charlotte; how she made sense of her life through death and domestic violence; how she made sense of trauma and how it affected her own emotional health. Furthermore, I was able to draw on a change within the family dynamic due to the presentation of PTSD and importantly the shift in relational dynamics. The change in relational dynamics became a focal point of the loss in the relationship with her stepfather and the effects this had on Charlotte's own emotional health and well-being.

4.3.5.1 Making sense of family dynamic.

Eeden-Moorefield and Pasley (2013) explain that stepfamilies are formed when an adult enters into a committed relationship (i.e., marriage or cohabitation) with a partner and at least one of the partners has a child or children from a previous relationship. Given that children usually live primarily with their mothers when biological parents separate, most stepfamilies involve a residential stepfather (Stewart, 2006). As Marsiglio (2004) postulates, stepfathers and family members sometimes consciously and unconsciously strive to construct some kind of 'we-ness' that resembles an experience often associated with biologically based families. Marsiglio (2004) goes on to explain, in family terms, a sense of 'we-ness' captures an individual's sense that he or she shares a familial reality with one or more family members; and can hold the perception of interpersonal loyalty, a sense of belonging and obligation, rights and sharing a homelife. Through Charlotte's narrative there was evidence that she drove the conceptual beginning of the relationship between her mother and her stepfather.

> *"I always saw the way he looked at mum and mum looked at him I was like, there's something, there has to be something there. I think the first big sign that I wanted them to be together, her birthday is in June, so he brought her a cake for her Birthday and brought it over to the house and all of us just had cake and ice cream. I was like. Mum you need to get with him, I know you like him, and he likes you and a can see the way he looks at you and there is something there".*

After Charlotte's stepfather moved in there was a period of 'grace' where Charlotte explained that she really took to her stepfather *"I was like thank god finally. Mums happy he's a decent person"* and they had a close bond and she welcomed him into the family, and there was a sense of "we-ness".

4.3.5.2 Making sense of stepfamilies and military PTSD.

Several studies including ones by Amato (2010) and Sweeney (2010) have raised concerns regarding the implications of the formation of stepfamilies on the emotional health and well-being of children and young people, indicating that children and young people within this demographic have a lower well-being than children and young people in households with two biological parents and tend to show little to no advantage over single parent families (Amato, 2010). Moreover, a body of literature indicates variability within stepfamily functioning and the quality of the parent-child relationship (Ganong, Coleman et al., 2011; King, Thorsen et al., 2014). Furthermore, the above literature also highlighted encouraging a solid child and parent relationship, resulted in positive child and young people's emotional health and well-being. Within the dynamics of this case, there was a degree of discourse between the narratives of Charlotte and the narratives of her mother Cindy, and the meaning attached to the relationships.

The following extracts from case one demonstrates there was a distinct difference in regard to the child versus parent versus stepparent relationship dynamic pre and post the presentation of PTSD.

Relationship pre-PTSD

Charlotte on her relationship with her stepfather

Paul: How well did you get on with him in the first six months?

Charlotte: I just so smiley and happy. That was like the first time since my nan died that I was actually happy., it's a bit odd to say! I was finally ok.

Paul: So, what was the relationship between you and your stepfather like in them first 6 months?

Charlotte: Fine, he would take me out for food, just he would do the father type stuff. Cos mum obviously told him about how I don't see my dad and he's not a part of my life. He was like a dad to both of us really. So, he would do the dad things, he would take us out, take us to the park. Let mum go to the spa and look after us. I couldn't fault him for anything. There was no arguing no nothing, nothing like it ended up being.

Paul: So, you got on really well with him?

Charlotte: Yeah.

Paul: ..and could you speak to him about anything?

Charlotte: Yeah.

Paul: so, you trusted him then really.

Charlotte: Yeah

Cindy on Charlotte and her stepfather

Paul: How do you think [stepfather] and Charlotte's relationship was like when you first got together?

Cindy: We had not been together very long, and her stepfather was tickling Charlotte and she got really upset because she said that he tried to hurt her. Now I don't, for a second, think that he tried to hurt her. I said to her stepfather, because we discussed it a lot, he thinks that she said it on purpose and making it up on purpose to get rid of him. I think there is potentially an element of that because she was very very upset that

I was spending a lot of time with somebody else, and she would maintain that he was too rough.

Paul: How did that effect the relationship?

Cindy: She had first of all lost me, as I had had another baby, then she had lost her dad moving to Manchester. Then she had lost my mum, then all of a sudden, she had had to share me some more with someone new; and yes, I was spending a lot of time with. But she still got picked up from school brought home and we would stay in and watch telly. You know it was definitely the straw that broke the camel's back, in my opinion. My thoughts on Charlotte's perspective are this is one thing that I can have some influence over. I couldn't do anything about those other things. Now actually, I want my mum back and I am not letting him take her.

Relationship post-PTSD

Charlotte on her relationship with her stepfather

Paul: After this 6 month of perfect family life, what changed in yours and stepfather relationship?

Charlotte: Him and mum had more arguments, more shouting, he would come home drunk. Throw stuff call mum names, it felt like he wasn't the person I met there was just someone else. He was an entirely different person.

Paul: From then how did your relationship with your stepfather change?

Charlotte: I start getting scared of him, I was very scared of him

Paul: Did you have moments of when it was good or was it just always hard?

Charlotte: Yeah. There were moments when I saw that person that I met the first time. But then it would completely change. He would snap and be that awful, horrible scary person.

Paul: Did he ever speak to you whenever he had an episode?

Charlotte: He would just text mum and say tell Charlotte I am sorry.

Paul: Did he ever say sorry to you?

Charlotte: No.

Paul: How do you think that made your relationship?

Charlotte: Just started to deteriorate, I wouldn't speak to him, I wouldn't look at him I'd argue more with mum for her keeping him here I wouldn't want to be around him at all. But I would think this isn't going to happen, this is not going to change him. Rehab is not going to help, what if he comes out and is the exact same person he was before and nothing's changed, nothings helped. I think I always had that in the back of my mind, always.

Cindy on Charlotte and her stepfather

Paul: So, is that how their relationship was throughout, or had it changed at any point or got better or worse?

Cindy: I mean there had been better and worse times, you know, whenever we were talking, she just felt rejected and I know that was what she felt by the fact that I had a new relationship and not available to her 24/7 like I was before. It was definitely a reaction to a build-up of all those things, in my opinion.

Cindy on her relationship with Charlotte due to her stepfather

Cindy: She was not very happy. She was very sad. She didn't understand why I wanted to be with him when he was so horrible. I was with him to try and keep her away from what was going on. But she still says she was terrified.

Paul: It's her perspective and it was quite strong that they would have those moments of emotionally supporting each other.

Cindy: I just think that's nice because my perception was, she would do anything that she possibly could to avoid ever having to be near him.

There is symbolic meaning within the discourse of this family. That is, their stories demonstrate a connectedness which enabled them to function as a single parent family and eventually move into a stepfamily with the introduction of Charlotte's stepfather.

Charlotte used the language of connectedness like "we were close", "we were always together" and "me and my nan or mum" when describing the relationship with the females within her family prior to the introduction of her stepfather. With the introduction of her stepfather, this language did not change, and Charlotte used the terms "he was nice", "he was caring" and "he was thoughtful", which paints a picture of a relationship which was one of love and compassion.

Cindy used a number of phrases which described a different perspective on the relationship between Charlotte and her stepfather "*She quite obviously didn't like the competition having to share me. So right from the off there was tension" and "So it was his fault, his fault that I was not around, it was his fault that she was having to share me".* This demonstrates that the introduction of the stepfather changed the dynamic of the family structure and its function.

Through the perspective lenses of Charlotte and Cindy, it is clear there was a distinct change in the emotional and practical connection between Charlotte and her stepfather and importantly between Cindy and Charlotte, when sharing their stories of post-PTSD.

Charlotte explored the transition from her pre-PTSD stepfather to a stepfather who changed due to a number of traumatic events, including the loss of a son and the loss of his father, whilst also coping with the memory of witnessing his friend be killed in combat. Charlotte used the following phrases to describe the change in her stepfather *"he would get tense", "he would vandalise things"* and *"he would just explode"* all of which created the following emotion *"it made me scared, I didn't know what to do".*

Cindy reflected on Charlotte's relationship with her stepfather and concluded there was a shift in connectedness and overall interaction due to the ongoing presentation of PTSD and the use of substances within the family home. Within Cindy's narrative there was a growing concept of displacement and rejection for Charlotte, explaining *"Her dad moves to Manchester, she has lost contact with her sisters, my mum dies and then I start a new relationship and she has a new little brother".* The narrative of displacement within Cindy's narratives highlighted Charlotte continually seeking her mother's affections and attention. Cindy explained "*she deliberately tried to cause issues…I couldn't be with her 24/7".*

Importantly, the symbolic meaning of what a relationship was to Charlotte changed due to displacement, rejection, and loss. This change of meaning was seen in how the collective interactions of the family changed due to the death of a close family member, the rejection from her father and the introduction of a new sibling and stepfather who over time presented with an increased severity of PTSD, which evidently caused the relationship between Charlotte and her stepfather to breakdown (Ganong, Coleman et al., 2011; Kalmijn 2013). I have surmised that due to the instability of the relationships within Charlotte’s home environment the only thing she could control was the care of her siblings and her stepfather. Charlottes stated *“I said I am not eating if you’re not eating, and he obviously said that I had to eat. So, he ate and that’s the way I can control what he is doing”*. There is the potential meaning that Charlotte was stabilising aspects of her environment and taking control through parentification (Burnett, Jones et al., 2006).

4.4 Case Two: Joseph, Izzy and Pauline

4.5 Constructing Interpretive stories:

List of Joseph's Story Titles:

The way he walks, he starts to walk differently.

You can just see the difference.

Because we have to!

List of Izzy's Story Titles:

It's like a different dad!

I don't want him upset.

List of Pauline's Story Titles:

Quite a home boy.

More than just a son.

She is literally always there. She is daddy's girl!

So, we use humour quite a lot to try and defuse the situation.

The first things I noticed within this family, compared to the other families within the study, was that as a whole they told fewer stories, but the stories they did tell collectively showed how each member of the family played a significant role in supporting the veteran with PTSD. Moreover, this family's stories, more than the other families, offered temporality. By temporality I mean helping to plot the 'life storied narratives' to explore the lived experiences of being a young person and transitioning to becoming a young carer from the perspective of a 'whole' family'. Additionally, the participants' stories highlighted their life journey of pre-Afghanistan, during Afghanistan and post transition from the military. When I looked at the structure of the stories within this case, the stories told about living with PTSD and its effects on the young person, alongside the transition to being a carer provider. The stories were short but filled with raw emotion and compassion.

Each individual story within this case offered a different perspective of living with PTSD. When breaking the individual stories down, Izzy's stories were concise and to the point, there was little theorising or augmentation, but lots of emotion. When looking at her brother Joseph's data, the full transcripts offered text not included in the interpreted constructed stories but offered moments where Joseph theorised aspects of his life living with PTSD. Whilst these aspects of Joseph's life were important, they would not help to answer the question of the study or meet its' aims, therefore they were left out of the constructed story. Pauline's transcripts were dominated by theorising and augmentation. I suspect this was due to Pauline having to reflect on her lived experiences as she, possibly, had never had to do this before and came to the realisation that PTSD was affecting the children's well-being. Therefore, the collective 'whole life' stories of this family offer greater analytical advantages in trying to identify what it is like to live in an environment with a parent with combat related PTSD and the emotional effect that this has on the young carers. To understand the meaning of and the emotional effects of living with combat related PTSD, I looked through the lenses of language, moments, context (McCormack 2000a, McCormack, 2000b) and symbolic interaction.

4.5.1 Lens of Language

Looking through the lens of language, I was able to assess the features of the language used within the transcript. Moreover, the assessment of language allowed me to note how words impact the story being told and to consider what is said, how it is said and what remains unsaid. The following section of analysis of language highlights word groupings, or phrases which indicate a relationship of self or society. Additionally, I analysed the frequency of used words, words which assume a common understanding, words which give opportunity for thought (e.g., erm) and importantly words which would answer the research question.

Izzy

The language used by each family member reflected their story, each offering a different aspect to the use of language. When analysing Izzy's transcript, she was straight to the point and was concise with her words, although very reflexive. Izzy would use words like 'I think', I don't know' and 'it didn't' when reflecting on a certain situation. Izzy paused when I asked her a question. This led to moments when Izzy would pause for short periods of time and she seemed to be thinking about her response, possibly trying to identify the period in her life which gave context when answering the question. However, in certain circumstances Izzy would also use the word 'Well…' which was extended at the start of her sentences when making a point.

In Izzy's first storied title, 'It's like a different dad!' the use of 'we' and 'he' was used often. When Izzy described what her father's presentation was like she used the word 'he'. However, when she was reflecting on life prior to the presentation of PTSD, which was in contrast to her current circumstances, she often used the word 'we' to demonstrate connectedness. For example, in the interview when Izzy described some of the symptoms of her father's presentation she said, "he gets stressed". Izzy explained, that when her father gets stressed the consequence of that is "we don't get to see him". Izzy was explaining a common symptom of the presentation of PTSD, which I have interpreted as avoidance, isolating, and withdrawing. Describing this episode made Izzy upset, and she began to cry, highlighting there had been a change in her dad's interaction with her due to the presentation of PTSD.

In Izzy's second story titled, 'I don't want him upset'; Izzy appeared to be emotionally stronger and there was a shift of responsibility with the use of 'I'. When analysing this story, the use of 'I' occurred more than any other word. Moreover, Izzy did use a reflective approach to this story and demonstrated she had a role to play in supporting her father. For example, Izzy started her role descriptions with "I just", "I would", "I wanted" and "I always". Her role as a young carer seemed to be something she was sure about. However, in contrast, her stories on the presentation of and living with PTSD were fraught with reflective pauses and emotion.

Joseph

When analysing Joseph's transcripts, there was a difference between his and Izzy's transcripts. Joseph used the word 'it' more than any other word. Joseph appeared to use the word 'it' to describe the symptoms and the presentation of PTSD whilst Izzy used the word PTSD when describing PTSD. Interestingly, Joseph's use of language regarding PTSD was dismissive and he did not use the word PTSD for the majority of the interview. He used 'it' when describing PTSD, as if to say this was something negative. This demonstrates 'it', the PTSD, changed his father and Joseph was upset about this. For example, Joseph stated "it was scary [the presentation of PTSD], he would get angry".

Joseph was very reflective even though some of his stories were quite short. When reflecting Joseph used the word 'sometimes', which is a word he used a number of times throughout all of his stories. Prior to answering the question Joseph would also pause, taking a longer period to actually give an answer. Joseph's use of 'sometimes' suggested a number of possible interpretations. The word 'sometimes' could have been used to highlight an episode within his life where the incidence of something was infrequent, spontaneous or when his father was in the right frame of mind to do an activity.

Interestingly, to support the use of 'sometimes', Joseph talked mainly in the past tense, as if the story of his and his father's life had changed. He used words like 'I would', 'he would' and 'we would'. It was this reflective approach to the language of Joseph's narratives which provided more insight into the presentation of PTSD, and its effects on his father and on himself. Joseph appeared to be trying to work out what had happened with regards to PTSD and his father, and their relationship; moving to understand what was now going on. When I put Joseph's narratives together, within his stories there was a shift in his use of 'I', 'it', 'he' to 'we'. I have interpreted this shift as PTSD ('it') had affected his father ('he'), but 'we' (collectively) were working this out and Joseph took on the role of a young carer.

Pauline on Izzy

I remember during the interviews with Pauline on how PTSD affected Izzy, that she would always pause, sometimes for a long period of time. Pauses occurred before responding to my question, and at times during her response. This reflective approach was consistent and was always done with a soft tone. Pauline would always respond to Izzy being a 'cuddle monster' (Izzy's role in keeping her father calm) with an endearing smile and fondness.

When Pauline described Izzy, she described her as a 'doing' person. Pauline used the words 'she will', 'she has', 'she just', and 'she would' when she talked about how Izzy supported her father. I feel it was the use of these words, which Pauline used to describe her daughter, that added to the duration of the pauses. I have interpreted these reflective long pauses as a realisation of the role Izzy had taken within the family home. My interpretation is supported within the augmentation (the participant talked more about a specific topic and provided wider context to the story which was not included in the researcher's interpreted story) and theorising text Pauline provided outside of her interpreted titled stories. For example, when asked *"How does that make you feel being a mum who has a 12 going on 13-year-old girl who is way above her years?"* Pauline reflected (theorised)

> *"Quite sad really (pause) because you kind of think how much she has missed out on growing up when you try and do something with holidays but there is only so much you can do as a single parent (long Pause) and just even trying to hold it together over the last 2 years has been hell and trying not to let Izzy see it. Yes, I don't know, (long pause) quite sad thinking about it actually, for both of them because it is not what they asked for, is it, so it is all our fault".*

The theorisation of the above text happened when Pauline identified the cause of her children's emotional response to living with PTSD and gave an opinion. For example, living as a single parent, living in a toxic environment and blaming herself and her husband for the issues the children had lived through.

Pauline on Joseph

The language Pauline used during the interviews suggests that she was working out how PTSD had affected Joseph, whilst he managed his own personal health issues. Moreover, Pauline was working out if Joseph's father's PTSD had affected Joseph and how this presented itself within the family home, his school and within his community. In addition, Pauline appeared to be trying to understand what Joseph's role was in supporting his father. Similarly, when Pauline spoke about Izzy, Pauline was reflective, pausing after being asked a question, as if to think and locate the answer.

Pauline's use of endearing descriptive words when describing Joseph demonstrated how affectionate he was towards his father and the family. Pauline used the words 'empathetic', ‘compassionate’, ‘home boy’ and ‘thoughtful’. Pauline theorised that this was possibly due to his experience of growing up with separation anxiety after his father was injured in Afghanistan and not being able to see him. It is this experience which Pauline aligned to Joseph understanding how anxiety effects a person. Moreover, Pauline explained that being the oldest child “Joseph sees his role as protector”, which she said was why he stayed at home. The role of protector was something I picked up on during the interview with Joseph when he shared a story of putting the bikes away correctly. Pauline said, “dad went mad because the bikes were not put away properly” and Joseph replied with “he just wants the bikes put away correctly”. Protection for Joseph would appear to be equitable and equal in that he was protective over his father’s outburst and protecting his family by keeping an eye on them and wanting to know what was going on within the family home.

Another interesting observation Pauline alluded to was how she felt Joseph was “disappointed” due to the change in relationship with his father. Pauline went on to state “I think Joseph maybe just doesn’t get his hopes up now at all and if anything happens”. It is this statement which provided the link to Joseph’s narratives, where he frequently discussed different moments using ‘sometimes’ when explaining moments with his father and his family.

When I looked to see which words were used in which stories and where the pauses often occurred, I noticed that when each participant within Case two spoke about the effects PTSD had on themselves and their family, they were reflexive, emotional and would pause for a considerable amount of time in comparison to the role of caring, where the conversation was fluid when they described how they supported their father. It is the context of these moments which I will provide a deeper insight into below. However, Pauline provided a thought-provoking contextual theorisation when discussing both Joseph and Izzy’s current life due to combat related PTSD:

> *“He signed up and gave his life to the country, sort of thing, but when you look at the bigger impact around it, it? is not just you that’s doing it, it’s your family as well. They have sacrificed so much, you know the children and it breaks my heart that our decision has given them this life, if you know what I mean. They deserve so much more, but we just do what we can and try to make it up to them somehow”.*

4.5.2 Lens of Context

As described in the data analysis section of the Chapter 3, the lens of context was used to underpin what culture meant to the participant. Looking at the situational context aspect of the interviews allowed me to develop understanding of the everyday experiences of living with a veteran with PTSD and its emotional consequences on the family. I was interested in paying attention to culture to understand how the culture of the family and military community shaped participants' views on what it was like living with a veteran with PTSD, and how it affected the activities of daily living. Cultural fictions are described as stories about culture. Importantly, when analysing the data, I was able to probe to see what I could learn from the participants' responses, their reactions and the interactions between myself and the participants.

Through the analytical process of looking through the lens of context I wanted to pay attention to what culture meant to the participants, by answering the following:

- What is the cultural identity of the participant which shapes them as a person?
- How have these ways of talking, thinking and being, been positioned by each participant?

To answer the first question, I had to ascertain what the transcripts were saying about culture. As previously discussed in the literature review of this study, military children and young people are a multi-layered complex population (Cozza, Chun et al., 2005). Children and young people within the military and veteran community are associated with having a unique subculture and cultural identity. Military culture is typically shaped by rank and file, branch of service and location of the family unit depending on the serving person. It is the location of the family and families who are in a similar situation which creates a connected community (Easterbrooks, Ginsburg et al., 2013). It is this sense of connectedness and community which Joseph and Izzy presented when discussing friendships within the military community. The following extract demonstrates belonging and provides the reader with an understanding of what it is like to live in the military community and be connected to peers who share their cultural identity.

Friendships and Belonging in the military community.

Joseph

Paul: What was life like for a four year old with his dad in the marines?

Joseph: It was cool, cos you would just say my dad was in the military.

Paul: Did you get to do much?

Joseph: We did a lot, because of the fairs they did at camps and stuff like that. It was good because there where loads of kids there your age so you could just play with them. Also, I got on really well with them.

From Joseph's text there is a sense of belonging, a bond with his community and a notion of being proud "*It was cool, cos you would just say my dad was in the military*".

It was a similar experience for Izzy whose use of language highlighted happiness, belonging and connectedness:

Izzy

Paul: Did you live in camp?

Izzy: We have lived in the home in camp in Naunton, which was nice because there was so many children there that you can play with.

Paul: So, there was ready made friends there?

Izzy: Yeah, there were lots.

Paul: and did that help you?

Izzy: Yes, I made a best friend. We would always play dolls and make little houses in our back garden.

Paul: Was it a lot of fun?

Izzy: Yeah, it was. We spent loads of time together when our dads went away.

The above extracts support Easterbrooks, Ginsburg et al’s (2013) work, which postulates that military children and young people tend to bond quickly with other military children due to their shared experiences. Moreover, it is not just the shared experiences which connect this population, it is the collective difficulties they face, and the loyalty found within the values of shared experiences. A theme running through both narratives is a notion that the military community is not defined by geographical location, but by a shared set of morals and values, based strongly on pride. It is these shared values and sense of pride which have helped shape Joseph and Izzy as young people.

To answer the second question, I had to understand the ways each participant spoke, thought and positioned themselves within their lives.

As noted from the previous section the military community is built on shared values, morals and loyalty. As reported by Williams and Mariglia, (2002) *“the military community requires all members, including the family to be accountable for their actions and to follow certain patterns of conduct”* (p.69). The following extracts from Joseph and Izzy highlight a sense of accountability with regards to what information they can or are willing to share.

Speaking without sharing

Joseph

Paul: When your dad’s back is getting better, did he go back to work soon after?

Joseph: (Pause) Yeah, after a while he went back

Paul: How was life then?

Joseph: (Long pause) erm…yeah it was alright.

Paul: In what way?

Joseph: Erm…(Pause) I can’t remember

Izzy

Paul: Did you get upset when you weren't together?

Izzy: (long pause) Yeah (begins to cry).

Paul: I know it makes you sad and upset, but what other feelings do you get when you're not together?

Izzy: (crying) erm…I don't know.

Both of the above extracts provide little textual detail. However, they reveal more about what is not said, which I have interpreted as keeping what goes on in the privacy of their home to themselves potentially due to stigma (Cree 2003; Cooklin 2010; Phelan, Griffin et al., 2011) or a sense of following the unwritten law within the military community, the sense of "we know what is expected of us, so let's get on with it!" (Williams and Mariglia 2002).

To answer the second question outlined above, I looked at contextual situations where we jointly constructed the answer to my question. As previously mentioned, narrative inquiry is not just about the participants but the interaction of the participant and the researcher, based on a shared experience (Clandinin and Connelly 1994). In the following example, we talked through the feelings of living with PTSD. I propose an idea of what I felt it was like living with PTSD, based on my experiences and we talked through how Joseph, Izzy and Pauline felt living with PTSD was affecting them.

McCormack (2000a) explains it is important to understand that participants and researchers in the context of narrative inquiry have shared similar experiences and collectively come up with answers to further understand the importance of the collective interaction during interviews. Below is the collective construction of a question I asked the participants of case 2.

Joint construction of answers

Paul: If I can ask. When Dad came back the second time, whatever happened out there the second time was a lot worse with the issues he had from the first tour, then adding *the second tour. In terms of the transition back into the family what did that feel like at home? Both the children have said that it was a bit scary at times.*

Pauline: He (dad) just used to go? nuts, if the kids were out on their bikes, and had not put the bikes back how they were meant to put back, but they put them away…

Izzy: Just not to dad's standards…

Pauline: ...yeah to be expected, obviously. He literally threw all the bikes into the stream…

Joseph: …at least they were clean…

Pauline: So, it was things like that. He would just fly off the handle for stupid things.

Paul: How was that for you both?

Joseph: When he shouted back then you would just be like oh no… then he would come downstairs, and I would try not to smile. He would tell me off and I would try not to laugh, when I did once he told me off even more.

Paul: Was it quite scary? I know you have both said you get around being scared by using humour. But in terms of accepting that, being scared. What was that like?

Joseph: We would just stay out of his way.

Paul: Did you get any feelings in your tummy?

Pauline: What happens when you get shouted at, what do you feel?

Izzy: Sad

Joseph: I am used to it now…it depends how he shouts at me.

Izzy: yeah, I agree

Paul: I know how you may feel. I was in a similar situation to you, although I was petrified and not scared. I even wet the bed I was that petrified, so I can understand where you are coming from. So that's what it is like living with PTSD

Pauline: I think it has been very rare occasions that the anger has been directed at the kids and me to be honest. I kept a diary of all the incidents, but it is always directed at physical items, like the laptop or the bikes for example. It's like he directs it at

> *something but it's the fall out of being in that environment for all of us. It's just like 'oh here we go again sort of thing' when he does…it is quite…well I got scared so the kids must have done.*
>
> *Joseph: when it first started happening that was scary it took a while to get used too.*

When I wrote the summary of the conversations with Joseph and Izzy, I remembered noting that they found it difficult to open up to me. It was this thought which led me to think about what was and was not being said. What I noticed from their individual interviews when discussing their lived experiences with PTSD were long pauses within the conversation. Both Izzy and Joseph's answers regarding PTSD were constrained and they preferred talking about life in the military, family or friends. It was as if they were hesitant in sharing something intimate about the family. I felt the hesitation in their answers was a reflective pause, as if to give themselves permission to share this private information. However, as noted above, the conversation with Joseph, Izzy and Pauline enabled the conversation to open up. It was as if Pauline was talking about PTSD and its effects, which gave Joseph and Izzy permission to disclose how it felt for them.

As McCormack (2000a), explains, when we are part of the group we are researching, we often feel we are developing an empathetic chord, so power differentials will dissolve. Within the interview with Joseph, Izzy and Pauline I felt, having 'lived' a similar life, that I was drawn in and captured by this empathetic chord. For me it was difficult not to relive my life through them. As a cultural insider I felt there was a dissipation of power, and we became equals, noting 'their story, is my story'. When reflecting on the conversations with each participant I was aware of how I felt but understood this may not have been the same for the participants, and they may have perceived power imbalance.

4.5.3 Lens of Moments

As suggested by the lens of language and context, I found many moments of uncertainty, which became moments of clarity and certainty, Denzin (1989) refers to these moments as 'epiphanies'. Using Denzin's (1989) four forms of epiphanies (a major upheaval, the culminative, the illuminative and the relieved moment) I was able to locate moments when

Joseph, Izzy and Pauline were uncertain as to what their life would be like due to combat related PTSD. It was through this process I was able to story the certainty of life events and their emotional impact on the participants.

Using the lens of moments when they emerged in the transcripts, I was able to locate within the narrative text specific episodes of the four forms of epiphanies. It was these moments which highlighted the changes of behaviour, feelings and relationships within the family due to the presence of PTSD. The focus of the next section is of ‘moments’ within the life experience of the participants. It was these life experiences or ‘epiphanies’ which radically altered and shaped the meanings which the participants assigned themselves and their life projects (Denzin, 2008). Therefore, it was important to plot and examine those moments within the text when the individual, in a variety of locations came into contact with the changes to their lives.

Below are extracts from the transcripts which highlight where I felt the father’s temporal change of presentation due to PTSD had been mapped within narratives shared by Joseph, Izzy and Pauline. The chosen narratives pinpoint a major upheaval, the culminative, the illuminative and the relieved moment based on Denzin’s (2008) framework.

A major upheaval can be classed as a big change which can cause trouble, confusion or worry and can change a life forever (Denzin, 2008).

A major upheaval: Changes a life forever

Joseph

Paul: What happened to your dad at that time?

Joseph: I don’t know. What when he was out there?

Paul: Yeah.

Joseph: I think he was in an impact explosion, and it broke his cheek bone, and he got some nerve damage. He is a bit deaf now.

Paul: Did your mum tell you what had happened straight away?

Joseph: She said dad had been injured so I am going to see him. That’s when I started to get worried. Obviously, we cried a lot when mum went, because we wanted to see him, but we couldn’t.

Paul: What does that feel like, obviously you…

Joseph: We hadn't seen him for a while, so we were like we wanted to go and see him really badly. When we got told we couldn't see him it was upsetting. He was in the country, but we can't go and see him.

Joseph demonstrated an understanding of trauma describing what happened to his father during his tour of Afghanistan. Joseph narrated the story of what happened to his father in Afghanistan "he was in an impact explosion". Joseph then moved on to describe the consequence of the explosion "it broke his cheek bone, and he has nerve damage". Joseph brought the story of his father's injury to the present by stating "he is a bit deaf now". What Joseph has presented to the reader is the temporal journey of his father's injuries, which had a profound impact on his own emotional health. The language Joseph used about his own feelings allowed him to articulate his feelings at the time his father was in hospital in the UK. Joseph explained he was worried but could not see his father to ease his anxiety, due to the military's standard operating procedures regarding hospital admission post Afghanistan.

Izzy

Paul: When he went to Afghanistan, because he has been twice hasn't he?

Izzy: Yeah

Paul: The first time he got injured – a sore jaw. What was that like for you?

Izzy: It was really sad.

Paul: How did that effect you?

Izzy: I didn't really see him that often, it was mainly mum.

Paul: Was that because he was in hospital?

Izzy: Yeah.

Izzy also recalled the time her father was injured in Afghanistan but was hesitant to provide any detail, only answering the questions with two- or three-word answers. When I read the transcripts and looked at the annotations I wrote, it became clear when analysing Izzy's text, that she was very emotional and cried many times. As Holmes, Rauch et al., (2013) explain, when discussing a moment in time when you realise your father has been injured in an explosion and like Izzy, you cannot see them, can bring a child right back to the actual event, which for many can be like reliving the event. It is this explanation from the above authors which I feel Izzy was experiencing at the time. Due to this experience, I was keen to support Izzy and ask if she wanted to stop the interview or whether she needed additional support from her mother. Izzy was keen to continue and declined support from her mother.

The culminative refers to the final build-up of crisis within a person's life (Denzin, 2008).

The Culminative: Witnessing my fathers' breakdown

Joseph

Paul: Post Afghanistan the second time, what was life like?

Joseph: Things like he started to get angry more and more often, to other people and us. He snapped more quickly. If something frustrated him, he would get really angry, so you had to be a bit careful and stuff.

Paul: Do you think living in the house then was totally different to life before he went?

Joseph: Yeah. You can just see the difference.

Paul: Was you more (I don't want to put words into your mouth I want to try and understand) was it a scarier place? a scarier home?

Joseph: It wasn't scary it was more like, you still had to be good you just had to be cautious I would say.

Paul: A bit more thoughtful?

Joseph: Yeah. Not to just think about yourself.

It is well documented that witnessing a parent's mental breakdown can have a negative impact on the child or young person's emotional health and well-being and their sense of feeling safe (Felitti 2009; Holmes, Rauch et al., 2013; Bucci, Marques et al., 2016; Fear 2017, Foran, Eckford et al., 2017; Collins 2018; Parsons, Knopp et al., 2018). As Joseph explained within the above episode, he began to describe the presentation of PTSD symptoms. Moreover, Joseph not only described the presentation of PTSD, but he also described what that looked like and felt like and outlined the impact this presentation had on him and his behaviour. For example, when discussing "being careful" he was sharing a new behavioural aspect of his life which he had learnt to reduce the symptoms of his father's PTSD presentation. The language used in this example also highlights Joseph's behaviour in response to the presentation had evolved over time and he had learnt how to act in the presence of PTSD to reduce the consequence of an outburst from his father.

Izzy

Paul: So how did he injure himself more?

Izzy: Well, he began getting PTSD, the symptoms of PTSD.

Paul: What are the symptoms?

Izzy: He didn't sleep very often he would try and distract himself. Well at night we could normally hear him walking around because he couldn't sleep very well.

Paul: …and what would he do to distract himself?

Izzy: He would normally work.

Paul: Was this still whilst he was still in the RM?

Izzy: Yes, he would try and work more and try to distract himself.

Paul: How was it for you?

Izzy: We didn't see him very often because he was at work, but it was sad because we didn't get to see him (becomes upset).

As previously explained Izzy used the terms PTSD when describing PTSD, unlike Joseph. What evolved from this textual extract was her knowledge of the symptomology of PTSD, for example, she talked about avoidance, distraction and poor sleep. When asked how her father injured himself more, Izzy replied "he began getting PTSD". Izzy's reply highlights she understood the concepts and presentation of PTSD but was unaware of how it manifested. Izzy believed or suggested her father injured himself more by getting PTSD, which was linked to the final answer Izzy provided regarding her father's avoidance of being away from the family home. Moreover, there was a notion of resentment of PTSD and its effects on her and her father's relationship. For Izzy, PTSD was causing a divide which was evidently upsetting as she described this whole episode as 'sad'.

Illuminative moments, as described by Denzin (2008) are moments in which the underlying existential structures of a relationship or situation are revealed.

The illuminative: A father being emotionally unavailable

Pauline on Joseph

> *Paul: So, before that then, what was Joseph like with his dad?*
>
> *Pauline: You could see when their father came back from the second tour that things started to change. Obviously at that point their father's injuries were really starting to hurt him, and he was just trying to cope, but there was definitely not as much closeness as what there was before not through Joseph not trying but just purely his father was pushing everybody away. We were isolated up there [in the hills] and that was the point but there definitely wasn't the closeness that we had before. That's when things definitely started changing and didn't do as much stuff with the family. There were a lot of times when their father was angry and everyone trying to be quiet and like walking on eggshells.*

The shift in family interaction due to combat related PTSD is again well documented (Holmes, Rauch et al., 2013; Kaplow, Layne et al., 2013; King and Smith 2016; Banneyer, Koenig et al., 2017; Fear 2017) in the extract above. However, the language used offers the reader a lived experience from a mother regarding her child. The episode above described by Pauline when she states ‘not as much closeness’ offers the first glimpse of a change in relationship between Joseph and his father. Importantly, Pauline acknowledged this shift by explaining “it’s not through Joseph not trying [with his father] but just purely his father was pushing everybody away”. This extract alone provides an insight into the presentation of PTSD symptoms of avoidance, and emotional withdrawal. Not only does the text highlight the significance of her husband’s injuries but also the moment his PTSD symptoms started to become prominent within the home. Pauline described how her husband’s physical injuries became too much and he could not cope or was finding it hard to ‘cope’, leading to a change in his presentation, creating an environment of ‘walking on eggshells’ leading to or resulting in the presentation of anxiety for Joseph and the wider family (Beks 2016; Sherman, Gress Smith et al., 2016).

Pauline on Izzy

> *Paul: Do you think there has been a difference between the way she was with her father and the way she is now?*
>
> *Pauline: Yes. She will judge the situations or how the day is going and keep out the way if it is a bad day, sort of thing, or she will look at me and say, “it’s a bad day isn’t it?” and just communicate how it is going and she will adjust her behaviour around what sort of day it is. Before she would just be a cuddle monster all the time but now, she judges the situation and you can see how she is working out whether it is going to be a waste of time, basically, in her giving support and love. You can see her working out if it is worth her while giving her time and energy doing it.*

When Pauline discussed the change in relationship between Izzy and her father there appeared to be a notion of hypervigilance from Izzy (Banneyer, Koenig et al., 2017; Creech and Misca 2017; Parsons, Knopp et al., 2018). Pauline noted, Izzy will ‘judge a situation’, saying to her mum *“it’s a bad day isn’t it?”*. Pauline’s evaluation provided the cognitive assessment undertaken by Izzy to understand how she should act, how she could interact and what role she may have had to play to ‘behave’ to counter the presentation of her father. This notion of assessment was confirmed by Pauline when she described the assessment process undertaken by Izzy. Firstly, Izzy ‘judges the situation’, then will process her assessment, and take appropriate action. As Pauline noted, Izzy knew whether to interact or not with her father based on her understanding of her father’s presentational ‘cue’s’.

The relieved moment happens wherein a person, after the event occurs, comes to define it in consequential terms (Denzin, 2008).

The relieved moment: Defining my father’s presentation

Joseph

Paul: When did he get a diagnosis?

Joseph: When I started secondary school, I think it was in Year 7.

Paul: So that’s 12 years old.

Joseph: I was 12 or 13.

Paul: Do you think that has helped the family with him having a diagnosis?

Joseph: Yeah. It helps a lot because he takes medication for it sometimes, which is good.

Paul: Sometimes?

Joseph: Yeah, if he remembers.

Paul: Do you have to help him remember?

Joseph: No, my mum and my sister usually helps him, or he has them by his bed.

Paul: …and is that helping do you think?

Joseph: Yeah, I think it is helping him. He still gets angry every now and then.

Paul: Is it as often as before or not?

Joseph: No, not as often. Just normally around work now and not around us. It can be around us sometimes.

Joseph offered a temporal picture of events leading up to the relieved moment, that is his father's diagnosis of PTSD. Joseph started by explaining how old he was when his father was diagnosed, offering a time scale. Moreover, Joseph used the term 'it helps a lot' to describe how having a diagnosis improved his father's behaviour. It appeared to be a relief to have the diagnosis, which lead to the tone and joviality within Joseph's use of language to return here. Importantly, this relief demonstrated and described by Joseph when asked about his father's current presentation compared to his father's presentation prior to his fathers diagnosis. Joseph highlighted his father's anger was now directed at objects 'the computer' and not at 'us' most of the time. In support of this change in presentation, Joseph used the terms 'now and then' and 'not as often' highlighting a significant change in the presentation of his father.

Izzy

Paul: When he got his diagnosis how was that? Was it better or worse for you?

Izzy: It felt better because we know what he actually had.

Paul: Do you think it's helped him?

Izzy: Yeah. Because we…I…I don't know how it helped him it just did.

As described within Joseph's text, Izzy also felt her father's diagnosis had supported the change in how she felt about her father's PTSD, explaining 'it felt better' with him having the diagnosis. For some families who have been through these epiphanic moments like Joseph, Izzy and Pauline there is often a sense of relief, a sense of acceptance and importantly a base from which to work from (Perkins, Ridler et al., 2018).

4.5.4 Lens of Symbolic Interactionism

As previously explained a symbolic interactional study attempts to capture moments of lived experience and give meaning to the narratives. Such a strategy presents three levels of cultural analysis: the contextual text, its meaning, and its connections to lived experience. Reading the transcripts through the lens of symbolic interactionism enabled me to understand the family using these three levels of cultural analysis (LaRossa and Reitzes 1993; Denzin 2008).

Moreover, this lens allowed me to appraise how PTSD had impacted on Joseph and Izzy; how they made sense of their life within the military; how they made sense of trauma and how it affected their own emotional health. Furthermore, I was able to draw on a change within the family dynamic due to the presentation of PTSD and importantly the shift in relational dynamics. The change in relational dynamics became a focal point to the loss in the relationship with their father.

4.5.4.1 Making Sense of living with PTSD

Fathers from the military may face challenging times when reintegrating back into the family (Karre, Perkins et al., 2018), this is potentially due to the family growing, personalities changing and roles within the family expanding to mitigate for the ‘loss’ of the father within the family home (Cozza, Chun et al., 2005; Park 2011, Bello-Utu and DeSocio 2015).

Much of the literature regarding families living with a family member with PTSD notes that the dynamics of the family home change along with the ‘feeling’ of the family home as if those living there can feel the change of presentation coming and try to pre-empt their actions to either prevent or respond to the symptoms of PTSD. After Joseph’s father had returned to the family home, Joseph noticed distinct changes in his father’s presentation, a change in the family dynamic and the subsequent self-discipline he had to use to prevent further outbursts from his father:

> *“Yeah. You can just see the difference. Not to annoy him too much because we were still quite young then, it was really scary when he would shout at you because he got upset quite easy then. We had to be good. We could be naughty every now and then, but not too naughty otherwise we set him off”.*

Izzy also picked up on the change in presentation of her father:

> *“Well, he began getting PTSD, the symptoms of PTSD. He didn’t sleep very often he would try and distract himself…he would try and work more and try to distract himself. We didn’t see him very often because he was at work, but it was sad because we didn’t get to see him”.*

When making sense of the family dynamic within case two it became clear the presentation of PTSD made Joseph and Izzy act differently within their home environment. The functionality of the family changed from one which was coherent and together; to one where there was chaos, unpredictability, avoidance and fear.

4.5.4.2 Making sense of a change in relationships due to PTSD

When making sense of parental relationships within the military community there continues to be a growing evidence base regarding how relationships change due to combat related PTSD. It is this literature which highlights the effects on the relationship dynamics between a veteran parent and their children, post combat related PTSD presentation or diagnosis (Parsons, Knopp et al., 2018; Watson and Osborne 2020; Zhang, Palmer et al., 2020). The following extracts from case two demonstrate there was a distinct difference in regard to the child versus parent relationship dynamic pre and post Afghanistan and the presentation of PTSD.

Pre Afghanistan:

> *"We went out to places and watch movies together. It was good, it was nice. We just spent time as a family. Yeah. We would mess around and watch movies, we never used to really go out" [Izzy].*
>
> *"Me and dad went on a lot of cycle rides, we went to the park and stuff like that. I used to go to work with him for a week, which I enjoyed. We went to the shooting range. Sometimes I would take out my toy guns and he used to teach me a lot of stuff, like stay on the hedge rows, check out the shadows. Stuff like that. Sometimes we would walk along, my brother would come, and we would jump in the puddles, and he would get soaking wet from the water. Dad wouldn't care, mum would have a go at us, but dad would be just laughing" [Joseph].*
>
> *"They did everything together. They were just really close, and I think it was like, yes, he's home, let's get away from mum. But father absolutely adores the children so it was like let's go to the park and dad was really cool and because they would go out and get absolutely covered head to toe in mud and nobody would be bothered and that sort of thing, which was good fun, it was always outdoor stuff and go to the theme park or somewhere like that and it would be daddy that would go on all the rides" [Pauline regarding Joseph].*

> *"They have got the same personalities which is like, a spade is a spade. And as she is getting older, and hormones are kicking in you can see the future of the teenage years and I am concerned about their relationship as she gets older because they are so similar and neither of them bites their tongue" [Pauline Regarding Izzy].*

Post Afghanistan:

> *"[I was happier when he came home] because we hadn't seen him in ages. I was like happy. It was like having my family back together. Its good. [Then] he would try and work more and try to distract himself. We didn't see him very often because he was at work, but it was sad because we didn't get to see him (becomes upset). He would be in a mood. He would isolate himself into his office and do work. Well, it made me feel quite sad as we didn't get time to spend together" [Izzy].*

> *"You could see when [father] came back from the second tour that things started to change. Obviously at that point [fathers] injuries were really starting to hurt him, and he was just trying to cope with the and things as well but there was definitely not as much closeness as what there was before not through Joseph not trying but just purely [father] was pushing everybody away. He [Joseph] just took it all in his stride and just like while this is my life and just crack on. It is such a disappointment having such a relationship with your dad and then it just goes south not because of anything either of them has done but the circumstances around his job" [Pauline regarding Joseph].*

> *"Before everything [PTSD], really close again and she is still a cuddle monster, but she is distancing herself, I think, not intentionally, I think it is just as she is growing up. She is definitely wary of emotions. It is so hard looking back trying to think how, but she has grown up with it, she has never really known anything different" [Pauline regarding Izzy].*

There is a symbolic meaning of change within the narratives of both Joseph and Izzy. That is, their stories demonstrate a nurturing dad child relationship, a collectiveness within the emotion of all the family pre-Afghanistan.

Izzy used the language of connectedness like *"We went out"* and *"We would"* when describing her relationship with her dad prior to Afghanistan. Joseph used similar terms when describing his closeness to his dad using the phrases *“Me and dad”, “I used to”, “he used to”* and *“dad would be just laughing”* which paints a picture of a dad who was fun and engaging. Pauline used a number of phrases which described Joseph and his dad’s relationship pre-Afghanistan *“They did everything together”* and *“They were just really close”.* It is these phrases from the text which demonstrate their dad ‘was’ a symbol of love, affection, fun and emotionally and physically connected to his family.

It is clear there was a distinct change in the emotion of the narratives of Joseph, Izzy and Pauline when sharing their stories of post-Afghanistan.

Izzy explored the transition from her pre-Afghanistan dad to a dad who changed on his return. Izzy used the following phrases to describe the change in her dad, *“he would try and work more and try to distract himself”, “We didn’t see him very often”, “He would be in a mood. He would isolate himself”* all of which created the following emotion *“it made me feel quite sad as we didn’t get time to spend together”.*

Pauline reflected on Joseph and his dad’s relationship post-Afghanistan and concluded there was a shift in connectedness *“definitely not as much closeness”* and *“just purely [father] pushing everybody away”.* Due to this change in relationship, especially the closeness of a dad and son Pauline explains, *“a relationship with your dad and then it just goes south… it is such a disappointment”*.

Pauline went on to interpret the shift between Izzy and her dad, explaining *“she is distancing herself”* which demonstrates a distinct change in behaviour, compared to pre-Afghanistan. This change in behaviour was due to Izzy being *“definitely wary of emotions”;* and therefore, withdrawn from interacting with her dad and removing herself from what could potentially be a toxic environment.

Importantly, the symbolic meaning of what a dad was to Izzy, Joseph and Pauline pre-Afghanistan had changed. This change was seen in how the interactions with their father had been disrupted and became fragmented due to the presentation of PTSD (Parsons, Knopp et al., 2018). Not only did the behaviour change within the family home, the behavioural effects from their father’s presentation also affected the family’s interaction with their friends and the wider community (Blumer 1962).

4.5.4.3 Making sense of loss

When making sense of both the family dynamic and the relationships with their father, the children's stories presented a picture of ambiguous loss - loss of a functioning family dynamic, place and order, the loss of what was once a positive and emotionally responsive relationship between a father and his children. Boss (2004) and Faber, Willerton et al., (2008) argue the notion that this feeling of loss is in part potentially due to the symptomology of combat related PTSD. Ambiguous loss happens when something or someone profoundly changes or disappears, for example, if someone is still physically present in our lives but is "psychologically absent" due to traumatic events (Huebner, Mancini et al., 2007).

It is important to acknowledge the loss of self within the lives of Joseph and Izzy. Due to parental combat related PTSD, they too changed. Their stories tell of young people who had to adapt. Joseph and Izzy both shared stories of loss of self-assurance and the happy go lucky childhood they once knew. Their childhood shifted to one of worry, anxiety and anticipation of what next, due to their father's presentation. Pauline also acknowledged the loss of childhood within her story noting:

> *"They have sacrificed so much, you know the children and it breaks my heart that our decision has given them this life, if you know what I mean. They deserve so much more, but we just do what we can and try to make it up to them somehow".*

It is this sense of loss and uncertainty that came out within the storied stories when analysing the data. Joseph and Izzy's stories demonstrated feelings of being torn between hoping things would return to normal and a sense that life as they knew it pre-Afghanistan was fading away.

4.6 Case Three: Thomas and Sandra

4.6.1 Constructing Interpretive Stories:

List of Thomas's Storied Titles:

That's when I became aware of it.
I can tell when he is in one of those moods.
I can't just slack off.
Now a little bit more.
A lot less time together.

List of Sandra's Storied Titles:

Thomas's stress response.
The intuitive carer.
Pressure building and keeping it in.
Not emptying that stress bucket.

In comparison to the other families within this study, the narratives told by this family were logical, lineal and articulated in a way which created a temporal timeline of significant events. They provided detail, and a sense of certainty, something which was missing from the other families. The stories highlighted within the storied titles demonstrated a family who were connected by an ethos of connectivity, understanding and a sense of being there for each other. The detail of the narratives was already presented in a temporal order which enabled the analysis process to be a little simpler compared to the other families. However, when I looked at the amount of detail shared it made the inclusion and exclusion of narratives more difficult, therefore, complicating the construction of the re-storied stories. When I looked at the structure of the completed re-storied stories within this case, the stories told of becoming aware of the presence of PTSD within the family home, the effects PTSD had on Thomas and the family, and highlighted Thomas's emotional response to living with and providing care for a parent with combat related PTSD.

This case offered a different perspective of living with PTSD than the others. When breaking down the re-storied stories from both Thomas and Sandra, they provide a breadth and depth of insight to life pre- and post-PTSD. Moreover, both collected narratives provided increased theorising and augmentation, and like the other families, were filled with emotion. Thomas's stories offered great detail and clarity about his mother marrying his stepfather, who was in the military, life growing up within the military community, and how this impacted on his life. The depth of detail when theorising enabled me to develop multiple stories. Sandra's transcripts were dominated by theorising and augmentation. I suspect this was due to having to reflect on what life was like for Thomas pre-and post-PTSD, and to contextualise these reflections based on the care provided by Thomas and the emotional effects this had had on him. Again, this process of reflection created an emotional response from Sandra, when she realised the impact that providing care had had on Thomas. To understand the dynamic and the effects caring had on Thomas, and to explore its meaning, as with all the cases within this study McCormacks (2000a; 2000b) multiple lenses were used.

4.6.2 Lens of Language:

Using the lens of language within this case I was able to assess the features of Thomas's and Sandra's language. Furthermore, the assessment of language enabled me to identify how their words, their meaning and their impact shaped their lives. By assessing what was said and the meaning of what was said at specific moments across a life span, I was able to provide an interpretive story. As with the other cases the analysis of language highlighted word groupings, or phrases which indicated a relationship of self, and interaction with others, allowing me to create meaning and understanding of the emotional effects of being a young carer. In addition, I analysed the frequency of words, words which held common meaning and words which offered insight into the thoughts and feelings of the participants within this case, which further enabled me to understand their experiences.

Thomas

The language used by the participants within this case reflected their told story, each offering a different perspective and use of language when describing moments in time. When analysing Thomas's data, I found that he was articulate, reflective and provided significant depth of his life's story. When Thomas was thinking about a question he would often pause, and then fully engage with the question. At times there were long pauses which suggested he was answering the question in his head or working out how he could word it in a certain way as he did not want to over share. This pause and reflection on his past would often be prompted by the word 'oh', to offer him some thinking time. 'Oh' was often followed by 'I remember' when starting a sentence. This word grouping was common throughout the whole interview, allowing Thomas to take his time and answer the question with depth. The use of 'oh' had a different tone to it when Thomas was sharing different stories within his life. There were times when Thomas would use 'oh' in a louder tone when he was excited or happy about the narrative he was about to share. However, when he was speaking about moments that where not as happy his tone and volume changed, and he became quieter. It was in these quieter moments that Thomas would really take his time to answer due to the sensitivity or the emotional hurt that could be caused by recalling difficult situations.

In Thomas's first storied title, 'That's when I became aware of it.' Thomas used 'I' and 'we' interchangeably when providing the contexts of his story. Thomas also provided insight into his position within the family when he described 'He [stepfather] just seemed distant from me and the family'. This suggests that Thomas may have thought or felt that he was not part of the family. Thomas used metaphors to describe what life was like to allow the listener to construct a picture of Thomas's description. When discussing the presentation of PTSD, Thomas described his stepfather being distant, not being in the room emotionally and being a million miles away. The use of 'him' and 'he' was used throughout this story to describe his stepfather. Thomas never used his stepfather's name throughout the interview.

In Thomas's second storied title 'I can tell when he is in one of those moods' it appeared Thomas was witnessing the emotional and physical presentation of PTSD in his stepfather. When analysing this story, the use of 'he would', 'he was' and 'he has' were used more than any other collection of words. I interpreted the use of this specific cluster of words as Thomas theorising within this story and demonstrating he was able to describe how his stepfather's mood would change, and that he could pick out pertinent moments of when this would be and could provide the cause of the change in presentation and discuss the potential consequences of those moments in time.

Thomas explained he had always been a big brother and supported his parents with his younger siblings. However, within this story Thomas highlighted how his role within the family home was changing due to the increased presentation of his stepfather's PTSD symptoms. This story contrasted with Thomas's other stories, where he demonstrated his emotional maturity, and took up his role of care provider to his stepfather as well as his two siblings. Thomas described himself as the third parent, which may go some way to understanding the words Thomas used when describing his actions. Within this storied title Thomas used the words 'I get', 'I am', 'I have to' and 'I can't'. It is these words which I interpreted as Thomas's action words. As Thomas stated, "I can't slacken off", he had to provide support. Moreover, the use of 'I can't' demonstrated that Thomas had some restrictions potentially due to his role within the family home.

Interestingly, Thomas explained he 'can't just leave his mum and dad to look after the kids, even though it's their job', which I have interpreted as him wanting to have a role within the family home and be part of the family structure. This interpretation is born from Thomas explaining that he was jealous of his siblings when they were born and he felt pushed to the side a little, and there was a change in his relationship with his stepfather. From this extract I was able to locate the perceived parenting role within the family home and the additional stress this put-on Thomas. For example, Thomas explained that when it was just him and his stepfather in the home, he had more chores to do, leading to more responsibility to get things done as his stepfather struggled to rationalise situations and cope with Thomas's siblings.

It was these moments of added stress which somewhat changed the closeness of the relationship between Thomas and his stepfather. Within Thomas's final story the use of 'a lot less' and 'less time together' indicated that the closeness he once had with his stepfather had diminished due in part to the presentation of PTSD. It was this reflective approach which provided more insight into the presentation of PTSD, and its effects of their relationship. Thomas appeared to understand the correlation and causation of their changing relationship. When I put Thomas's narratives together, within the context of his stories, there was a distinct temporal change in his use of language, to describe the changing landscape within his family home. For example, Thomas used 'we' to describe the collective relationship. This collective relationship then moved to ‘he was’ and ‘he would’ which highlighted that his stepfather ws emotionally moving away from the collective relationship.

Sandra on Thomas

I remember during the interviews with Sandra on how PTSD had affected Thomas, she would at times pause to reflect on the question being asked. At times these pauses lasted longer than others. The use of continual reflection and intermittent pauses created moments of silence where Sandra was working out how PTSD had affected Thomas, and how the presentation of PTSD was affecting his emotional health and his relationships. In addition, Sandra appeared to be trying to piece together the journey the family had been on and was explaining how Thomas had taken on more and more responsibility due to her work and the presentation of PTSD within the family home. This reflective approach was consistent and always narrated with a tone of compassion and understanding.

Sandra’s use of endearing descriptive words when describing Thomas demonstrated how affectionate he was towards his family. Sandra described Thomas as being the kind of young person who needed and wanted to care for people. Within the augmentation of Sandra’s developed stories, Sandra explained this was potentially due to Thomas having high emotional intelligence and automatically falling into a caring role. Moreover, Sandra was mindful of the amount of caring responsibilities Thomas undertook, stating ‘Thomas had to take on more of a caring role for me as well as his stepfather and helps manage his brothers’. The role of carer with additional responsibilities was something I picked up on during the interview with Thomas when he shared the stories of his mother working extra shifts, his stepfather being away training and him already looking after his two siblings. Being a care provider for Thomas would appear to be intuitive from his mother’s perspective, however, as Thomas explained he ‘can’t just slack off’, meaning he felt he had a role to play and was committed to undertaking that role; he was taking on the responsibility of care provider and as he stated, to ‘be the third parent’.

Another interesting observation from Sandra’s data was around how she perceived caring for all the family at different moments in time was affecting Thomas’s emotional health and well-being. Sandra explained “I think he feels he is a burden” on the family, and especially his parents. Sandra continued and stated, “he doesn’t share his emotions… so he feels he is dealing with a lot of emotions on his own [due to our issues]’. It was statements like this within Sandra’s narratives which linked to Thomas describing feeling ‘annoyed, stressed and left out’ when explaining critical moments across his life, including the birth of his siblings, and his relationship with his stepfather.

When I analysed the spoken text to see which words were used in which stories and where the pauses were, I noticed that when the participants within case three discussed life before PTSD and their family relationships they would not hesitate to share in storying their story. This receptive and open access discussion continued when we began to discuss the lead up to the presentation of PTSD and its effects on the family dynamic. The participants within case three were not afraid to share what was happening at home, or the effects this was having on them and their family. It is the context of these moments which I will provide a deeper insight into within the sections below.

4.6.3 Lens of Context:

As described in the data analysis section of this study in Chapter 3, the lens of context was used to underpin what culture meant to each participant. Looking at the situational context of the data allowed me to develop a deeper understanding of the everyday experiences of the participants within this case and to determine the effects living with PTSD had on them as a young carer and as a family. I was interested to understand how military life and parental PTSD shaped the culture of the participants within case three and how it affected their emotions and activities of daily living. Through this process I was able to probe into the data and annotate my thoughts regarding the participants' responses, their reactions and the interactions between myself and the participants.

In order to understand what culture meant to the participants I had to decipher what the data were saying about culture. Moreover, when looking through the lens of context for Thomas I was able to focus on his shared narrative to develop a greater understanding of the context of his life as a young child moving into the military community, whilst developing a new relationship with his stepfather, and to determine how the introduction of new half siblings changed the family dynamic.

As previously discussed at length, military children and young people are a multi-layered complex population (Cozza et al., 2005) who have many shared experiences. These shared experiences offer children and young people from the military community a common connection (Easterbrooks et al., 2013; Watson and Osbourn, 2020). Thomas was born outside of the military; his mother separated from his biological father and met a serving member of the military when Thomas was very young. This relationship continued and Thomas and his mother then became members of the military community themselves. Thomas described his early years and being part of a military community and he described some of the difficulties he associated with being part of a transient population. The following extract demonstrates the transition into the military community and provides the reader with an understanding of what life can be like within the military community.

Being part of a transient community.

> **Thomas**
>
> *Paul: What was it like being classed as a military child, as that was something new for you. What was military life like for you as you were not born into it?*
>
> *Thomas: I didn't feel it particularly affected me apart from moving schools. I moved schools once in that period and I missed my friends from my previous school, but I made friends.*
>
> *Paul: In the three years from your mum getting married up until your brother was born describe what life was like for you. What was your friendship group like?*
>
> *Thomas: I had moved round school a lot, so it was difficult to make friends.*
>
> *Paul: How many schools?*
>
> *Thomas: I went to about 4 or 5 primary schools. I have been to two secondary schools. I am used to moving round.*
>
> *Paul: What was friendships like between 5 and 9?*
>
> *Thomas: I think in between I had found a school I had stayed with for a bit and I was having birthday parties and we would go bowling. I had good friends then, I would invite them to my place, and I would go to their place every now and then.*
>
> *Paul: Did you find it quite easy making friends?*
>
> *Thomas: I think so. I am not exactly the person to have loads of friends, I am not particularly popular, but I had a close small group of friends that I would hang around with.*
>
> *Paul: A solid friendship group?*
>
> *Thomas: Yep.*

From Thomas's text there is a sense that being a military child affected his schooling and the relationships within the school environment. Thomas' extract supports the work of the Service Children Progress Alliance (2016), which postulates that multiple school moves and changes in curriculum can have a negative effect on a child or young person's educational attainment. Moreover, frequent moves for military children and young people can affect the development and retainment of friendship groups (Stepka and Callahan 2016; Huebner 2019; Veri, Muthoni et al., 2021). However, it is important to note, as Thomas's narratives demonstrate, that although many children and young people from the military community frequently move home and schools, many are able to thrive and develop new friendship groups and do well academically at school (Park 2011; Kudler and Porter 2013; Bello-Utu and DeSocio 2015; De Pedro, Astor et al., 2018). It was through this extract that I was able to see the level of maturity within Thomas's reflections. His ability to identify moments in time and theorise the causes and correlations of certain circumstances I believe enabled him to rationalise the transitional lifestyle he was living.

A shift in attention

> *Paul: Your mum has had another baby. How was that for you?*
>
> *Thomas: It was chaotic. Having the two brothers now was very different. The attention had to be spread between the two of us and I had to share a room with my middle brother.*
>
> *Paul: What does attention mean to you because it means different things to different people?*
>
> *Thomas: There was less on me obviously, but I had my middle brother before and I have been through that transition before.*
>
> *Paul: So how was that for you – having a baby who needed attention and three-year-old who needed attention and at 12 year old who didn't quite need as much attention?*
>
> *Thomas: I think it was very difficult and I was given more responsibility to look after myself a little bit more and look after my middle brother whilst they were looking after my baby brother.*

> *Paul: Did you ever feel any jealousy?*
>
> *Thomas: I did. I think so, a little bit. But I always saw how it was for them and they struggled, and it wasn't their fault I wasn't getting attention. I still had attention but just not as much as before. So I wasn't that jealous, but every now and then I did feel a little bit of resentment, but it never lasted long.*
>
> *Paul: How does that make you feel?*
>
> *Thomas: When I did go through those periods of feeling a little bit resentful and jealous of my two little brothers because it was quite upsetting because I had been a lonely child for 9 years and I had my stepfather to myself for 4 years, for most of my life, I felt quite upset and distraught by it.*

The above extract provided by Thomas demonstrates the thoughts, feelings and emotions he experienced with the birth of his second brother accompanied by a shift in attention from his stepfather due to the birth of his son. As King, Thorsen et al., (2014) explain, the majority of children who reside within stepfamily homes live with a stepfather rather than a stepmother (Stewart, 2006), and it is the relationship between the child and stepfather which potentially will dictate the functionality of the family unit (Coleman, Ganong et al., 2000). Thomas described a positive introduction to his stepfather, and he reported that they developed a close bond quite quickly. When talking about his introduction to his stepfather Thomas explained "I warmed to him very quickly as I never really had a father figure round. My dad left when I was very young so having that male role model round, I really warmed to him". It is this extract from Thomas which supports the work of King (2006) who highlighted that close and supportive relationships with stepfathers and stepchildren are beneficial for the child's development and their achievements.

However, as Thomas's mother and his stepfather had additional children there was a perceived shift in the relationship between Thomas and his stepfather. The work of Stewart (2005) highlights that at times stepchildren can feel displaced due to the birth of a biological child. Thomas explained that the introduction of his half siblings created a feeling of jealousy and resentment and threatened his position within the family dynamic. Interestingly, Thomas did not theorise as to why his position had shifted nor did he determine the focus of his resentment. However, Thomas did explain that the birth of his second half-brother brought his relationship with his first half-brother closer, which I have interpreted as Thomas directing his resentment to his stepfather and the new born baby, due to the increased time his stepfather and the new born were spending together (Stewart, 2002). Moreover, it was at this point within the narrative that Thomas recognised that at 12 years' old he had to start looking after himself a little more, as well as his middle half-brother. It was at this point within Thomas's life narrative that I identified that he became a young carer.

4.6.4 Lens of Moments:

As previously discussed, using moments in time as a lens to locate specific episodes by using the four forms of epiphanies I was able to identify changes in behaviour, feelings and relationships within the family dynamic due to the presentation of PTSD. When Thomas' 'moments' throughout his life radically altered he had to reshape the meaning he assigned to himself and his life (Denzin, 2008). It was therefore important to plot and examine each epiphany within the text when Thomas in order to understand Thomas' environment, and his role within the family home.

Below are extracts from Thomas and Sandra's narratives which highlight where I felt the effects of a change in role, the presentation of PTSD, and the change in family dynamic affected Thomas' emotional presentation.

A major upheaval can be classed as a big change which can cause trouble, confusion or worry and can change a life forever (Denzin, 2008).

A major upheaval: When he came home from war.

> *Paul: Where did he serve?*
>
> *Thomas: Three tours of Afghanistan.*
>
> *Paul: When did he first go to Afghanistan?*
>
> *Thomas: I think his first tour was 2007.*
>
> *Paul: What about the others?*

> *Thomas: I think it was this tour in 2009/10 because he was away over Christmas. I remember him coming back from that and he was not so happy and friendly around me anymore. He was still a loving father, and we would spend time together, but I remember him being a lot angrier and more upset and he would get into arguments more frequently with my mum.*
>
> *Paul: What do you mean by being more angry?*
>
> *Thomas: One vivid argument they had – me and my mum were sat on the sofa, and he kicked the table and broke the table leg, he very angry and shouting, he was very hysterical. That was after he came back.*

Thomas demonstrated his understanding of the deployment cycle and explained that his stepfather's integration into the family home was difficult due to combat exposure. Thomas narrated the story of his stepfather's return and the difficulties he faced returning to the family home, explaining "he was not happy and friendly" (Holmes, Rauch et al., 2013; Duax, Bohnert et al., 2014). Thomas went on to describe how this presentation would change the dynamic within the home due to increased arguments between his mother and stepfather and the presentation of anger. What Thomas presented to the reader was the temporal journey of a returning combatant and the emotional affects combat had on his stepfather. The language Thomas used to talk about his own feelings allowed him to share what life was like during this time, and to recount the effects this had on his own emotional wellbeing.

Sandra on Thomas:

> *Paul. When Thomas's stepfather came back after that tour, what was Thomas like?*
>
> *Sandra: Different, very quiet. He started to become more reserved, but I don't think that was necessarily just Thomas, I think it was his stepfather as well, because that was the start of things unravelling mentally so he was less involved with the kids, less fun to be around, more angry. That was the beginning of his unravelling so although that time is a bit murky for me and in terms of thinking back to how it was, it was a really dark time for everybody including their relationship.*

The above extract from Sandra provides an insight into how the return of her husband affected Thomas and his relationship with his stepfather. As King and Smith (2016) and Collins (2018) identify, the integration of a returning parent and the presentation of mental health issues, including PTSD, can affect the emotional health and well-being of their children, and this change in emotional health can have a detrimental effect on their short-, medium- and long-term health (Le Menestrel and Kizer 2019). As noted within the above extract, Sandra used a lot of augmentation to provide contextual reflection on the effects the presentation of PTSD was having on Thomas, and how it was affecting the family.

The culminative refers to the final build-up of crisis within a person's life (Denzin, 2008).

The Culminative: My stepfather was scary at times

> *Thomas: I wasn't aware of his PTSD I was slightly scared because I didn't know why he was like this and I used to ask mum, but I never remember her giving me a response to what was wrong with him. I just remember him being angry and I didn't know why. I felt sorry for him, I was scared and was just concerned.*
>
> *Paul: What did it feel like physically when you witnessed that?*
>
> *Thomas: I remember shaking and watching him, wondering why he was being like this. I had never seen anyone behave like this before, as it has only ever been me and my mum and close family, so I had never seen anyone behave like that. So, I was scared. I don't remember much other than that.*
>
> *Paul: How long did that go on for?*
>
> *Thomas: From when I was 6 till my brother came along. So, three years, on and off.*

As documented within the literature review in Chapter 2. witnessing the presentation of parental mental health issues including PTSD can have a negative effect on a child or young person's emotional health and well-being (Fear, 2017; Collins, 2018). In the above extract Thomas was giving the reader a time frame where the presentation of PTSD symptoms began and started to affect his own behaviour. Not only did Thomas share what was happening within his environment with regards to his stepfather's presentation, he was also describing how his stepfather's presentation made his body react, both physically and emotionally. As Parson's, et al (2018) explain, children and young people who witness traumatic events can also be emotionally traumatised by the event, and this trauma can manifest in physical symptoms. Moreover, Thomas acknowledged he had no understanding of why this was happening by explaining "I didn't know what it was and why he was doing it", but he demonstrated compassion and understanding of the situation stating, "I just felt sorry for him". As Newman (2002) notes, children and young people may not know what is going on with their parent's health, but they want to understand and feel a sense of wanting to provide support.

Sandra on Thomas:

> *Paul: Was there a reason why he wouldn't talk about it [his fears]?*
>
> *Sandra: I think he had a fear because he is quite emotionally intelligent, and he is very aware of other people's feelings so because of that he doesn't want to cause upset especially when he recognises stress in somebody else and doesn't want to put extra stress on somebody by talking about something that might upset them.*
>
> *Paul: Do you think that witnessing that behaviour has made any difference to him growing up?*
>
> *Sandra: I think that has affected his childhood a little bit as he has become older before his years and think he takes on a lot of responsibility and doesn't share the burden that has on him mentally. I think he keeps a lot to himself. He also doesn't understand his feelings although he can pick up on other people's feelings and process them he is not very good at understanding his own feelings. So I think all that pressure building it up and keeping it in hasn't done him any favours as a teenager.*

As Thomas described within the extract above, his stepfather's presentation of PTSD, namely anger, promoted fear and anxiety within himself. Sandra's extract offered a different perspective of the same situation. What is interesting about Sandra's extract is the depth of information regarding Thomas's emotional presentation due to his stepfather's PTSD symptoms. Sandra was able to articulate Thomas' emotional response to the situation he was currently living in. The example provided by Sandra is also discussed by Banneyer, Koenig et al., (2017) whose systematic literature review outlined the effects parental mental health issues, including PTSD, had on the emotions of children and young people.

Illuminative moments, as described by Denzin, (2008) are moments in which the underlying existential structures of a relationship or situation are revealed.

The illuminative: His PTSD changed our relationship

> *Thomas: That's when I started to notice it, he was being different to how he was before.*
>
> *Paul: What was different?*
>
> *Thomas: We were spending a lot less time together and I was by myself or with my mum. I would go and visit my dad on weekends and was spending less time with my stepfather and enjoying him less. We did less as a family and doing things families enjoy doing.*
>
> *Paul: How did that make you feel because from what you are discussing it sounds as though PTSD has put a block between what you have in a really good relationship?*
>
> *Thomas: Yeah. I think so even now I recon there is a difference in our relationship. When I was younger it was more about spending time together having fun. And now it's like just emotionally being there for each other. It's not been blocked off, its shifted [the relationship]. We are still close; I think we talk less to each other, and we spend a lot less time together. We are less communicative.*

The above extract from Thomas depicts a shift in the relationship between himself and his stepfather. Marsiglio (2004) alludes to the fact that stepfathers often make claim to their stepchildren and treat them as their own. However, within the context of Thomas' narrative, this 'claim' had wavered, and Thomas and his stepfather had drifted apart. Stewart (2006) highlights that living in a stepfamily can be stressful for its members, noting there are many stressors a family can face including moving into a new home, a lack of parenting quality and disharmony between the new members of the household. However, Thomas described warming to and being close to his stepfather until the presentation of PTSD. It is at this moment when the relationship between Thomas and his stepfather became disjointed or begins to break down that Smith (2004) suggests the stepchild will potentially seek solace from their biological parent. In this case. the culmination of the presentation of PTSD and the breakdown in the relationship between Thomas and his stepfather resulted in Thomas going to see his biological father more.

Sandra on Thomas:

> *Paul: What do you think was the biggest issue regarding their relationship?*
>
> *Sandra: Everything had gone wrong and there was so much, he [stepfather] wasn't around but not his fault but still angry about it. I had to prompt Thomas's stepfather to engage with the children. So, there was anger and frustrations on all parts from Thomas which probably gave him a sense of abandonment not just physical but mental as well.*
>
> *Paul: About the emotional abandonment what did that look like within the house?*
>
> *Sandra: Thomas was really just quiet, just a very quiet child, wouldn't display his emotions, he has never been argumentative, he has always been a child to do what he was asked and when he was asked. So there just seemed to be less fun in him and not bothered about doing things.*
>
> *Paul: How did that then affect their relationship?*
> *Sandra: They stopped having fun together. I think that affected Thomas's relationship with everyone.*

The above extract provided by Sandra demonstrates a number of issues with regard to the context of the relationship dynamics not only between Thomas and his stepfather, but also between Sandra and her husband. Firstly, Sandra explained she had to act as a gatekeeper and direct Thomas' stepfather to engage with his children. The work of Seery and Crowley (2000) supports Sandra's efforts to promote, build and maintain affectionate and involved relationships between stepfathers and their children. The development of the gatekeeper role was an attempt to facilitate the stepfather-child relationship and encourage them to spend time together and mediate their relationship (Weaver and Coleman, 2010).

The relieved moment happens wherein a person, after the event occurs, comes to define it in consequential terms (Denzin, 2008).

The relieved moment: I sometimes refer myself as the third parent.

> *Paul: When your mum is not there and it is just the four of you, your brothers and your stepfather do you have to do more?*
>
> *Thomas: I do yeah, with one parent gone the other has added responsibility of looking after the kids, usually when they are both here one will look after one kid and the other with another kid.*
>
> *Paul: In what way?*
>
> *Thomas: When there is only one parent it is quite difficult for all of us so that will affect his mood and he will be a lot more stressed out. So we sit down together in the evenings and watch TV and have dinner. It is only then when he will relax and calm down, and then we can talk, and he will discuss how mums stressing him out sometimes or the kids are just being kids. That is how it is when it is just us.*
>
> *Paul: When it is your mum and your brothers how much support do you give with your brothers?*
>
> *Thomas: A lot. I sometimes refer myself as the third parent. I have to help out a lot with the bedtime routine, babysitting them.*
>
> *Paul: How does that make you feel?*
>
> *Thomas: It's difficult. I get a mix of emotions. I am annoyed and stressed. I can't just leave it to mum and P to help with the kids, although it is their job, I can't just slack off.*
>
> *Paul: Out of five, [one being lots of support] when your stepfather is away and it's your mum what is it like for your providing support?*

> *Thomas: I would say 3 or 4 because I do have to help my mum a lot. She could do it alone, but she would struggle because of her mental health declines. But she doesn't constantly have to rely on me.*
>
> *Thomas: What about when your mum is away, and you are with stepfather?*
>
> *Thomas: I would say more, as mum is better at dealing with her stress of being a parent. But P with his condition he struggles sometimes to rationalise and deal with the stresses of kids, so a 2 or a 3. It's mainly during the day.*
>
> *Paul: So, there is a difference between one set of the four of you to the other set of four?*
>
> *Thomas: I think there is, I can feel the difference.*

Thomas' ability to offer a temporal picture on his own journey to date appeared as a relieved moment, that is the self-recognition of his current position and role within his family. When interpreting the above extract by Thomas I was drawn to the fact that Thomas saw himself as a third parent. Thomas started by explaining his caring responsibilities within the family home and having to provide support with looking after his stepsiblings due to his parents' careers and to his stepfather, due to his presentation of PTSD. Thomas' description of his role is supported by Gough and Gulliford (2020) and Cameron, Walker et al., (2022) who explain that children and young people move into a caring role in the absence of an adult and start to act as a primary carer. During the interview it appeared Thomas was at times perplexed with his role, but he came to his own realisation that he had to do it stating, "I have to step up". Moreover, Thomas also demonstrated to the reader that the variety of his role as a young carer depended on the make up of his family at specific times and how this made him feel.

4.6.5 Lens of Symbolic Interactionism

As previously discussed, a symbolic interactional study tries to capture moments of lived experience and attempts to give those chosen moments meaning over three levels of cultural analysis. Analysing the data through the lens of symbolic interactionism allowed me to understand the family from the perspective of Thomas and his mother (Denzin, 2008). Moreover, the lens of symbolic interactionism enabled me to appraise not only how PTSD had impacted on Thomas' life, but also how the introduction of his stepsiblings changed his relationship with his stepfather and understand how his caring role differed depending on which parent was at home. By appraising these moments, I was able to identify change within the family dynamic and understand how it was affecting Thomas's emotional presentation.

4.6.5.1 Making sense of the family structure and process

As previously discussed within the literature review in Chapter 2, military families experience unique working environments which require the family to be flexible, adaptive and tolerant (Arnold, Lucier-Greer et al., 2017). Moreover, there is an argument that military families are best understood by considering their structure, (how they appear) as well as the processes of the family (what occurs within them). As Cavanagh (2008) indicates the structure and the process of the dynamic within the family, and its situation at any given point, impacts on the emotional health and well-being of the children. As highlighted with this case, the structure of the family was formed when Sandra met her partner, and over a time became Thomas' doting residential stepfather (Stewart, 2006). As Thomas explained *"He was very good with me, and we became close friends and that I think made mum love him a bit more"*. This connectivity can be interpreted as the 'we-ness' Marsiglio (2004) coined within his work. Moreover, within the context of the aforementioned narrative there was sense of belonging, loyalty and the construction of new beginnings. Throughout Thomas' narratives there was evidence of the development and closeness of Thomas and his stepfather's relationship.

Thomas' narratives regarding the beginnings of this new family unit were supported by his mother Sandra:

> *Paul: How did your partner then adjust to becoming a stepfather?*
>
> *Sandra: He adjusted really well mainly because he just loves kids, and he is a big kid himself. One of the things I would never have even considered another relationship, but we were friends before we were even together. He is very good with children and if he hadn't been good with children and put Thomas first, I would never have entered into a relationship with him.*

It was this development of new beginnings which created the structure of this now, military connected family. As discussed at length within the literature review in Chapter 2, military families are transient families who often face multiple moves which for some families can be difficult (Cavanagh, Schiller et al., 2006; Esposito-Smythers, Wolff et al., 2011; Briggs, Fairbank et al., 2020). The difficulties of transition were evident in the narrated stories of both Thomas and Sandra. Thomas and Sandra both shared their experiences of Thomas's stepfather's multiple deployments, its effects on them and the disruption deployment caused to the family structure and processes within it.

However, there was a change in the family structure with the introduction of a new born post deployment, which presented the beginning of the changes within the structure and the dynamics of the family.

> *Paul: Your 9 and have a baby brother. What's that like?*
>
> *Thomas: I loved it. I love being a big brother and I had been lonely, as I only had mum. So having a brother was amazing.*
>
> *Paul: Did you do stuff for him, or would that be left to your mum?*
>
> *Thomas: Yeah. I would entertain him, just everyday brotherly stuff.*
>
> *Paul: How was your mum and your stepfather then?*
>
> *Thomas: I think my stepfather had calmed down a lot as he had his new son, and it was quite special for him as I wasn't his biological son. So, to have his own son he felt very privilege and loved him a lot. He was busy doing the father thing.*
>
> *Paul: How did that make you feel as you had his undivided attention for 4 years?*
>
> *Thomas: I don't know actually. I don't think it affected me then. Now a little be more, I think it affects me but then I don't think so. I just loved my brother so much that I wasn't really bothered.*

Within the above text Thomas offered the reader an insight into his thoughts and feelings with regards to the birth of his first stepsibling, but importantly Thomas also indicated displacement within the relationship with his stepfather. The use of language Thomas chose to use was profound and also provided what could be interpreted as an explanation for his stepfather's withdrawal of attention. Thomas rationalised this withdrawal when he stated "it calmed him down" as if to explain that the birth of his child regulated his emotions. Thomas perceived this as a good thing. Moreover, Thomas went on to say, "I was not his biological son…it was a privilege for him [to have his own son]", it is this statement which depicts a moment in time where Thomas physically and emotionally stepped aside. This interpretation was supported by Thomas who stated, "I think it affects me now, I just love my brother…I wasn't bothered". Thomas appeared to sacrifice his relationship with his stepfather for the benefit of his brothers.

4.6.5.2 Making Sense of the presentation of PTSD

It is well documented that military families have the potential to face numerous challenges due to military life, and specifically deployment and re-integration to the family (Louie and Cromer 2014; Bello-Utu and DeSocio 2015; DeVoe, Ross et al., 2020). As previously discussed much of the literature regarding the integration of a returning parent post combat, who over time presents with symptoms of PTSD, notes a change in both the emotional and physical presentation of the returning family member. After Thomas' stepfather returned to the family home from his third tour of Afghanistan, Thomas noticed a distinct change in his emotional presentation which subsequently changed the dynamic of the family structure and processes.

> *Paul: What did PTSD look like to you?*
>
> *Thomas: I remember him being a lot more angry and upset, a lot more and he would get in to arguments more frequently, I noticed he was distant; he would be in a room and like a million miles away. We were spending less time together; he would be working more. He just emotionally seemed distant from me and the family.*
>
> *Paul: Was he doing anything significantly different?*
>
> *Thomas: He was going out a lot with friends drinking a lot, and it would change the atmosphere [at home].*
>
> *Paul: Why do you think this was happening?*
>
> *Thomas: He had a lot going on, he had been to war, he wanted to be with his mates.*

In this case when making sense of living with PTSD and its effects on the family dynamic it become clear that the presentation of PTSD made Thomas theorise and look at what had caused this change in the presentation of his stepfather. Moreover, Thomas demonstrated the meaning within the context of this episode and demonstrated his ability to conceptualise and rationalise his stepfather's presentation. It appeared that Thomas really understood what was happening, which led to a tone and calmness in Thomas' use of language to be delivered as I feel it was meant to be received. Thomas attributed no blame, he explained that it was what it was, and it was something he had to live with (Beks, 2016).

Sandra corroborated Thomas' description of his stepfather's presentation, explaining;

> *Sandra: I am just literally cooking dinner, kids haven't seen him for a week and I haven't seen him for a week and he just walked out the door in his shirt and trousers and wouldn't probably come back until 3,4,5.*
>
> *Paul: Were there many arguments, I know families argue, but escalated arguments within the home?*
>
> *Sandra: At that time there were raging arguments and I would say we can't do this in front of the children but sometimes there is nowhere else to go, and it comes out there and then. In hindsight, an awful lot of things do but, yes, there were.*

Both Thomas and Sandra's description of temporal moments when PTSD presented itself, highlighted that anger was the most prominent symptom. It was this presentation of anger which changed the dynamic within the family structure, therefore changing the functionality and closeness of the family.

4.6.5.3 Making Sense of a change in relationship due to PTSD

As previously discussed, making sense of military connected families and their structure is a complex process due to a multitude of circumstances, including different roles within the family pre, during and post deployment as well as the transient nature of military families (Mulholland, Dahlberg et al., 2020; Veri, Muthoni et al., 2021). Research by Parsons, Knopp et al., (2018) and Watson and Osborne (2020) to name but a few, have demonstrated the relational effects between the serving parent and their children due to military deployment and the presentation of PTSD. The following extracts from case three demonstrate a distinct difference in regard to the child versus parent relationship dynamic pre and post the presentation of PTSD.

Pre PTSD:

> *"I warmed to him very quickly as I never really had a father figure round. My dad left when I was very very young so having that male role model round was amazing. He had a flat on camp and we used to go and visit him, and I would see pictures of me with him, and remember spending a lot of time with him. He taught me how to ride a bike, I just developed my relationship with him. The fact that he was so good with me and he was naturally good father. He has been in my life for as long as I can remember, he has always been that fatherly figure. I do have my biological dad, but he is my father" [Thomas].*

> *"It was really good [the relationship] and his stepfather was very good with children in general so was the fun one and was the one who would let him sit on his lap and drive around in the car on camp. He would take him down the woods and play shoot the aliens, rather than shoot the fairies, so their relationship was very good, a really positive relationship with fun and laughter" [Sandra regarding Thomas].*

Post PTSD:

> *"…that's when it started [change in relationship]. I think he [stepfather] had been diagnosed not long after my brother was born. I noticed he was distant; he would be physically in the room with us, but it felt like he was staring into space. As a family and with me, we were spending less time together. He seemed to be emotionally distant from me and the family. That's when I started to notice his mood swings and him getting angry, and damaging things in the house, he was being different to how he was before." [Thomas].*

> *"Angry, unable to connect properly, not easy to be around. I would say he was like that 80% of the time he and 20% of the time he was back to his old self, being full of fun and he just became more and more angry and disconnected from his family." [Sandra regarding Thomas].*

There is symbolic meaning within the discourse of this family. That is, the stories shared by Thomas and Sandra demonstrate a relationship with was organic in its development.

There was mutual respect and connectedness between Thomas and his stepfather. This connectedness cemented the development of a stepfamily. During the interview Thomas spoke with fondness and with a smile when he spoke about the first time he met his stepfather, and how he "warmed" to him quickly. Thomas's tone and the softness of his voice when he reflected on the time, they spent together demonstrated his stepfather was the missing piece of his early childhood and overtime Thomas stated "*he is my father"* and a "*role model".* It is these quotes form Thomas which highlighted a shift in his symbolic meaning of fatherhood. Interestingly, Thomas used the term biological dad, to describe the person who he was biologically connected to, and the label of father, when referring to his stepfather, something many would say is a contradiction within the social construct of the male parent (Lamb 2013).

Thomas used language of connectedness like *"we would"*, *"me with him"*, and *"with me*" when describing his relationship with his stepfather prior to the presentation of PTSD. Sandra used similar language when describing Thomas and his stepfather's relationship pre-PTSD *"they are so close"* and *"always together".* It was these collective words within the text which demonstrated that Thomas' stepfather 'was' a symbol of affection, love and emotional connection.

It is clear from the analysis of the data that there was a distinct change in emotion from Thomas and Sandra when sharing their narratives of Thomas' stepfather post-PTSD. Thomas explored the transition from his pre-PTSD stepfather to a stepfather who changed on his return from numerous tours of Afghanistan. Thomas used the following phrases to describe the change in his stepfather's presentation, *"he would work more", "he went out often", "He would be angry. He would damage things"* all of which created the following emotion *"it made me feel sad, I was scared".* This can be interpreted as Thomas feeling sad and scared, resulted in him withdrawing from the relationship. This interpretation and its meaning are supported by Sandra who reflected on Thomas and his stepfather's relationship post-PTSD. Sandra explained there was a shift in connectedness *"they spent less time together"* and *"Thomas would avoid situations and interactions"*. Due to this change in the relationship, especially to the closeness of their relationship, Sandra concluded "*PTSD gave him [Thomas] a sense of abandonment not just physical but mental as well from his stepfather".* As highlighted previously, the relationship between a stepchild and a stepfather is a complex and at times a fragile development in search of 'we-ness'. However, as the reader will identify within this case, 'we-ness' can be disrupted due to stress (Le Menestrel and Kizer 2019), and in the case of this family, the presenting symptoms of PTSD had not only been stressful they had changed the functionality of the family and the dynamic between Thomas and his stepfather (Parsons, Knopp et al., 2018).

5 Chapter 5: Cross-case findings ‘between families’

This chapter explores cross-case findings. The previous chapter indicated that the stressors that some service personnel face during combat deployment can influence young carers’ overall experience of family life, both during the deployment and on their return. Moreover, as highlighted within the literature review in Chapter 2, as well as in the previous chapter, during deployment service personnel experience a number of difficult challenges, obstacles and pressures which can have an impact on the emotional wellbeing of their children and adversely affect their relationships with their children. Chapter 4 presented ‘within-family’ stories which demonstrated that major family upheavals had changed the young carers’ lives forever. This chapter builds on those findings by presenting ‘between-family’ themes.

The second stage of the data analysis process which was outlined in Chapter 3 resulted in the development of a number of key themes being identified which were common across the three case study families. These were:

- Presentation of PTSD within the home;
- Relationships;
- Young carer identity; and
- The effects of caring for a parent with PTSD.

These four key themes and their associated sub-themes are outlined below.

Themes	**Sub-Themes**
Presentation of PTSD within the home	Noticing Change Anger
Relationships	Relationship Disruption Attachment Adolescent Maturation Emotional Numbing
Young Carer Identity	Providing Care - Practical Support - Emotional Support Parentification
The Effects of Caring for a parent with PTSD	Psychological Effects Behavioural Effects

5.1 Theme 1: Presentation of PTSD within the Home

All of the young carers shared individual stories about how their father's PTSD presented within the home which were explored in Chapter 4. The presentation of PTSD was not one the families suspected or felt in the family home immediately, however, over time the presentation of symptoms became more frequent and more intense. The theme of presentation of PTSD within the home is further explored below under the two sub-themes of noticing change in parental poor mental health and anger.

5.1.1 Sub theme 1: Noticing Change in Parental Poor Mental Health

The volume of combat related exposure and the ferocity of that exposure has the potential to have a profound after effect on those who experience it (Renshaw, Allen et al., 2014). The concept of active war time experiences elicits many different emotional presentations ranging from excitement to fear. As Sherman (1864), explains "War is cruelty. There is no use trying to reform it. The crueller it is, the sooner it will be over" (p.2). Cruelty is an act that begets violence, incivility, and carnage. This unfortunately is the nature of war which combative military personnel experience and it will remain a reality for those who try to navigate the transition back into the civilian population. As Renshaw, Allen et al., (2014) concludes the volume and ferocity of exposure to military combat has the potential to have a profound impact on those who experience it. Moreover, Cozza, Holmes et al's. (2013) research highlights that those who have been physically injured due to combat can suffer significant psychological distress, and this distress can change the way the injured person thinks, feels and behaves towards themselves and their family members. Furthermore, Cesur, Sabia et al., (2013) explain military personnel do not need to be part of the fire fight and to kill the enemy to have mental health issues, witnessing the death of a friend in combat can also have a significant impact on the mental health of those who witnessed the death.

In common with the veterans in the aforementioned literature the fathers within this study had been part of a major upheaval which negatively changed their lives forever. However, it is important to remember that this study considered the impact of these changes from the perspectives of the young carers and their mothers not the individuals who presented with PTSD who may have offered a different perspective of this. Nevertheless, the participants' narratives of the consequences of these major upheavals in their fathers' lives were illuminating. Joseph explained his father had a broken jaw and nerve damage and had hearing loss and Izzy supported her brother's comments when discussing how her father's injuries had hospitalised him, so she and her brother were unable to see him. Charlotte explained that her stepfather found the incident difficult to discuss, and so used alcohol and drugs to numb his memories. Thomas discussed his stepfather being argumentative with his mother, drinking more and not being at home due to being out socialising.

All four young people within this study provided an insightful snapshot of what it is like to be confronted with parental PTSD for the first time, for example:

> *"I remember shaking and watching him, wondering why was he being like this? I had never seen anyone behave like this before, I was scared" (*Thomas).

> *"Absolutely terrifying. I can't even describe it. It feels like you're under attack and there is no way of escaping." (Charlotte).*

It is these life changing moments which were emphasised within the young carers' narratives and which they reported as having changed the presentation and behaviour of their fathers. For example, after Joseph's father had returned to the family home, Joseph reported that he noticed distinct changes in his father's presentation, and he explained that he had to employ subsequent self-discipline in order to prevent further outbursts from his father:

> *"Yeah. You can just see the difference. Not to annoy him too much because we were still quite young then, it was really scary when he would shout at you because he got upset quite easy then. We had to be good. We could be naughty every now and then, but not too naughty otherwise we set him off".*

Joseph went on to state:

> *"...he started to get angry more and more often, to other people and us. He snapped more quickly. If something frustrated him he would get really angry, so you had to be a bit careful and stuff".*

Joseph's mother Pauline provided further validation of Joseph's experience of his father's return from combat, explaining:

> *"When he came back from there, that's when things changed completely. His back was really bad at that point, to the point where the kids would run up to try and give him a cuddle and he would collapse, through the pain [of his physical injury]. Which was quite scary for the children".*

Pauline continued to describe her husband's presentation:

> *"He came back injured off that tour, things did start changing, more around anger for him, but obviously we didn't twig what was going on, and obviously he was in a lot of pain from his injuries..."*

When sharing the narratives of how it felt about his father's change in presentation Joseph shared his feelings, stating:

> *"It wasn't scary it was more like, you still had to be good you just had to be cautious I would say".*

Joseph's sister Izzy similarly picked up on the change in presentation of her father due to PTSD:

> *"Well he began getting PTSD, the symptoms of PTSD. He didn't sleep very often, he would try and distract himself...he would try and work more and try to distract himself".*

This was supported by Pauline who described the children's abilities to understand the situation:

> *"They are acutely aware of the atmosphere in the house, so when my husband wakes up in the morning you kind of just know, if it's going to be a good day or a bad day".*

The sub-theme of noticing change within parental poor mental health post-Afghanistan, ran through the narratives of Joseph, Izzy and their mother Pauline and were similarly shared in the other 2 cases. Thomas recalled:

> *"I remember him coming back from that and he was not so happy and friendly around me anymore. He was still a loving father and we would spend time together, but I remember him being a lot more angry and upset a lot more..."*

Thomas went on to explain further:

> *"I wasn't aware of his [symptoms of] PTSD I was slightly scared because I didn't know why he was like this and I used to ask mum, but I never remember her giving me a response, I just remember him being angry and I didn't know why...".*

Charlotte discussed a very similar presentation of symptoms of PTSD, describing how her stepfather changed over a period of time:

> *"[He became] just completely be a different person. I wouldn't know who he was, and I would be so scared".*

Charlotte, offered a detailed description of the physical characteristics of the changing presentation of her stepfather:

> *"He got a lot more angry! His eyes, I always remember his eyes, like something just clicked and he was an entirely different person".*

Charlotte’s mother Sandra offered further insight into the changes of her partner’s presentation over a period during their relationship:

> *“One night in particular I remember he just wrapped his arms around me and wouldn’t let me move and he knew it was me cos he was saying, babe, babe, babe, and that was what woke me up but he said we have got to watch 11 o’clock, they’re coming over the fields and to get to the check point. The mornings were the worst times as when he got up in the morning he would be shouting and aggressive”.*

Transition from the military can have a significant effect on the service leaver’s mental health (Cramm, Norris et al., 2020; Smith-MacDonald, Raffin-Bouchal et al., 2020). Furthermore, the literature surrounding military transition highlights that transitioning out of the military due to poor mental health is a major event that can and does become a stressor for the family unit (Meadows, Tanielian et al., 2017). It is important to remember that a veteran has played and continues to play many roles within their personal and professional life. The roles within this study included soldier, sailor, husband, father, and veteran and these roles changed significantly when the individual transitioned out of the military.

A period of transition due to poor mental health was highlighted within all of the case families. Three of the four young carers described their fathers as finding it difficult to transition and finally move out of the Armed Forces as they reported that this had been their life and their identity, something they were proud of and somewhere they belonged. Thomas explained his stepfather would sit and cry and become agitated at the slightest thing, knowing his time in the military was coming to an end due to his mental health. Joseph and Izzy shared a similar experience and described their father being angry, and avoidant when he was transitioning out of the military. However, when the young carers in this study tried to explore these feelings with their fathers, they said their fathers would not want to talk about it and became verbally agitated and removed themselves from what could be interpreted as a potential conflict. As Andres (2014) explains, veterans are people who do not often share their experiences of deployment with those who they believe do not understand what they have experienced and been through and this can include family members.

Much of the literature regarding families living with a family member with PTSD notes that the dynamics of the family home change along with the ‘feeling’ of the family home; as if those living there can feel the change of presentation coming and try to pre-empt their actions to either prevent or respond to the symptoms of PTSD (Fear, Jones et al., 2010; Lester, Peterson et al., 2012; Bello-Utu and DeSocio 2015; Beks 2016). When discussing the atmosphere within the family home all of the families in this study articulated very similar presentations, thoughts, feelings and emotions:

> *"You just know because he is stomping around downstairs. He wouldn't be himself he wouldn't be taking the mick out of one of us or something or making jokes" (Izzy).*

> *"We would just stay out of his way, he started to get angry more and more often, to other people and us. He snapped more quickly. If something frustrated him, he would get really angry, it was really scary" (Joseph).*

> *"They are acutely aware of the atmosphere in the house, so when my husband wakes up in the morning you kind of just know, if it's going to be a good day or a bad day. Bless her [Izzy] has kind of grown up with it, so it's never been any different for her. I guess when you grow up in that environment, you learn from a young age what she needed to do." (Pauline).*

The presentation described by Izzy, Jospeh and Pauline above, was very similar to what happened in Thomas' family home:

> *"It will be like there is a cloud over the room and mum will normally pick up on it, she usually says something, and he will be in denial and say "I'm fine I'm fine" and there will be an argument about that. I think that's when it started to become aware of it". (Thomas)*

5.1.2 Sub theme 2: Anger

When living with the uncertain presentation of PTSD, the projection of the symptoms on to others, has the potential to be life changing and promote fear, anxiety and uncertainty (Cozza, 2013; Watson & Osborne, 2020). Pauline offered an insight into the fear her children must have experienced:

> *"It's like he directs it at something but it's the fall out of being in that environment for all of us. It's just like 'oh here we go again sort of thing' when he does…it is quite…well I got scared so the kids must have done".*

The above extract demonstrates that living in an unpredictable environment is anxiety provoking for all involved and the families all reported that they began to 'walk on eggshells' in order to avoid upset or confrontation.

The participants in this study described anger as a frequent presentation of parental PTSD. McNulty (2010) suggested anger and its presentation, ferocity and frequency have a detrimental effect on the function of the household and the relationships between the person with PTSD and their close family. As the literature reviewed for this study in Chapter 2 highlighted, alterations in cluster symptoms like arousal and reactivity can influence parenting behaviours, especially with regards to irritability and aggression (Fear, Jones, et al., 2010; Rona et al., 2006). As described by all the young carers within this study, fathers presented with increased stress levels which meant they could become angry and more inflexible with regards to what was expected of their children's behaviour. As Thomas explained he had to be good and could only be a bit naughty but not too naughty.

Within all three cases, the presenting angry behaviour from their fathers was described as different and 'out of character' when compared to their personality pre-Afghanistan. Such findings are not only present within the military population but have also been found within the civilian population. For example, Pidgeon and Sanders' (2009) research on PTSD and parenting within the civilian population also found that parental anger was related to an increase in parental stress, unhappiness, and a negative attribution bias to ambiguous child behaviours.

The findings of this study complement and expand on Sherman, Gress Smith et al's (2016) research on how a veteran's perspective of anger effects children, by providing narratives of how anger affected the home and the family unit from the perspectives of young carers and their mothers. For example, Charlotte's narrative explained how her stepfather overreacted to her 'normal' teenage behaviour, for example, being on her phone, listening to loud music and being cheeky. Moreover, Charlotte explained her father would become angry when he did not have any cigarettes left or the batteries in the TV remote did not work, which led to him often break the remote by throwing it. The presentation of anger was at times directed towards Charlotte and her mother as well as towards physical objects. These findings highlight moments of over arousal from Charlotte's stepfather, which caused arguments between Charlotte and her stepfather, and resulted in the family being embroiled in larger collective arguments. Anger could also manifest itself in the presentation of the young carers as well as their fathers. For example, Charlotte's mother reported that due to the escalation of anger of both Charlotte and her stepfather, she would intervene to try to calm the situation. Sandra explained how difficult it was for her to intervene when Charlotte and her stepfather would argue, stating "it was like managing two teenagers". Interestingly, what appeared from the narrative interpretation of the moments of anger within the context of what was happening to Sandra, was that she felt she could not win. Sandra appeared to be being pulled between her daughter and her partner and was unconsciously being asked to take a side.

As noted within Charlotte's narratives the constant presentation of agitation, and explosive anger from her stepfather, and the rift it created within the family, appeared to have caused Charlotte to resent the man her stepfather had become. There is also an argument from Charlotte's perspective, hidden within the text of the narratives, that the relationship between her mother and her partner [Charlotte's stepfather] had taken attention and interaction away from Charlotte. Charlotte potentially saw her mother taking sides with her partner which caused her to feel rejected. Sandra also reflected on this finding, claiming Charlotte was jealous of the attention she had to give her partner due to PTSD, and his anger issues, which added to the stress of having to support her children and her partner (Lambert, Engh et al., 2012). Flanagan (2003) proposed that there are many important roles which parents play in their children's development including developing social trust and self-esteem, and making the child feel worthwhile. Charlotte's stepfather's moments of anger not only precipitated a shift in relationship between her and her stepfather but also changed the way she and her mother interacted together. This led Charlotte to change the way she felt about herself. Living with her stepfather's PTSD and its associated presentation of anger resulted in Charlotte presenting with low self-esteem and poor emotional health and as a result she began to reject her relationship with her stepfather.

Thomas, Joseph and Izzy had similar experiences of the presentation of anger, however it reshaped their relationship with their father differently. Joseph and Izzy highlighted moments where their father became angry often due to irritability with objects, for example, the computer, or when painting the walls and getting paint all over the place, or regarding putting the bikes away in a specific way. Moreover, they reported that these moments of anger were compounded by poor sleep hygiene, as Izzy explained “dad found it difficult to sleep”. However, instead of this causing conflict within the family home as it did in Charlotte’s home, Joseph and Izzy developed ways of managing their father’s anger. As Kallander, Weimand et al., (2018) highlight, children and young people who provide care for a parent or parents with mental health issues often adapt to the way they interact with their parent to manage the interaction between the child and their parent. The reason for this is due to unpredictability of the presenting mental health symptomology and unpredictability of the reaction from the parent with the mental health issue. Both Joseph and Izzy became apprehensive when interacting with their father when he presented with anger. Joseph would retreat from the situation both physically and emotionally and would remove himself and retreat to his room, where he would not engage with the situation. However, Izzy would advance towards the situation, in the hope of providing her father with comfort in the way of affection. Importantly, however, overtime, Izzy also removed herself from the situation, potentially due to carer fatigue (Stamatopoulos, 2018).

Similarly, Thomas shared stories of his stepfather’s bursts of anger being directed at objects and his mother. However, Thomas’s relationship with his stepfather began to destabilise due to the context of specific and reputative moments of aggressive outburst and his stepfather leaving the family home in search of escapism through the use of alcohol and socialising with friends. Like Charlotte, Thomas was very close to his mother and was catapulted into a relationship with a stranger when his stepfather joined the family. However, unlike Charlotte’s situation, Thomas’ mum Cindy became a buffer between his stepfather’s presentation of PTSD and the family, and while the anger was also directed at physical objects it was mainly directed towards Cindy. There is a growing body of literature regarding combat PTSD and specifically anger being directed at the spouse (Lambert, Engh et al., 2012; Bjornestad, Schweinle et al., 2014; Yambo, Johnson et al., 2016), which has led to an additional body of research emerging regarding military spousal relationships and domestic violence; (Glenn, Beckham et al., 2002; Hayes, Wakefield et al., 2010; WORK and WELFARE, 2018; Lahav, Renshaw et al., 2019; Williamson and Matolcsi 2019). Domestic violence was similarly a finding within Charlotte’s narratives.

Importantly, for Thomas and his siblings parental buffering was seen as a positive in protecting and supporting the continual emotional and physical development of a child (Harper, 2019).

Parental ‘buffering’ is a term used within the literature to describe how a parent can protect children from toxic environments, by providing safe, secure and nurturing interactions, and for Thomas this went some way towards negating the negative effects of PTSD and anger within the family home (Milardo 2009; Sumner, Boisvert et al., 2016; Hambrick, Brawner et al., 2019).

5.2 Theme 2: Relationships

Denzin’s (1989) four forms of epiphany were used to develop stories from each of the 3 case families in Chapter 4, and this highlighted that there was a temporal build up to the change in relationships between all of the young carers and their fathers. The theme of relationships is explored below though the sub-themes of relationship disruption; attachment; adolescent maturation and emotional numbing.

5.2.1 Sub theme 1: Relationship Disruption

As symbolic interactionism seeks to understand how individuals and groups interact there is a focus on the creation of personal identity through interaction with others. One central component of this perspective is that people act as they do depend on how they define their present situation (Prasad, Khasgiwala et al., 2009). In the sections above and in the previous chapter we saw that there were moments when the young carers noticed the change in the behaviour of their fathers due to their combat experiences. In the case of PTSD, trauma acts as the arbiter of change. Through the exposure of stressful experiences, according to their children, the fathers within this study emerged into different states of being and became limited by the behaviours and experiences of PTSD symptomology (Galovski and Lyons 2004; Dekel and Monson 2010). As outlined above the young carers reported that there was a clear shift in their fathers’ personalities which indicated something had changed. The culminative phase - witnessing a father’s breakdown or change in presentation highlighted transition in both the functioning of the family and the relationships within the home environment. Through the young carers’ narrative stories descriptions of parental PTSD started to emerge. As outlined above Joseph described the symptoms of PTSD by explaining that his father started to get angry more and more and he stated that he would snap. Izzy also shared that her father did not sleep, and she said he always distracted himself. Thomas described his stepfather being a lot angrier and more upset and Charlotte described moments when her stepfather argued with her mother explaining that he would argue more, shout more, and would come home drunk. It is these descriptive moments within the narratives of the young carers within this study which illuminated how PTSD had impacted the family dynamic and the way the young carers interacted with their fathers.

Rosenbaum (2009) notes, as people interact, they derive meanings through symbols and shared understanding, and over time they develop personas in which society requires them to act. It is clear from the findings of this study that parental combat related PTSD affected the relationship between fathers or stepfathers and their children. It was at this point within the participants' narratives that I observed the symbolic meaning of what a father was and what their father was, which attributed to a change in role through the temporal interactions with their father, his presenting symptoms and the home environment. In addition, it was at this point within the 'storied stories' that the young people became 'young carers' for their fathers.

There is a growth of research regarding children and young people's relationships with a military parent, but previous studies have predominantly focused on the deployment cycle and re-integration and the effects that combat related PTSD has had on the child. This body of research has shown that when family members are physically and emotionally absent, children face a sense of ambiguous loss (Huebner, Mancini et al., 2007) and present with an increased level of stress and anxiety (Chartrand, Frank et al., 2008; Esposito-Smythers, Wolff et al., 2011; Swedean, Gonzales et al., 2013), resulting in maladaptive behaviours (Kaplow, Layne et al., 2013). What the aforementioned research failed to articulate was what the families' lives were like before PTSD in comparison to what the relational connection between young carers and veterans was like once PTSD presented in their homes.

Doyle and Peterson (2005) postulate that during re-integration within the family, roles and boundary negotiations and reestablishment of relationships are challenging for many military families. After the family member returns from operations, individual family member's attachment relationships and the function of the family system and subsystems generally do not return to the exact state that existed prior to the deployment (Riggs and Riggs, 2011). These findings are also supported by Paley, Lester et al., (2013), who conclude that difficulties with re-integration can be exacerbated by long or frequent deployments by a parent figure, such as those experienced by Thomas, Joseph and Izzy, which result in service personnel, spouses and their children going through physical, developmental and emotional changes. The whole family unit can be changed by the experience of deployment, thus increasing the complexity of the re-integration process (Riggs and Riggs, 2011). This was true of Thomas and the re-integration with his stepfather. Thomas described the moment his stepfather returned home stating his stepfather looked different and acted differently after he returned from his third tour of Afghanistan. The point of recognition of an attachment figure is discussed by Barker and Berry (2009) whose research identified that children and young people sometimes find it a challenge to recognise their returning parent due to physical and emotional changes. Moreover, if the child or young person is in the separation or anxiety phase, as Joseph was, reunions can be even more distressing for the returning parent (Louie and Cromer, 2014) and can cause additional challenges to re-connecting (Bowlby, 1973).

5.2.2 Sub theme 2: Attachment

A theme which ran throughout the pre-PTSD narratives, was the strong connection children had with their father or stepfather and how much time they spent laughing, playing together, going on family outings and just being together. What all the young carers articulated was that they had a secure attachment to their father or stepfather. For two of the four young carers who participated in this study the person presenting with PTSD was their stepfather, however, they both referred to their stepfather as their father which suggests they viewed their stepfather as a father figure.

As outlined above the main theoretical underpinning of this study was symbolic interactionism which was used to seek to understand how young carers constructed their emotional response to caring for a parent with combat related PTSD. As highlighted within Chapter 3 the methodology chapter of this study, the concept of interactionism is based on studying how human beings act towards things based on meaning, for example, how they act towards another human being. The theory suggests that the meaning of such things are derived from the social interaction with one’s fellow humans which is an interpretative process used by the person when dealing with their encounters (Blumer, 1986). Blumer (1981) explains that interactionist purists do not like theories which are imported from other disciplines, for example, the natural sciences, or psychology, as they do not fit into the lived emotional experience of interacting human beings. However, I felt it was important to understand the relationships the young carers in this study had with their fathers by introducing attachment theory to support the symbolic meaning of interaction. As a theoretical concept attachment theory relies heavily on the emotional interaction between the child and their parent or primary caregiver. Therefore, both attachment and symbolic interaction and what is meant by the interaction shapes how well the child interacts with their primary group (family) and their reference group (their community) (Blumer, 1962), creating a secure base for infants and children to grow which, depending on the attachment figure, could have lifelong implications for the child (Bowlby 1958; Ainsworth 1967; Bowlby 1973).

Attachment theory has been used as the foundation to understand the relationships between a child and their primary caregiver. The emphasis on the child and mother relationship was the initial focus of the seminal development of Attachment Theory. Attachment theory began to emerge in the 1950's as a valuable model in child development and mental health through the joint yet independent work of John Bowlby and Mary Ainsworth (Bowlby 1951; Bowlby 1958; Ainsworth 1967; Bowlby 1973; Bretherton 1992). Bowlby offered a coherent, formulated theory based on the dynamic forces of evolutionary biology and ethology. Two key constructs evolved from Bowlby's (1958, 1975, 1980) formulation: that attachment is a biological necessity and that the mother-infant/child bond is the primary and essential force in child development. Bowlby signalled to the world, that the conditions needed to promote healthy child development were that the mother needed to achieve attunement with her baby and create a healthy attachment (Fitton, 2012). However, there are numerous critics of Bowlby's theory. Attachment theory has been criticised for concentrating on early parent-infant relationships without accounting for the way in which 'interactional maintaining factors' influence continuity (Brown and Wright, 2001). Harris (2011) argues that attachment theorists assume that kind, honest, and respectful parents will have kind, honest, and respectful children; and parents that are liars, rude and disrespectful will have children that are the same way. Research by Kobak and Duemmler (1994) and later by Bartholomew (1997) suggests that the child's behavioural strategies and expectations of the contingencies being reinforced within a relationship can support and confirm one another by offering continuity. This, therefore, challenges the idea that models of attachment are impervious to change, and highlights the role of context in relation to attachment stability, in that the person is thought to exist within numerous ecological influences (Belsky and Isabella, 1988).

Until the mid-1970's, most studies on parenting and parental relationships focussed on mothers and their interaction with their offspring, and only gradually has this trend changed, with greater focus on the parental role of fathers (Lamb and Oppenheim, 1989 in Cohen, Zerach et al., 2011). The development of attachment progressed through the work of Ainsworth (1967) and Schaffer and Emerson (1964) whose empirical observations revealed that the majority of children became attached to more than one familiar person during their first year. Although Bowlby (1973, 1982) emphasised ‘monotropy’ the need to attach to one main attachment figure. Kerns and Barth (1995), Schneider Rosen and Burke (1999) negate Bowlby’s notion of one main attachment figure. They argue, ‘secondary’ attachment figures are more influential than originally thought, and therefore, become an important foundation for the infant and or child. This is supported by Cassidy and Shaver (2016) who explain, that generally, the mother’s role as an attachment figure is clear but the father is also particularly likely to become an additional attachment figure early in the infant’s life (p.15).

Within all of the cases in this study the mother was the constant attachment figure while fathers were engaged in training, deployments and re-integration. Whilst this is an important factor to bear in mind when understanding the context of military life for the cases within this study, the relationship with fathers was also important and was a key component of the emotional health and well-being of the young carers. Ainsworth’s (1967) study of Ugandan mother-infant attachment noted that children also used their fathers as attachment figures and observed the special infant-father relationship that sometimes emerged. All of the young carers within this study similarly shared stories of their closeness with their fathers both in play, intimacy, and discipline and it was this parental behaviour which created a secure attachment to their father.

Importantly, Ainsworth’s Ugandan study holds further significant relevance to this study, in that the infants within her study had intermittent connections with their father, explaining “attachments were formed, even in the cases of babies who saw their fathers relatively infrequently” (p.352), which was replicated within this study. As discussed within the literature review in chapter 2, the deployment cycle can for some children and young people become a very stressful and anxiety provoking period. Bowlby’s (1973) theory on separation, anxiety and loss suggests the main source of children’s anxiety and fear is separation and regularly threatened access to an attachment figure. In most cases, children and their parents are regularly in close proximity to each other. If a child moves away then the parent will follow, and if the parent moves away the child will follow or signal for the parent to return (Cassidy and Shaver, 2016). However, for military children and young people this proximity to their attachment figure cannot always be achieved. Regular and increased deployment periods have resulted in an increase in research regarding the effects on a child’s emotional health due to separation from a military parent (Pincus, House et al., 2001; Huebner, Mancini et al., 2007; Chandra, Burns et al., 2008; Cozza and Lerner 2013). The young carers within cases two and three all shared stories of feeling worried, anxious, and scared when their father went away to Afghanistan, and they thought he might not return. For Joseph, the fear of his father not returning or getting the ‘knock on the door’, a term used to notify family members at home of serious injury or death of a loved one, led him to develop separation anxiety. The ‘knock on the door’ was also something Izzy spoke about without actually saying this, stating “I was scared he wouldn’t come home, and I wouldn’t see him again”. This figure of speech was replicated by Thomas whose stepfather completed multiple deployments in quick succession, causing significant stress and disruption and impacting on the overall functioning of the family.

Re-connecting child parent relationships has always relied on the type of attachment (secure, ambivalent - insecure and avoidant-insecure) between the child and the attachment figure (Ainsworth and Wittig 1969; Bowlby 1973). According to this model, children with a *secure attachment* style are reported to have better conduct, a higher level of maturity, to be less aggressive, and to be more empathetic than insecurely attached children. Children with *ambivalent-insecure* attachment are typically wary of strangers, extremely upset when the caregiver leaves, and they are not comforted on their return. Moreover, they typically reject comfort from the caregiver or display aggression towards the caregiver. Finally, children with *disorganised-insecure* attachment show a mixture of ambivalent and avoidant responses. They seem confused or agitated in the presence of the caregiver which stems from the simultaneous feelings of comfort and fear in the presence of their caregiver (Miller, Miller et al., 2010). As Lester, Peterson et al., (2010) note, parents who are deployed on multiple tours with relatively little time at home between tours are absent for large portions of their child’s life, and often during their child’s key developmental periods which can have a significant effect on the relationship, and this was also noted by all of the young people in this study.

5.2.3 Sub theme 3: Adolescent maturation

As highlighted previously, some critics of attachment theory have noted there is a distinct lack of literature regarding attachment and the adolescent period, with research focussing primarily on infant attachment and adult attachment systems. Due to the ages of the young carers within this study, adolescent attachment theory supports the findings of relationship disruption, which as previously outlined, was a key indicator of change within this study.

It is important to note that the aim of this study was to understand the emotional response of providing care for a veteran parent with PTSD. However, it is also important to identify the emotional response of providing care, by addressing relationship transformations from the perspective of adolescent maturation. The young carers within this study were aged between 12 and 15 and their body system was going through a number of significant changes to prepare them for adulthood. As Collins and Laursen (2004) highlight, conceptual models of transformation in parent-adolescent relationships vary depending on whether the primary focus is on the adolescent or on their relationship. For most, the perspective was on the adolescents' physical, cognitive, and social maturation which undermined patterns of close relationships which were established in early childhood (Lerner and Steinberg, 2009). More recent studies have focused on stable child-parent relationships, detailing enduring bonds forged between the parent and their child, assumed to be the foundational properties of the relationship which transcends age-related changes in the characteristics of participant and alterations in the content and form of their interactions (Lerner and Steinberg, 2009).

As outlined in chapter 4, the interactions between the young carers and their father or stepfather changed due to combat related PTSD, and however, consciously or sub-consciously, the stages of maturation also impacted on and resulted in changes to the relationship. Individual change in adolescents can cause disruption due to the processes of maturation and there is the potential that this may destabilise the parent-child relationship, which may provoke functional changes within the family (Cassidy and Shaver, 2016). As Collins and Laursen (2004) conclude, most adolescent-parent relationships assume a period of diminished closeness and heightened conflict accompanies adolescent maturation and these perturbations continue until the parent-adolescent relationships and roles are renegotiated. Diminished closeness and heightened conflict were evident within case 1 in this study. Charlotte and her mother spent periods of time arguing with each other about roles within the family home, caring for siblings, wanting space and disagreements about how to support Charlotte's stepfather. This 'combative wedge' as described by Blos (1979) was due to contentions of parental fallibility and psychic emancipation which drives a wedge between parents and adolescents that is exacerbated by the inner turmoil brought on by adolescent hormone fluctuations. As noted in the literature regarding parental attachment and the interactions between the adolescent and parent, the maturation period for an adolescent is complex and laden with periods of conflict, both internally and externally. Moreover, the literature identifies this behaviour as normal and part of adolescent growth, and notes that conflict should become less frequent and better managed, and relationships should reform and eventually become more sophisticated (Collins, 1997). I observed Charlotte's maturation in her narrative and saw that she was engaged in an internal conflict of trying to find out who she was, and where she 'fit' within her family, causing her to search for belonging. Charlotte and her siblings had been brought up by a single mother, and Charlotte had a close relationship with her mother. However, a new character was then introduced to the family, Charlotte's stepfather. The introduction of a new partner can be a complex 'life event' for an established family (Cassidy and Shaver, 2016), particularly children, and can cause insecurity and perceived 'displacement' of affection. The complexities of the introduction of a new person into a family can be compared to the re-integration period post deployment and the shift of roles, relationships and knowing where you belong within the re-structuring of the family dyad, resulting in an insecure base.

As Mulholland, Dahlberg et al., (2020) note, with the re-integration of the father to the home post combat, there can be a shift in roles amongst the family, and the relationship can become one of fragility based on the presentations of both the father and the maturing adolescent. Due to the shift in advancement of maturation from the adolescent during periods of separation from their father due to deployment, adolescents can aspire for reciprocity and equal power in their interactions with their returning parent.

Relative to preadolescents, adolescents demonstrate less companionship and intimacy with parents and report less satisfaction with family life. At the same time the fathers in this study often sought intimacy in the form of warmth, play and micky taking, in search of the connection demonstrated in earlier periods of the relationship prior to deployment (Gray and Steinberg, 1999). As the findings from this study demonstrate, the search for intimacy by the fathers was at times in conflict with the search for parental self-regulation due to the presentation of PTSD symptoms, through withdrawing (physically and emotionally) and distraction. In each case of this study the change in presentation came not only from the young people, due to their stages of maturation, but also to the often subtle and frequent symptoms of PTSD, which caused disruption in the relational dynamic between fathers and children, which overtime created an emotional and physical divide.

5.2.4 Sub theme 4: Emotional Numbing

The cluster of symptoms of PTSD include intrusion symptoms, negative alteration in cognition and mood, alterations in arousal and reactivity and avoidance (APA, 2013). The findings of this study strongly highlight two prominent cluster symptoms of PTSD. The first of these two prominent clusters is anger which was described above. The second is emotional withdrawal. This section explores emotional numbing and the effects this had on the relationship between the young carers and their fathers.

The research regarding PTSD and family relationships which was presented in the literature review in Chapter 2 highlights that other PTSD cluster symptoms are correlated with several relationship variables and that many of these variables disappear and emotional numbing remains statistically significant in its effects on the relationship between a veteran and his family (Fear, Jones et al., 2010; Tanielian, Haycox et al., 2008). The findings of this study support the aforementioned literature. They suggest there is a distinct disinterest, detachment, and emotional unavailability which characterises emotional numbing that may diminish a father's relationship, and his ability and willingness to seek out, engage in, and enjoy interactions with his children, post diagnosis of PTSD, leading to a change in their relationship.

A critical evaluation of the literature on emotional numbing in Chapter 2 highlighted a number of studies which focused specifically on military families post combat and the effects emotional numbing has on the dynamic of the family relationship. As highlighted within Chapter 2, there may also be an association between PTSD and parenting difficulties. Gewirtz, Polusny et al., (2010) found that veterans with PTSD symptoms reported decreased parenting satisfaction, impaired attachment, child behavioural problems and family violence. Impaired attachment and family violence featured in the narratives of the young carers in this study and have already been documented in this chapter.

Parsons, Knopp et al., (2018) noted that PTSD symptoms were also associated with less effective parenting, for example, inconsistent discipline and poor supervision. When trying to explain how PTSD symptoms result in parental difficulties, it can be argued that avoidance and numbing symptoms may produce impaired relationships through a lack of emotional connection and physical detachment. Both emotional connection and physical detachment were of significance within the findings of this study and families highlighted that emotional numbing had created a wedge between the father-adolescent relationship. The body of research on this topic has identified the emotional numbing and hyperarousal components of PTSD as being particularly disruptive to the veteran and family relationship, and veterans have reported difficulties in their abilities to feel. It is these reports of an inability to feel which experts have described as emotional numbing, while those who suffer from this have characterised it as a kind of 'emotional anaesthesia' (Svetlicky, 2013). The symptoms of emotional numbing refer to a 'diminished response to the outside world', which is hypothesised by Svetlicky (2013) as an *"automatic biological response to an extended state of uncontrollable hyperarousal"* (p.84).

Within the literature, a number of studies have concluded emotional numbing is a key factor in the functionality of a veteran with PTSD and their interaction with their family. Galovski and Lyons (2004) conclude that fear and guilt over violent impulses acted on during combat situations and in the home, and current attempts to control their impulsivity, have the potential for veterans to avoid certain roles and activities within the family home which may affect their abilities to perform familial responsibilities and may result in them becoming isolated further from their family. This is something which was evident within all the cases of this study, as the young people within this study articulating their fear of the change in relationship with their father/stepfather due to parental emotional numbing. The findings of emotional numbing within this study are supported by Sayers, Farrow et al., (2009) who noted among parented veterans with children that feeling that the child was afraid or not acting warmly towards their child significantly increased their withdrawal from the family. Similarly, Rodriguez, Holowka et al., (2012) found that emotional numbing, along with avoidance clustering, resulted in significant and direct effects on the relationship with partners, whereas only the emotional numbing cluster showed a significant negative direct effect for military and veteran relationship functioning. With regards to the young people within this study articulating their fear due to parental emotional numbing, research by Sayers, Farrow et al., (2009) noted among parented veterans with children that feeling that the child was afraid or not acting warmly towards their child significantly increased their withdrawal from the family.

The aforementioned research identifies emotional numbing as being a significant factor in the functionality of familial relationships. As this study has highlighted, emotional numbing impairs the functionality between the whole family, and effects the relationship between fathers and children. As noted within case 1 in Chapter 4, Charlottes' stepfather withdrew from certain situations and would require additional support to carry out basic functions like form filling, making appointments and not forgetting the appointments he had made. This role was then undertaken by Charlotte. As Harkness (1991) notes, the role Charlotte undertook could be seen as the 'rescuer', a term used to describe a child who tries to compensate for the responsibilities that their parent cannot handle due to PTSD. Highlighted within case 2 in Chapter 4, Joseph and Izzy's father was able to carry out functions within the family home, however he would withdraw from the family and spend excessive time in his office at home or stay away at work. In case 3 Thomas's stepfather would also emotionally withdraw from his partner and avoid interactions with his family by spending more and more time out of the family home, in favour of spending time with friends. In all three cases within this study the presentation of emotional numbing was very present and had negative effects on the family, and the emotional health of the young carer. However, the presentation of emotional numbing was very different within each of the cases within this study; and the way in which family relationships within the family dyad were affected was also very different. Notably, the disparity of emotional numbing within case 3, had impacted on the balance of responsibilities within the home. It can therefore be argued such withdrawal and avoidance notably has the potential to create additional problems within the home due to the veteran's partner or the veteran's children having to take on additional responsibilities, due to the struggle of increased responsibility and burden being placed on the veteran with PTSD (Leen-Feldner, Feldner et al., 2011).

5.3 Theme 3: Young carer identity

As outlined in the literature review in Chapter 2 young carers are often hidden, that is, they are young people who undertake caring responsibilities, yet may have little to no knowledge they are caring for a family member (Gray, Robinson et al., 2008; Stamatopoulos 2018; Dearden and Becker 2005; Joseph, Sempik et al., 2019). The young carers in this study similarly did not always identify as young carers but they all undertook roles within the home which would suggest they had assumed caring responsibilities associated with being a young carer. The theme of young carer identity is explored below through the sub-themes of providing care; and parentification.

5.3.1 Sub theme 1: Providing care

One reason for young people not identifying themselves as young carers relates to the nature of having a caring relationship and naturally providing a supporting role within the family. Importantly, young carers may state that they provide care because they love the family member (Joseph, Sempik et al., 2019) and not because it is a role that is given to them This was the case with all of the young people who participated in this research.

> *"I've been a carer for 5 or 6 years and I didn't know. It feels weird, not different you don't really know, you just think it's normal for you every family is different it's like*

> *this is your normal everyone's different normal - it was weird to put a label on it…" (Charlotte)*

> *"I sometimes refer myself as the third parent. I have to help out a lot with the bedtime routine, babysitting them. It's difficult, I get a mix of emotions. I am annoyed and stressed. I can't just leave it to mum and my stepfather to help with the kids, although it is their job, I can't just slack off" (Thomas).*

The mothers in this study had not normally realised that their children were young carers either. Pauline offered an emotional insight into her thoughts and feelings when she spoke about Joseph providing care for his father and the potential impact this had had on all of the family:

> *"I don't think that any of us did [identify as a carer] after what happened in September the hospital carers came to see me and said you need to get registered as a carer. What? Really! well none of us realised, it is just the card you have been dealt and for me looking at it now for my kids, it is just wrong, you know what I mean, it shouldn't be like that for them".*

Cindy explained that she did not regard Charlotte as a young carer:

> *"Not a young carer as such, I didn't see it that way at the time but I did see her taking on things that didn't necessarily need to be her responsibility and she didn't need to be worried about".*

Charlotte was the only young carer within this research who had been assessed as being a young carer by a young carers' organisation. Charlotte's recognition was due to her family requiring additional support from social services because of domestic abuse within the home environment. When asked if she thought Charlotte was a young carer Pauline explained:

> *"I wasn't 100% sure why she had been referred because I didn't perceive those caring relationships to be as it was but I think it was for all of us because of the impact [of stepfathers PTSD] and then just focussed more on the kids first really".*

The perspectives of all the mothers within this research demonstrated they were reflective of the role their child had undertaken to support the functionality of the family home. The mothers' narratives demonstrated that all the young carers had quietly just got on with caring for their families, out of love to one another, and not because they had to. It would appear that for all of the young people there had, therefore, been a natural progression into the role of being a young carer for a veteran with PTSD.

As highlighted within the young carer literature outlined in the literature review of this study the knowledge about characteristics of young carers is categorised by age, gender, family constellation, care recipients and the variety of caring activity (Chikhradze, Knecht et al., 2017). As Ireland and Pakenham (2010) conclude, children in single parent households are more likely to provide care than those children and young people who live in a two-parent household. With regards to this study, all the young carers lived in a two-parent family. However, for military families two parent families often have to operate as one parent families due to deployment. Thus, the young carers in this study were involved in caregiving roles during the deployment cycle, by supporting their mothers with emotional health as well as caring for siblings. For example, in case 1 when Pauline was separated from her partner, Charlotte undertook caregiving roles by supporting her mother's physical health issues and looking after her siblings. The young carers also described having increased chores within the home during the multiple deployment of their father.

There are a number of roles which a young carer normally undertakes when caring for a parent or family member. The key characteristics identified within the literature review in Chapter 2 were that young carers globally are children or young people who provide a form of unpaid care – physical, emotional, psychological, financial or practical support to a parent or sibling for a non-specific amount of time (Aldridge, 2000). Within this research, the young carers provided a range of practical, psychological and emotional support to their fathers/stepfathers.

During periods of deployment the young carers within this study took on extra responsibilities within the family home to support their mother and help fill the gap of an absent parent. This support was mainly looking after siblings or doing extra chores. Throughout the period of separation due to deployment, there appeared to be a shift in responsibility, and the young carers "stepped up". By stepping up and taking on more responsibility, the young carers may have felt more of an equal undertaking the role of an absent parent. The notion of 'stepping up' was presented a lot within the narratives of all the young carers, due to multiple contextual elements of their lives. Charlotte was supporting her mother by caring for her siblings prior to the introduction of her stepfather. Thomas was also supporting his mother and stepfather by caring for his siblings when his stepfather was away on tour, or his mother was working. Moreover, both Joseph and Izzy supported their mother by doing additional chores when their father was away training or on tour. It is this need for equal power which can shift the dynamics of the relationship stabilisation (Collins and Laursen, 2004).

5.3.1.1 *Practical Support*

All the young carers within the study undertook a practical caring role for their father due to combat related PTSD. The practical roles undertaken ranged from extra chores around the family home, to looking after siblings or providing prompts to take medication.

> *"yeah, I do, I always make sure he has them as you can see a difference when he does not take them" (Izzy).*

Pauline validated Izzy's role in supporting her father taking his medication by stating:

> *"Yeah. she is the one out of all of us who get on him about his medication. She even does it to her brother".*

Whilst Joseph did not prompt his father to take his medication, he provided other practical support by doing his chores and additional tasks within the family home:

> *"We do the hoovering and stuff [round the house] because we have to do a lot more. I don't know we just let him do what he does. He may need help when the computer gets annoying, he shouts at it…"*

When discussing Joseph's role in providing practical support to his father during poor mental health episodes, Pauline simply said:

> *"He is such a loving boy, kind and caring and more so than you would expect from a 15-year-old boy. He has just stepped up!"*

The prompting of medication was a concurrent theme within Thomas' household when his mother was away working. Moreover, Thomas' role significantly increased during the periods of time his mother was away when he supported his stepfather to look after his siblings.

> *"Yeah, he forgets to take them, he is often drowsy and sleepy and doesn't think straight and will forget things. I have to prompt him when mum is away, she is away a lot with work".*

Thomas went on to state:

> "*…it was very difficult, and I was given more responsibility to look after my middle brother whilst they were looking after my baby brother [and stepfather's PTSD symptoms]".*

Pauline added her perspective of the role Thomas played within the family home and his caring responsibilities:

> *"He [Thomas] was in a caring role for me when I was pregnant and on the two occasions when I was pregnant, his stepfather was away, so Thomas had to take on more of a caring role for me and manage his brothers, so it put extra pressure on him which I don't think was a good thing".*

Interestingly, Charlotte had a similar practical role within her household in that she supported her siblings and prompted her stepfather to take his medication. Moreover, Charlotte also assisted with form filling and making sure her stepfather attended appointments:

> *"I have to call him to make sure he has taken his pills when I am out or at school, he has to have them before he eats and check that he is going to AA meetings".*

Charlotte went on to discuss her practical supporting role caring for her siblings:

> *"… I make sure my mums ok and that the boys [brothers] are ok, because mum has a slipped disc in her lower back. When it's bad, it's really bad! She can't get up I will have to help her get up".*

5.3.1.2 Emotional/Psychological Support

A pertinent theme presented in the literature review in Chapter 2 was that of providing emotional support for a parent, sibling, or other family member. Typically, young carers provide emotional support in the guise of active listening, being empathetic, providing love, trusting, encouraging, reflecting with and offering reassurance. The concept of young carers providing emotional support was also pertinent within this research study demonstrating it is a key part of the 'role' of a young carer. Much of the literature denotes females or girls undertaking more of a caring role and being identified as 'natural' carers by their parents (Aldridge, 2013) providing significant levels of emotional and practical support. However, the males or boys within this study provided very similar types of support to their fathers as the females did, demonstrating they also had the ability to provide emotional and practical support.

Izzy was very tactile and able to sense the mood within the room, often providing the hands-on calming of her father's presentation before it potentially became worse. Izzy explained:

> *"I give him a cuddle or try and make him watch a movie with me. I enjoyed giving him cuddles and everything. It made me feel happy, knowing that he wasn't angry. It makes me feel happy because I can spend time with him and have snuggles".*

Pauline also explained how Izzy was able to pre-empt situations and often put herself in the firing line to help reduce the presentation of her father's PTSD escalating:

> *"Yes, she had become quite cuddly and very aware if there was not a happy mood and could just tell when there was an underlying vibration, the feeling something is going to go wrong. She would get him [father] to try and sit down and chill and just take him out of the situation that was causing him angst when she was 5, she still does it".*

With his common interests in the military Joseph would often walk with his father for hours in the woods or over moorlands talking about life in Afghanistan and trying to understand what it was like for his father. Joseph commented that walking really helped his father and enabled him to relax and open up a little. Importantly, they spent time together:

> *"I would ask him what it was like [to understand and empathise] in Afghan and he would just tell me bits, he wouldn't tell me loads but just little parts, about helicopters and air support. probably the same but it would depend on what we were talking about. On the walk he was calm, we had the dogs which helped, and it was just me, him and fields. Yeah. It's just us two so we can just talk about things between us, that helped. I really enjoyed it".*

The closeness of their relationship and keen interest for the outdoors was captured by Pauline, who described their relationship prior to Afghanistan, which goes some way to explaining why Joseph and his father were connected with the outdoors, and why the outdoors appeared to be a safe space:

> *"They did everything together. They were just really close, and I think it was like, yes, he's home, let's get away from mum. But [father] absolutely adores the children so it was like let's go to the park and dad was really cool and because they would go out and get absolutely covered head to toe in mud and nobody would be bothered and that sort of thing, which was good fun, it was always outdoor stuff, it would be daddy that would go on all the rides".*

Providing emotional support was evident in the homes of all the young carers within this study. However, Charlotte used her skills to connect and co-deliver ongoing support by using her emotional health issues in supporting her stepfather with his presentation of PTSD, which could be labelled as peer led support.

> *"Me and my stepfather have been working together to eat and control our anxieties. So, we have been working together a lot and we sit and talk about our issues, which is helping him".*

Not only had Thomas been providing care for his stepfather with regards to his PTSD, but Thomas had also been mindful of his mother's emotional and mental well-being,

> *"Mum didn't show she was struggling because she is a very tough cookie. I was still quite young so wasn't asked to do too much. Just had to support her emotionally…"*

This is the case for a number of young carers who are often the care provider for both parents (Aldridge, 2006; Becker, 2000). Thomas went on to discuss another factor which has emerged within the literature on young carers, the loss of a parent (Aldridge, 2013). This is not always due to parental death or family separation but may be due to a parent working away for long periods of time. As Thomas explained this had its own difficulties with regards to supporting his stepfather:

> *"When there is only one parent it is quite difficult for all of us so that will affect his mood and he will be a lot more stressed out. So, we sit down together, only then when he will relax and calm down, and then we can talk, and he will discuss lots of issues".*

Whilst the role of being a young carer has over the years been broken down in to five domains of caring roles described by Aldridge & Becker, (1993), which include, Practical, Financial, Emotional, Physical and Phycological. However, the role of protector when living with parental PTSD, due to combat was something which, for one young carer was a regular occurrence:

> *"…he would like throw things, hit my mum and call her every name under the sun that he could think of…I would have the telephone in my bed with me, just in case I had to call the police because I was that scared…".*

This extract demonstrates the hidden lived experience one young carer was living with during these times; and whilst there were extracts from the other young carers in this study regarding arguments within the family home, none of the others outlined the need to protect a family member from a veteran with PTSD. As noted within the literature (Williamson and Price 2009; Williamson and Matolcsi 2019; Alves-Costa, Lane et al., 2021), and outlined above, domestic violence can proceed the onset of the condition [PTSD] and can sometimes continue once the condition is diagnosed.

5.3.2 Sub theme 2: Parentification

With regards to the adolescent-parent relationship, the idea of 'parentification', or an assumption of adult and parental roles being carried out by children and young people, is an important factor to understand when discussing how caring could affect the quality and nature of relationships between the parent and child, and the child and wider society. As highlighted within the literature review, various 'types' of parentified children have been described, including young carers (Earley and Cushway, 2002). It can be argued that parallels can be drawn between the roles, responsibilities and outcomes typically experienced by young carers and other 'types' of parentified children and young people, such as those who have experienced military separation due to extended deployment like the children in this study. Such children often meet the emotional needs of their mother and take on a caregiving role when she is separated from her husband (Bride and Figley 2009; Burgh 2011; Lester, Peterson et al., 2012).

Importantly, as noted within the literature review in Chapter 2, three studies (Houston, Pfefferbaum et al., 2009; Harrison and Albanese 2012; Misra and Singh 2014) identified parentification within military families during the deployment cycle. This also took the form of carrying out additional household chores that depleted childhood roles, and also included adolescents feeling or becoming responsible for the mental health of the at-home parent during deployment (Harrison and Albanese, 2012). Harrison and Albanese's (2012) research identified that some adolescents felt psychological strain as a result of feeling responsible for the mental health of the stay at-home parent and would refrain from sharing their own feelings. In this study Thomas discussed the strain of taking care of his mother's mental health during his stepfather's deployment.

With regards to the parallels of parentified children and young carers, parentified children have also been described as having responsibility for a range and scale of tasks and roles within the home environment. These roles include domestic and caring tasks, providing childcare for siblings, providing emotional support, companionship and decision making (Jurkovic, Thirkield et al., 2001). These roles are identical to those undertaken by the young carers in this study and have the potential to have the same detrimental impact on their education, health, and relationships. The aforementioned points provide an argument that young carers, including the ones in this study, can also be viewed as parentified children and young people based on the undertaking of adult roles before they are fully developed emotionally and physically and this has been referenced significantly within the young carer's literature (Becker, Dearden et al., 2002; Hooper, Moore et al., 2014; Stamatopoulos 2015; Chen and Panebianco 2020).

Within the findings of this study these assertions can, however, be challenged. Both Thomas and Charlotte undertook a range of practical and domestic tasks which they both termed 'parental' roles. However, they did not conceptualise the relationships shared with their stepfathers in terms of 'role reversal' and they still recognised the relationships they had with them as parent-child relationships. Importantly, this suggests that role reversal does not necessarily equate to parent-child 'identity' reversal. Regardless of any task undertaken by all the young carers within this study, their father still retained his identity and was given respect accordingly.

5.4 Theme 4: The effects of caring for a parent with PTSD

As highlighted within the literature review and in the previous chapter, the presentation of parental PTSD can and does physically and emotionally effect those living within the home environment (Kaplow, Layne et al., 2013; Yambo, Johnson et al., 2016; Fear 2017). Importantly, caring and the responsibility of caring can have benefits to children and young people's psychological well-being. These positives include building self-esteem, making them feel closer to the person they are caring for and developing a sense of purpose and pride in their role and abilities (Joseph et al., 2019). However, there is also mounting evidence that excessive caring, unsupported caring and caring for more than two years, can have a detrimental effect on a young person's emotional health and well-being, social activity, educational attainment and overall life chances (Aldridge, 2008). The positive and negative effects of caring for a parent with PTSD are explored below under the sub-themes of psychological effects; behavioural effects; and social effects.

5.4.1 Sub theme 1: Psychological effects

As previously stated, Izzy was a very tactile young lady who appeared to have a high level of emotional intelligence and was able to gauge the temperature of the room with regards to the presentation of her father. This had an effect on her emotional well-being because she was always pre-empting situations and putting her feelings before her father's:

> *"He would just get angry. I just went and gave him a cuddle to make him feel better. I wanted to make the computer load, or the internet work a bit quicker, instead of getting angry. [on being upset herself] Only a bit, I don't want him upset"*

The effects of caring for a veteran parent with PTSD appeared to influence the mood of the whole house. Pauline similarly described Joseph's continuing behaviours of anticipating situations, living in constant high alert and its frequency within their everyday lives:

> *Paul: "Does he still try and anticipate a kind of home environment, in terms of ways, the 'walking on eggshells' kind of things because he mentioned it quite a few times at his interview about the situation?"*
>
> *Pauline: "Yes, we have had it today. It has not been great, today, so everyone is like on super high alert at the moment. So yes, that definitely still happens, which happens more often than not, I would say".*

Thomas articulated his struggles with growing up when his siblings arrived, and his caring role expanded. Importantly, Thomas demonstrated a call to arms, and a sense of duty, even to the detriment of his own emotional well-being:

> *"…it was very difficult, and I was given more responsibility. It's difficult. But, I can't just slack off".*

Sandra also highlighted the support Thomas provided for her as well as his siblings when his stepfather was away on training or in Afghanistan:

> *"Thomas had to take on more of a caring role for me and manage his brothers, so it put extra pressure on him which I don't think was a good thing".*

Sandra went on to explain her perception of Thomas providing care when things at home were difficult, with regards to his stepfather's presentation when he returned from Afghanistan:

> *"Thomas absorbed all of that [toxicity within the home]. Thomas would be the one to comfort me and pick me up and help me do whatever I was doing. I was then pregnant with [sibling] and all that was going on and I was really sick".*

For Charlotte, the psychological effects of caring were very different to the other young carers within this study. Charlotte had her own personal emotional health issues which at the time were undiagnosed and unsupported. The role of caring for a veteran had impacted on her mental health, leading her to overdose at school:

> *"I would wake up and he would be screaming at her and stuff and that's like, I think that's when, I didn't obviously realise it – that it started affecting me. Now that I think about it that's what started me having anxiety, I have really bad anxiety and I overdosed in November last year".*

Charlotte had been supported by CAMHS (she is now discharged) and was happy to disclose this information.

The forementioned extracts, particularly the one from Charlotte, demonstrate the detrimental psychological effects that caring for a veteran with PTSD can have. Moreover, it is clear that the young carers in this study were living in an environment of apprehension, constantly forecasting the future presentation of their fathers' or stepfathers' PTSD symptoms to intervene and ultimately were living in an environment which was creating toxic stress.

5.4.2 Sub theme 2: Behavioural effects

There appeared to be a correlation between young carers' behavioural presentations of anxiety, being on high alert and wanting to support their parents. When there is an emotional response to any given situation there is often a presenting behaviour. For the young carers within this study, living in an environment which constantly kept them alert had a behavioural presentation, for example anxiety, low mood and isolation. This was noted previously with regards to Charlottes' overdose. Whilst Charlotte was providing a caring role this may not have been the cause of her overdose but there is likely to be a definite correlation with her overdose, due to living in a constant stressful environment. Living in constant stressful environments changes the way in which children and young people develop and grow (Bucci, Marques et al., 2016) and importantly changes the way in which they may present in public or in private (Cozza, 2013).

As Izzy and Joseph explained, they adapted their behaviour to reduce the impact on them from their father's PTSD presentation.

> *"…not to annoy him too much…it was really scary when he would shout at you because he got upset quite easy then. We had to be good otherwise we set him [father] off" [Izzy].*

> *"…it was like quite scary because I was quite young. I didn't like people shouting at me then. But now I am older there is shouting at home I will just go to my room or get sent to my room, so he didn't shout at me more" [Joseph].*

The change in Joseph's behaviour was also noted by Pauline who explained;

> *"Yes, he will hide away in his bedroom…He is older and a lot more anxious because obviously his dad was injured on the first one [deployment] and even at that point, we didn't know how severe his injuries had been and they got sent back out. Joseph struggled with that tour because he didn't obviously know, and they still do it to this day, and even now when the doorbell rings, they get to the door before anybody else. Even to this day they are at the front door before anybody realises. It is things like that".*

Sandra also noted the change in Thomas's behaviour and explained;

"Thomas is really just quiet, just a very quiet kid, wouldn't display his emotions, he has never been argumentative, he has always been a child to do what he was asked and when he was asked. So there just seemed to be less fun in him and not bothered about doing things. You could ask Thomas, do you want to do this, do you want to go here, and he'd say, ... well ...., and that is hard to display itself. There was never any anger, shouting or crying he was just really withdrawn".

There is a depth of literature which demonstrates young carers are unable to switch off when they are not in the family home or able to connect to the person they are caring for (Robison, Egan et al., 2017; Järkestig-Berggren, Bergman et al., 2019; Margaret Gowen, Sarojini Hart et al., 2021). The young carers within this study appeared to be experiencing similar circumstances:

> *"It was very hard to concentrate I would be worried all the time. Constantly checking my phone and getting into trouble for talking, always be on my own. Just in case mum or [my stepfather] needed me, I would always be pulled out of class and people would talk about me, why I was always being pulled out of class". [Charlotte].*

5.5 Conclusion

The cross-case findings within this chapter highlight the temporal and transitional journey of children and young people who live with a parent with combat related PTSD, who become young carers due to parental PTSD. The first theme demonstrated the presentation of PTSD within the family home impacts those living within the family home. Moreover, the young carers within this project noticed the change in their parent, and how the prominence of anger changed not only their relationship with their father or stepfather, but also changed the way they carried out their own activities of daily living, due to pre-empting situations and forward forecasting. The result of pre-empting and forward forecasting was the catalyst to a change in the relationship with their father or stepfather.

The young carers within this study identified relationship disruption, which affected their attachment to their father or stepfather during their own physical and emotional developmental stage of adolescent maturation. Even during the complex period of adolescent maturation, emotional numbing was the leading cluster symptom from their father or stepfathers PTSD which had a significant effect on their relationship.

Furthermore, the young carers also described the change in their identity, the moment they became young carers and described the roles they undertook to support their father or stepfather, along with other members of the family. Moreover, there were discussions regarding taking charge of situation, stepping up and being parental figures within the family home. Importantly, the extracts provided by the young carers within this study have demonstrated that there is a distinct difference regarding the child *versus* parent relationship dynamic pre- and post-Afghanistan and the presentation of PTSD; they also demonstrate how parental PTSD has affected their own emotional health and well-being. Chapter 6 provides a deeper understanding of the emotional response to being a young carer of a veteran with PTSD and the impact caring has had on the young carers’ emotional response.

6 Chapter 6: Discussion

In this chapter I will provide an in-depth commentary and analysis of the outcomes of the study, by reviewing the findings presented in Chapter 4, the ‘within-families phase’ which provided an interpretive story for each case family, and Chapter 5, the ‘between-families’ phase, which identified cross-case themes. This will include critically appraising whether the aims of the study have been met. To recap, the aims were:

- To explore the impact that having a parent with Post Traumatic Stress Disorder, which is associated with combat, has on children and young people within the home environment.
- To explore the impact of parental and child or young persons relationships when the child assumes the role of ‘young carer’ for the parent who has combat attributable Post Traumatic Stress Disorder.

The ‘within-families’ findings which were presented in chapter 4 provided an in-depth analysis of the language used by young carers and their mothers, when describing what it was like to live with combat related PTSD. The interpreted stories which were presented in that chapter helped to identify meaning with regards to life events and elements within each life event. The ‘between-family’ analysis which was presented in chapter 5 highlighted common themes from Chapter 4, demonstrating that families shared very similar experiences. It is proposed, therefore, that the ‘between-family’ shared moments presented in Chapter 5 helped to illuminate the individual findings presented in Chapter 4. They demonstrated the wider impacts of caring for a parent with combat related PTSD and answered the research questions that this research study sought to answer.

The discussion in this chapter begins with a consideration of the effects that parental PTSD and the caring role had on the emotional health of the young carers within this study. The chapter will then move on to consider relationships and relationship disruption due to the presenting symptoms of combat related PTSD, as based on the narratives of the young carers and their mothers. Symbolic interactionist theory is used to interpret the findings. To conclude, the discussion chapter considers the future implications of the findings in relation to the long-term effects on young carer's emotional health, due to living with and supporting a parent with combat related PTSD.

6.1 The emotional effects of caring for a veteran parent with PTSD

As demonstrated within the literature review of this study there is limited research describing the outcomes for children who provide care within the military and veteran community. However, it is notable that there are relatable themes within the body of research which focus on parental illness or injury, through military combat, and its effects on children's well-being. The literature does include children and young people who presented with increased behavioural problems, violence, and hostility when their parents had a combat related injury or illness (Glenn, Beckham et al., 2002; DeVoe, Kritikos et al., 2018; Briggs, Fairbank et al., 2020). The findings of this body of research are paramount to this study, due to the participants' experience of deployment and their father returning with combat related injuries, namely PTSD and its effects on their emotional response due to becoming a carer for their father. As Briggs, Fairbank et al., (2020) explained, the severity of the returning parent's injury or illness due to military combat has been associated with higher rates of child conduct problems. The findings from Briggs, Fairbank et al., (2020) were similar to those of DeVoe, Kritikos et al., (2018) whose study focused on combat related PTSD and children's behaviour. They found the severity of parental PTSD increased behavioural problems amongst children. Importantly, a number of studies (Drummet, Coleman et al., 2003; Huebner 2019; Briggs, Fairbank et al., 2020) which were highlighted within the literature review, found that children and adolescents whose parents had combat related injuries including PTSD presented with internalising behaviours, for example, social withdrawal, nervousness, or fearfulness; and also presented with externalising behaviours such as physical and emotional aggression or being disruptive. According to Bowlby (1973) children build expectations about future interactions with parents based on repeated patterns of interaction. As those largely unconscious expectations become elaborated and organised, they form the internal working model, which guides the interpretations and behaviours of future interactions (Cassidy and Shaver, 2016). This was identified within all the cases of this study and could be interpreted as the young carers' pre-empting negative situations or mimicking their father's presentation. Moreover, the previously mentioned literature regarding the psychological outcomes for children and adolescents due to parental combat related PTSD found this population of children were at risk of presenting with depression and anxiety. As the finding's chapters identified, all of the young carers in this study appeared to present with anxiety due to the presentation of parental PTSD.

As highlighted in the findings chapters the young carers within this study were frequently confronted with a multitude of feelings and emotions due to their role as carers. Importantly, this study has surmised that providing care can be both a positive and a negative experience. It can be associated with positive emotional health outcomes, for example building self-esteem, providing purpose and happiness. As documented by Hartup and Laursen (1999) intimacy as expressed by cuddling and extensive joint interactions decreases as children mature, whereas conversations in which information is conveyed and feelings are expressed increases (Lerner and Steinberg, 2009). This was evident with Thomas and Joseph, who both sought to spend more time talking to their fathers.

However, caring can also be a negative experience, and can impact on the emotional health and well-being of the young carer in different ways. Within this study there was a temporal shift of emotions based on the context of the presentation of parental PTSD on any given day. As described by the young carers and their mothers in this study, the whole feel of the day was driven by how the father woke in the morning based on his symptoms [of PTSD]. All the families described this episode as 'walking on eggshells' and tried to pre-empt situations to not create a negative atmosphere which would affect the whole family dynamic throughout that day and potentially for the next few days. Highlighted within the literature and identified as a prominent factor within the finding's chapters of this study, fear for and of the parents, is typical for young carers whose parents have chronic mental health issues, especially when the parent with PTSD is having a mental health crisis. Moreover, as Cree (2003) and later Waddell, Pulvirenti et al., (2016) explain, there is the potential for young carers to also suffer emotionally when they witness a parent in pain or in acute crisis. Furthermore, compared to their non-caregiving peers, young carers of parents with chronic illness are at risk of stress related disorders, affective dysregulation and weakened immune response systems. The presentation of a multitude of emotions were found within this study. Unlike much of the literature on military children and young people, the young carers within this study, demonstrated an emotional response to living with parental PTSD and providing care. They presented with anger, fear, sadness, and resentment, which can be classed as surface meaning. Surface meaning as noted by Goffman (1961) reflects the taken-for-granted feeling of the person; that is the glossed structural self. Moreover, the findings from the young carers within this study provide detailed narratives of the relational interactions between their father and themselves and how the interactions changed their emotional response to their fathers and the symptomology of PTSD. The detailed narratives within this study provided depth. By inquiring into the narratives of the young carers, and their mothers, the findings provided a deep, inner moral self, the self of pride, shame, fear, anger or resentment (Strauss, 1959). The presenting emotions in these interactional experiences over the temporal landscape of pre-during and post combat, reflected turning point moments for the young carers, their fathers, and the family dyad.

6.2 Symbolic Interactionism and the Emotional Response

Emotions are an inherent part of relationships (Kleinman, 2002) and as such the co-construction of knowledge in this study involved the moulding of the young carers' current and historic emotions being shared. Hubbard, Backett-Milburn et al., (2001) argue the denial of young carers' emotions within research distorts the representation of the data and in analytically drawing on 'emotional' knowledge' we can enrich our understanding of the lived experience of caring for a veteran with combat related PTSD. However, the consideration of emotions within the findings, on many levels is analytically challenging as the presenting emotions are merely historic glimpses of moments in time. Hubbard, Backett-Milburn et al., (2001) make a comment with which I agree that researchers must become more practiced in recognising and interpreting emotion, to make more sense of respondents' words and actions.

Symbolic interactionism occupies a unique and important position in family studies. As the name suggests, 'symbolic interactionism' focuses on the connection between *symbols* for example shared meaning and *interactions* for example the verbal and non-verbal actions and communications (LaRossa and Reitzes, 1993). The use of narrative inquiry and in particular language and its interpreted meaning helped shape the landscape of this study which sought to understand the emotional response of being a young carer of a veteran with PTSD. As highlighted within the findings chapters all the young carers described PTSD [the symbol] differently. Izzy, Thomas, and Charlotte described PTSD as a range of presenting symptoms and concluded this was PTSD; Joseph, however, described PTSD as 'it'. The difference in descriptive language demonstrated there is not a shared meaning of the symbol. The difference in shared meaning of the symbol, had changed the interaction between themselves [their emotional response], their primary group [their family, namely their father], and their reference group [their community] when communicating the effects of their fathers' combat related PTSD. It can be argued, the young carers within this study used symbolic interactionism as a frame of reference to understand how they connected with others and created symbolic worlds, and how these worlds, in turn shaped human behaviour. For example, the findings of this study clearly demonstrate the presence of parental PTSD changed the way the young carers within this study re-shaped their world. It changed the concept of self, and through altered interactions with fathers not only did their identity change within the family home, but so too did their relationship with their father, creating a negative emotional response to their father during times when he presented with cluster symptoms of PTSD.

As highlighted in the literature review and the findings chapters of this study cultural identity is a prominent theme. Culture forms the stable core of human interactions, and as noted within the military connected families within this study, they strove to maintain those sentiments. Lively and Heise (2014) explain many situations will include characteristic emotions consistent with the identity a person brings to that situation. We saw these characteristics within all of the families in this study. For example, young carers and their mothers described their fathers/partners as characteristically strong military men, who were organised by rank and file, and who embodied the values of the Armed Forces, structure, routine and discipline. However, due to military combat, the fathers within this study presented with a number of cluster symptoms of PTSD. According to the young carers and their mothers, it was these cluster symptoms which changed the characteristics and identity of the fathers, and in turn changed the way they and their children interacted physically and emotionally together.

As Denzin (1989) notes emotions *per se* have received inconsistent attention in the symbolic interactionist literature. Mead's unit of analysis (the social act) and Bulmer's triadic theory of interpretive meaning (act, object and self) locate emotionality in the field of experience that confronts the interacting individual (Denzin, 1984). For example, within Case 3 Thomas described feeling scared when his stepfather became angry. The social act of Thomas's stepfather 'being angry' when interacting with Thomas [the object] changed the meaning of the interaction, which in turn changed the way Thomas responded emotionally. The result of this interaction is that Thomas became scared of his stepfather in that moment of time, and consequently, Thomas became frightened of his father in future moments of presenting anger. Denzin (1984) postulates emotion is a self-feeling that has a three-fold structure, that is, a sense of feeling, a sense of self feeling the feeling, and a revealing of the interactional meaning of the feeling itself. For example, in Case 1, Charlotte intuitively sensed the negative atmosphere at home, the beginning of an argument between her mother and stepfather. Charlotte was then able to reflect on how this argument made her feel. Charlotte described feeling anxious, fearful, and scared. Understanding how the situation made her feel, Charlotte 'interacted' with her feelings and removed herself and her siblings from exposure to the escalating argument. As the findings of this study have demonstrated, emotions drew the young carers into social, moral and emotional relations with others. These others are termed emotional associates who are implicated in the young carer's emotional world experience (Denzin, 1984). The emotional associates may be witnesses to an emotional experience or event or share the experience after the fact. They may be intermate significant others, situational others and as described by Schutz and Luckmann (1973) persons in a "we" relationship with the young carer. It is the "we" which was a consistent word used throughout all of the cases. The word "we" was more prominent within Joseph and Izzy's narratives and demonstrated the temporal journey of how their relationship and emotional connection, and reactions changed with their father's presentation of PTSD. As Case 2 showed, the emotional connection to the word "we" denoted emotions of sadness. Both Izzy and Joseph reflected on what "we" used to do, how "we" once went out together as a family and how "we" spent quality family time together. Those "we's" became "I's" and both Izzy and Joseph, isolated themselves from interacting with their father, due to fear, anxiety, and sadness. These were new ways of coping with the relationship breakdown due to the presentation of PTSD which were in turn, shaping the relationship between a father and his child in to one which had become disjointed and dysfunctional.

Importantly, the young carers within this study identified their thoughts, feelings, and emotions, whilst also providing their perceptions that others (in this case their parents) needed to recognise the importance of how caring may hide their feelings. I considered the use of emotions and the emotional response of the participants within the context of this study to tentatively suggest why a particular expression or term was used in a particular moment. I would argue that whilst the context of caring for a veteran with PTSD has negative connotations, the participants within this study demonstrated understanding and empathy about their fathers' presenting condition. There were various ways the young carers demonstrated empathy and understanding; partly by the way they articulated the problems with anger; partly by rationalising their father's presentation of anger and avoidance; and finally, and importantly, in their views towards their fathers' change in behaviour. The articulation of emotion signified the importance of the young carers full life stories being captured, allowing the young carers to have ownership of their thoughts and feelings and demonstrated emotional capacity. The extent of emotional capacity was at times challenging to extrapolate due to the topic being spoken about, the tone which the young carer used, their inclination, using one- or two-word answers, and sometimes it was what was not said rather than what was said which enabled their stories to be storied. In many ways, this demonstrated ‘emotionally sensed knowledge’ (Hubbard, Backett-Milburn et al., 2001).

There were many ways in which the young carers and their mothers spoke about problematic and frightening moments due to the unpredictable presentation of their fathers’ PTSD. As noted within the finding’s chapters, there were many feelings associated with the presentation of parental combat related PTSD. Most frequently, particular incidents were shared alongside the consequential emotional response; for example, Charlotte described moments when her stepfather got angry, began shouting and started to throw things, she would go to her room to just stay away, explaining her emotional response was being scared and crying. This emotional response led Charlotte to sometimes punch the door. This is a significant concept of the body holding particular importance ‘as a direct source of agency’ (Fingerson, 2009). What is meant by Fingerson’s comment is children inherently use the body as a way of expressing emotion. It is evident that the young carers within this study due to the presentation of combat related PTSD, had all developed maladaptive behaviours, which had resulted in poor emotional responses to providing care, and in contextual moments of caring had continued to negatively affect their overall emotional health.

6.3 Roles and relationships

The family is often one of the first support systems for those who have a physical or psychological health issue. Support from the family often becomes a long-term commitment as this study has demonstrated, and young carers need to form a new identity or role within the home as they anticipate or react to the pathology of PTSD (Berger and Weiss, 2009). The notion of a young carer providing care as a young person has become an increasingly familiar term used throughout contemporary western society. As identified within the literature review of this study, which was presented in chapter 2, a growing body of research within the UK, Canada and Australia has provided a deeper insight into the lives and experiences of children and young people who have become carers for siblings, parents, and extended family members. Essentially the growth of research on this population of children and young people who provide care, has helped shape public policy (Aldridge and Becker 1993; Newman 2002). In spite of this growing body of research, however, a universally accepted definition of a ‘young carer’, has not been defined, which has in turn created ambiguity and confusion (Aldridge and Becker 1993; Aldridge 2018). Therefore, it can be argued that the lack of a universally accepted definition of a ‘young carer’ has complicated the recognition and the identification of young carers by professionals and family members and in turn, has resulted in a lack of self-identification by children and young people who provide a caregiving role as was the case with all of the young carers in this study.

As Newman (2002) postulates, children and young people who become young carers are predominantly identified and ‘labelled’ through contact with multiple professionals from different statutory and third sector disciplines. It is this multi-disciplinary approach to defining young carers which has created recognition ambiguity when working with families from multiple agencies. As Becker (2007) argues, most definitions of and research on and with young carers, has tended to migrate towards understanding the ‘role of’ and the ‘effects’ caring has on the young person. Research studies and multiple definitions of a young carer which are used in policy offer different levels of understanding, as well as unique sets of difficulties. If we quantify young carers according to the roles, they undertake this has the potential of excluding young carers who provide less quantifiable forms of care, such as emotional or psychological support within the home or within their wider family. We may therefore overlook those young carers who provide an emotional caring role as opposed to a more practical caring role. Therefore, it could be argued that some of the young carers within this study who undertake caring roles due to parental PTSD have the potential to be overlooked by external service providers. Charlotte was an exception but only because she was identified as a young carer due to safeguarding concerns relating to domestic abuse within the family home.

As highlighted within the literature review chapter, failure to identify young people whose parents suffer with mental health issues, may be problematic considering that providing emotional support has been associated with poor emotional health and well-being outcomes for young carers (Järkestig-Berggren, Bergman et al., 2019; McGibbon, Spratt et al., 2019; Margaret Gowen, Sarojini Hart et al., 2021). As highlighted within the young carers’ literature as well as within the findings of this study, young carers commonly report a sliding scale of ‘impacts’ which result from their caring role. Impacts which are highlighted within the literature are education, social life, future employment, relationships and emotional health and well-being (Aldridge and Becker 1993; Becker 2000; Järkestig-Berggren, Bergman et al., 2019; McGibbon, Spratt et al., 2019). The most important impacts highlighted by young carers within this study were emotional health and well-being and relationships with their father. In contrast, the young carers within this study were also asked about the impact that their caring responsibilities had on their education but none of the young carers said their education had been affected by providing care. Moreover, all the young carers within this study described school as a place of structure and routine which provided them with stability, support and access to their friendship groups (Gough and Gulliford, 2020). As O'Neil (2017) explains, children drift in and out of vulnerability due to the context of their environment. It is clear from the narratives of the young carers in this study that their school environment provided a protective and supportive environment.

Whilst the effects of being a young carer, and the impact on family relationships has been considered within the literature, experiences across different caring contexts have yet to be compared, including the experiences of young carers of veterans with PTSD. Therefore, I argue that awareness of the specific needs and issues which may present within this population of young carers is fundamental to informing current policy and practice. The impact of caring for a family member with PTSD has been described within the literature, as one which can and does have a significant effect on the child versus parent relationship (Lerner and Steinberg 2009; Weimand et al., 2018). This was especially true within this study. As stated previously, the parent-adolescent relationship is already full of intricacies due to the stages of maturation of the growing adolescent. When a parent presenting with PTSD is added to this stage of development within adolescent-maturation, there are a number of complex moments which require navigating due to potential conflict (Lerner and Steinberg, 2009). To add to the complications of the adolescent-parent relationship, the literature regarding this subject suggests that the presence of parental mental health issues or disability is often described in detrimental terms and correlated with ineffective parenting (Aldridge and Becker 1993; Kallander, Weimand et al., 2018). As presented within the finding's chapters of this study, parenting could be ineffective when it was undertaken in the context of PTSD symptoms, but it was not necessarily so. Rather it tended to instigate a number of multi-layered complexities including a role change for the young carer and a shift in family which created a cacophony of raw emotion within the family home, resulting in the dysfunction of the young carer-parent relationship. Moreover, the findings of this study highlight there were several contributing factors which impacted on the relationship between the young carer and their father. These factors included, the presentation of PTSD, the role of the young carer and the consequences of the interactions due to PTSD.

6.4 Implications and Conclusions

Understanding the lived experience of the young carers and their mothers within this study raised issues of continual ambiguity concerning the various issues of experiences and the emotional impact of being a young carer of a veteran with combat related PTSD. Previous research regarding military connected children and young people has demonstrated that those within this population will drift in and out of vulnerability based on the context of their family structure and their environment (O'Neil, 2013). In this study key differences were highlighted which have important implications for policy and practice. Whilst not to make assertions, in general terms those enduring the most adverse effects of providing care were involved in some frightening episodes of care, namely in the contexts of parental combat PTSD and the clusters of anger and emotional numbing. The young carers within this study were dually disadvantaged as they were less likely to be identified. As highlighted within the literature review of this study, a young carer is an already hard to reach population to access and support. However, as noted within the military section of the literature review, military connected children and young people are a significantly hard to reach population. Therefore, this adds a further layer of complexity when identifying and supporting young carers from the military community.

As discussed within this thesis, the military community is already a closed group to the outside world, which increases the risk of those children and young people who are providing care not being recognised and supported. Therefore, it is fundamental that professionals are aware of the issues young carers from the military community face and become more aware of this population and its culture and focus their interventions with young carers from the military community. Also, it must be acknowledged that the young carers within this study had experienced different issues and problems compared to their civilian counterparts. Whilst the literature regarding all young carers highlights the positive and the not so positive aspects of providing care for a family member, the military culture adds a complex layer to being a military child, especially one who is providing a caring role. As the literature on military life and its effects on the military family highlight, there are many challenges associated with living within the military community. As the leading body of research regarding the challenges military families face highlights the deployment cycle is the catalyst of family dysfunction.

Research regarding the deployment cycle has noted that the frequency, and ferocity of recent deployment experiences significantly impacts on those returning from combat, and importantly, significantly impacts on the integration of that person back into the family. As case 1 highlighted the personal struggles with integration back into a family can be experienced long after service life has been terminated. It is this unique aspect of military life which separates the culture of young carers from the military community from their civilian counterparts.

As this study has demonstrated, from the perspective of the young carers and their mothers, all the fathers had a strong relational bond with their children and demonstrated a solid family connection. The young carers and their mothers supported this notion and all the participants shared stories of connectedness, compassion, affection, and warmth. However, due to military combat these fathers returned as a different person, a shadow of themselves and this change was identified by the young carers. The fathers found it difficult to transition back into the family home, and over time, presented differently. It is evident within this study that the presentation of PTSD cluster symptoms changed both the relationships between the father and his child, and the role of the child, who became a carer for their father. With regards to these changes, the young carers discussed their actual experiences around particular issues such as feeling scared, anxious, and worried about how their actions would have negative consequences with regards to their fathers' PTSD; something which has not been investigated previously within the military community.

As discussed within this study, the mothers did not know, or in Charlotte's case, accept that their children were young carers. The lack of understanding regarding young carers remains a constant conundrum for families and service providers alike. This conundrum is in part due to the lack of continuity regarding the definition of 'what' a young carer is. Providing a universal definition and classification of 'what' a young carer is, is fundamental and necessary in terms of identification and supporting young carers and their collective and individually specific needs. The importance of this cannot be overstated as the problem with being a hidden population originates mainly from ambiguity regarding the definition. As the literature review within this study demonstrated, there is still no universal agreed definition in policy or research. The lack of a universal definition has resulted in a range of comprehensions and misconceptions, and therefore, ultimately this creates a lack of recognition and identification.

Although a collective definition would go some way to addressing the hiddenness of young carers, this will not completely address young carers' lack of self-identification, identification from their families or their community, or remove the problem of hiddenness. As highlighted within the literature review of this study, being aware of and understanding the term 'young carer', does not completely equate to personal, or collective recognition, nor does it enable public recognition of the role of being a young carer. Whilst young carers' awareness features heavily within statutory, voluntary and third sector organisations, the most important factor is to reduce the stigma, the myths and poor health and well-being outcomes for those children and young people who are providing care. Being a cultural insider has supported the development of this study and allowed me access to a hard-to-reach and culturally sensitive population, something I am grateful for. However, non-military service providers may not have the opportunity to reach this population of young carers, due to 'cultural secrecy'. The military community is built on trust, and access to services require that development of trust. I would therefore argue that service providers and education establishments require education on military culture, which will go some way towards developing trust, identifying and sharing information on young carers within military families. In conjunction with the development of military cultural education, co-produced educational material with children and young people from the military community who provide care, should be a fundamental component to the facilitation of educational material. Moreover, it is vital that education regarding young carers from military families is fed into the military community, so they too can become aware of the role young carers play within their homes, and seek support to maintain positive health, well-being, educational attainment, and social connections for their children, those they care for and the connected family.

7 Chapter 7: Final thoughts and conclusions

In this chapter I will provide my final thoughts and offer a conclusion to this study. I start by offering my reflections and a critical appraisal of the chosen research design. I will then move on to discuss the limitations of the study before considering the contribution to knowledge this study has afforded. Finally, I will present the implications, where I identify the need to recognise the impact caring has on children and young people within the military and veteran community; to address the need to improve recognition and identification of young carers within the military community and to develop dedicated service provision for this population of young carers.

7.1 Reflections and critical appraisal of the research design

The use of a qualitative design for this study enabled me to elicit and process young carers and their mothers' experiences and provide meaning to those experiences. Furthermore, the narrative paradigm used within this study enabled me to discover and 'interpret' what was experienced by the participants, and importantly enabled me to validate these experiences (Clandinin 2016). Thus, the research design used for this study was employed to exploit the advantages of using such a method to provide depth, detail and the lived experience of those who participated (Clandinin and Connelly 2000; Clandinin 2016).

This study was a co-constructed accomplishment (Denzin, 1989) which consisted of myself as the researcher, collecting the narrated stories of young carers and their mothers, through the use of open interviews. Acknowledging, and enabling the voice of young carers appeared to influence the amount of information they shared. As Clandinin and Connelly (2000) postulate, the act of observing a population or phenomenon, for example, the telling of the story, has influence over that phenomenon, that is the story they tell. However, I felt my role and contribution to the interviews and data analysis played an important role in the construction of the stories, to develop the 'storied stories' (McCormack, 2000a,2000b). I would, therefore, acknowledge that the development of the 'storied stories' were influenced by my own views and experiences. For this reason, the 'storied stories' within this study are not exclusively objective accounts but co-constructed interpretations of moments within the lived experiences of the young carers and their mothers.

Narrative interviews were useful in that they enabled the young carers to share their life story from as far back as they could remember. As Clandinin (2016) explains, some researchers have stated that children and young people can find it difficult to recount specific memories. However, by using an unstructured interview technique all the young carers were able to talk about when they started primary school, which importantly was pre-PTSD. With the exception of Charlotte, the young carers shared stories of living on the patch, then moving to new homes, moving school and making new friends, friends who had something in common with them. They identified as military children and talked about living a shared life. This identity of being a military child is comparable to other studies which have been undertaken with this population whose participants also embraced the identity of being a military child (Mmari, Bradshaw et al., 2010). That said, Watson and Osborne's (2020) study of Danish military children highlighted that many of the participants did not know the difference between being a military child compared to a civilian child, so they classed the label of 'military child' as something which was normal to them.

7.2 Limitations

A 'limitation' of this study is the lack of generalisability of the findings. Ritchie, Lewis et al., (2013) argue that a lack of generalisability is one of the disadvantages of using qualitative research designs; that is, the study's findings cannot be extended to other populations. Narrative inquiry was chosen to investigate a specific population of young carers to produce in-depth and intense descriptions of a specific lived experience and as outlined above this method enabled me to successfully present the participants' stories. However, such a method is necessarily combined with small sample sizes which reduces the generalisability of the findings.

The number of participants who participated in the study was always going to be small due to the recognition, identification, and hiddenness of this population of young carers from a military community. As discussed within Chapter 3, the methodology chapter, I initially wanted to interview 10 young carers, however, I was only able to recruit 4 young carers from three families and, therefore, made the decision to interview their mothers as well. Reluctance to participate could have been for a number of reasons especially factors raised within Chapter 6 the discussion chapter regarding identification and understanding. Importantly, however, some young carers may have been reluctant to take part because they did not want to share sensitive information. As Wilkerson, Iantaffi et al., (2014) note, participants need to feel the stories they share will be kept safe, that they can articulate their stories, and are confident they can articulate their thoughts effectively. Participants need to be interested in a study, to understand its aims and to relate to those aims and I am immensely thankful that 4 young people were sufficiently interested in the study that they were willing to share their personal thoughts and experiences.

On reflection the sample size could have been improved by using a different method of recruitment. As discussed previously, due to the wording of the recruitment poster which used the term ‘young carers’ I had very little uptake, due to the hiddenness of young carers nationally and specifically within the military connected community. As discussed, I had to change the wording used in the recruitment poster to children and young people who lived with a parent with combat related PTSD. However, the inclusion criteria could have widened to include those who lived with a parent with the presenting symptoms of PTSD, to include self-reported symptomology by the parent. This method of participant inclusion was used by RAND (Ramchand et al., 2014), when undertaking a national research project for the Elizabeth Dole foundation in the USA. Interestingly, not all of their participants had a clinical diagnosis of PTSD as stated within my recruitment criteria, a significant proportion of the participants self-reported symptoms of PTSD, which increased the sample size of their study. Therefore, I would also adopt this method of recruitment to increase my sample size if I was conducting the study again.

In addition to the above, the process of data collection had both strengths and limitations. One of the strengths of this study was the focus on hearing the voices of young people themselves. This enabled a unique insight into the lived experience of what it is like to provide care to a military parent with PTSD. However, the limitations of the data collection method were two-fold. Firstly, one danger of any qualitative study is that participants may attempt to provide the researcher with answers they believe they want them to hear. This could have been the case for the participants within this study, however the use of an open interview and the study design focused on a ‘whole’ life approach to collating experiences and moments within time helped mitigate against this. Secondly, a further issue with qualitative data collection and noted within this study is that participants may purposefully or unconsciously refrain from sharing certain aspects of their life narrative. As the findings of this study have highlighted research with children and young people is vital in terms of furthering understanding of their lives. At times the young carers in this study did withhold information until their mother became part of the collective conversation. In certain situations, I felt the addition of their mother gave the young people permission to discuss difficult situations within the family home. For example, Izzy often began to discuss the presentation of PTSD, but would then pause and move on, potentially to protect her father, his illness, and its effects on the family. However, when we had a collective discussion with her mother Izzy really opened up and shared a lot of detail about PTSD and its effects on her and her family. This does not question the trustworthiness of the study, as the purpose of the study was to investigate the lived experiences of young carers who provide a caring role for their father, a combat veteran with PTSD and I would argue that mothers have important perspectives to contribute and by including mothers I was able to more fully understand these lived experiences. The method allowed young people to articulate an experience which was relevant to them in moments of time, and by having their mothers there they felt comfortable to disclose sensitive information. Any further prompting into situations where the participants were not comfortable would have been ethically and morally unjust. Of note, many researchers choose to interview children and young people alone, however, what this study has highlighted is that mothers' presence at an interview can enhance the quality of the data and this may be something other researchers might want to consider.

A final limitation of this study is that the findings are based on my interpretation of the young carers and their mothers' told stories which could be deemed to be a third hand analysis of the narrative data. Nevertheless, the storied stories within this study were based on the real narratives of the young carers and their mothers and I have used their words as much as possible to stay true to their own narratives. Therefore, the findings of this study were conditioned by the unique characteristics of the participants who were living within the military community and providing care for a veteran who had combat related PTSD.

7.3 Contribution to knowledge

This study was conducted in England. It provides a unique insight into the lives of 4 young people and 3 mothers from the military community. I myself live in England and also belong to the military community. It is therefore important to acknowledge that the study has been influenced by the cultural values and norms which are prevalent within the military community. Consequently, it is these shared lived experiences and common cultural values which have shaped and influenced the outcomes and insights of this study. Arguably, the 7 narratives presented, and the storied stories produced, shed light on a number of events which have become significant to the lived experience of each of the participants. These descriptions, whilst not being undisputed truths, contribute to the unveiling of the experiences and add to the development of knowledge of a hard-to-reach population, who are guarded by cultural sensitivity, namely young carers of veterans with PTSD. To date, as outlined in the literature review in Chapter 2 very few researchers have investigated the views of young carers of veterans, particularly in England, and no studies have considered the perspectives of both young carers and their mothers.

While earlier studies have examined the relationships between military personnel and their children (Ruscio, Weathers et al., 2002; Cohen, Zerach et al., 2011), this study expands on the findings from these studies to provide a detailed and expansive look at how combat related PTSD can disrupt family functioning and change the relationship between a father/stepfather and his children, to the extent that the children, whether they are aware of this or not, become young carers. More specifically, this study builds on the works of Sherman, Gress Smith et al., (2016) whose research used a mixed methods approach to examine veterans' perspectives of (a) the impact of PTSD on parenting, and (b) children's reactions to their parents' behaviour; and Parsons, Knopp et al., (2018) who examined the associations between fathers' military-related PTSD symptoms and parent ratings of children's emotional problems. However, Sherman, Gress Smith et al., (2016) and Parsons et al's (2018) studies both focused on military fathers' perspectives. In contrast, this study provides new insight into 1) the child's emotional response to parental PTSD and 2) the consequence of combat related PTSD on the emotional health of the young carer, from both the young carer's perspective and that of their mothers.

Much of the literature around young carers notes that a higher proportion of care (67-75%) is provided to chronically ill mothers (Pakenham, Chiu et al., 2007; McDonald, Cumming et al., 2009; Ireland and Pakenham 2010), and young carers are less likely to care for male members of their family (McDonald, Cumming et al., 2009; Lloyd 2013). However, in military families it is often the father who presents with chronic illness. This study, therefore, also adds to the current knowledge base by providing an insight into care provided to fathers with chronic illness and furthers the understanding of the effects this has on male and female young carers' emotional health and well-being.

7.4 The implications for future research

This study indicates that some children and young people from military families and military communities may be at significant risk of emotional harm due to the frequency and ferocity of their parents' deployment to Afghanistan and other combat zones. Due to the nature of combat, returning parents sometimes present with difficulties when embedding themselves back into the family, thus creating a dysfunctional family. For the families in this study this dysfunction was in the main due to the presentation of PTSD and a number of dominant cluster symptoms, namely anger and emotional numbing. These two cluster symptoms appeared to affect both the functioning of the returning parent and the interaction between the returning parent and their child/ren. Moreover, the presentation of the cluster symptoms was accompanied by a reduction of functionality of the returning parent, and this also affected the relationship between the parent and child. A main finding of this study was that the role of the child changed to one of support or caring. It was the combination of the caring role and the presenting cluster symptoms of PTSD which affected the emotional response of the young carer. Although there were some similarities amongst all the cases within this study, there were also unique differences, and it would be important to further explore these differences with a larger sample. I would argue that in order to fully capture what is different about the experiences of young carers who are caring for a veteran parent with PTSD, larger studies need to include a 'control group' and compare their experiences with other groups of young carers within the military community who care for a parent with other conditions, such as a physical health issue, other mental health issues or a father with dual diagnosis. Moreover, this study did not recruit young carers where the parent with PTSD was the mother. This was not intentional. It would, therefore, be pertinent to seek the voices of young carers of mothers who have a military contributed illness or disability.

Another aspect of this study which could be addressed by future researchers is the sample size. As previously mentioned, the sample size for this study was relatively small including only 4 young carers from 3 families and their mothers. A larger sample size would possibly enable further insights and a larger narrative data set of the experiences of being a young carer of a parent within the military community. However, how feasible this would be is questionable. The narrative data collected from the 7 participants and the process of storying the stories was very time consuming and demanding. I would therefore argue that for a larger sample size to be included a different methodology would need to be used, for example mixed methods. This approach has worked well in research designed to investigate the military population, especially with children and young people, where qualitative research is needed to gain the breadth and depth of experience (Watson and Osborne 2020). The strength of using a mixed methods' approach which would include a quantitative aspect alongside a qualitative design would allow future researchers to identify, describe as well as quantify young carers' experiences.

7.4.1 Recognition of the impacts of caring

The findings of this study present a range of impacts and issues which are experienced by young carers that need to be recognised, including the unique issues of being a young carer within the military community. In response to this service providers need better awareness of the unique needs of young carers from the military community so they can provide individualised and family focused interventions. In addition to this, service providers and policy makers may need to recognise that young carers within the military community may be at increased risk of emotional harm, social isolation and family breakdown. Therefore, I would argue, that young carers within the military community should explicitly be recognised as an 'at risk' group due to parental deployment, specifically those whose parents have been exposed to combat, especially since as previously discussed. the cultural sensitivity of the military can lead to families and children being reluctant to speak out about their experiences meaning young carers can be more hidden in military than in non-military communities.

7.4.2 Improved Recognition and Identification

To be recognised as an 'at risk' group there needs to be an improvement of, and a more consistent approach to identification of young carers from the military community. This in part could be improved by the use of a universally accepted definition of 'what' a young carer is. Arguably, a standardised definition would create uniformity across different stakeholders within statutory, third sector and voluntary organisations to support the identification of young carers from the military community. Moreover, identification of those who are at significant risk would require appropriate early intervention to reduce harm and improve outcomes for the young carer and their family.

7.4.3 Dedicated Service provision

As indicated within the young carer literature outlined in chapter 2 dedicated young carer support projects are the services which are mainly frequented by young carers, and rightly these services are viewed as offering appropriate service provision and education for and about young carers. However, these projects are mainly provided by the voluntary sector and rely largely on grant funding, which in most cases is unsustainable and offered at reduced levels of need. I would therefore argue that there is a duty of care to ring fence funding for appropriate service provision for young carers. Having a dedicated fund from central Government for young carers would enable appropriate and multiagency approaches to support young carers as part of a family focused approach to health and social care. These dedicated services are vitally important in terms of addressing the needs of young carers. They have and continue to be fundamental in facilitating access to peer support networks, creating social opportunities and benefiting the overall health and well-being of young carers. However, as this study has identified, young carers have specific needs, and in the context of the military community, young carers have an added layer of complexity. I would argue the findings from this study have highlighted the unique needs of young carers from the military community and identified that they may require more individualised support, for example, from trained military aware counsellors or primary emotional health care professionals who understand the impact of parental military combat. Therefore, increased funding and appropriate allocation of funding is required to address the needs of young carers from a military community.

7.5 Overall Conclusion

In conclusion, this study sought to identify the lived experience of young carers of veterans with combat related PTSD by investigating their own perspectives as well as the perspectives of their mothers. The findings of this study suggest there may be common experiences amongst young carers who care for a veteran with PTSD. However, whilst the young carers within this study shared a common experience of providing care for a father who had a diagnosis of PTSD due to military combat exposure, each family, and each young carer's experience was very different. These individual experiences were captured and have been presented in this thesis. The findings of this study suggest being a young carer to a veteran father with PTSD affects young people's emotional responses to and interactions with their father. The young carers in this study were severely or adversely affected with regards to their emotional health, their social connectedness, and the functionality of their family, due to parental PTSD. They all presented with maladaptive coping strategies which conversely effected their overall emotional health and well-being, as well as their activities of daily living. Ironically, despite the effects of caring for their father, these young carers were less likely to be identified or even have their caring role recognised, even within their own homes.

I have argued that there is a need for policy makers and service providers to devise a universal definition of 'what' a young carer is in order to aid identification and hiddenness of this small population of young carers. By providing a universal definition service provision can be more responsive to need. As well as providing a standardised definition, the awareness of the needs of young carers from the military community requires significant funding and promotion, as well as military awareness training for those who provide support to young carers and their families from the military community, especially those who have been deployed to Afghanistan. There is a need to provide specific service provision for young carers from the military community due to their unique needs which come from living in a culturally sensitive population. This improved recognition and specific support for young carers and their military families, requires co-ordinated, co-constructed development to ensure young people with lived experience are placed at the heart of decision making and future policy developments.

8 Chapter 9: Reference List

Agency., D. A. S. (2021). *DASA outflow statistics.*

Ahmadi, K., Azampoor-Afshar, S., Karami, G., & Mokhtari, A. (2011). The association of veterans' PTSD with secondary trauma stress among veterans' spouses. *Journal of Aggression, Maltreatment & Trauma, 20*(6), 636-644.

Ainsworth, M. (1967). Infancy in Uganda: Infant care and the growth of love.

Ainsworth, M., & Wittig, B. (1969). Attachment, exploration, and separation: illustrated by the behavior of one-year-olds in a strange situation. *Determinants of infant behaviour, 4*, 113-136.

Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect, 15*(2), 79-88.

Aldridge, J. (2008). All work and no play? Understanding the needs of children with caring responsibilities. *Children & Society, 22*(4), 253-264.

Aldridge, J. (2018). Where are we now? Twenty-five years of research, policy and practice on young carers. *Critical Social Policy, 38*(1), 155-165.

Aldridge, J., & Becker, S. (1993). *Children who care: Inside the world of young carers*.

Aliance, S. (2016). *The Educational Progression of Children from Military Families: National Innovation Conference*

Althusser, L. (1971). Ideology and ideological state apparatuses. Lenin and philosophy and other essays. *Trans. Ben Brewster. New York: Monthly Review Press, 1270186*.

Alves-Costa, F., Lane, R., Gribble, R., Fear, N., & MacManus, D. (2021). Experiences of Intimate Partner Violence and Abuse among Civilian Partners of UK Military Personnel: Perceptions of the Impact of Military Life and Experiences of Help-seeking and Support.

Amato, P. R. (2010). Research on divorce: Continuing trends and new developments. *Journal of Marriage and Family, 72*(3), 650-666.

Andres, M. (2014). Distress, support, and relationship satisfaction during military-induced separations: A longitudinal study among spouses of Dutch deployed military personnel. *Psychological Services, 11*(1), 22.

Anzul, M., Ely, M., Freidman, T., Garner, D., & McCormack-Steinmetz, A. (2003). *Doing qualitative research: Circles within circles*: Routledge.

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*: American Psychiatric Publishing.

Arnold, A. L., Lucier-Greer, M., Mancini, J. A., Ford, J. L., & Wickrama, K. A. S. (2017). How Family Structures and Processes Interrelate:The Case of Adolescent Mental Health and Academic Success in Military Families. *Journal of Family Issues, 38*(6), 858-879.

Arya, S., Kaji, A. H., & Boermeester, M. A. (2021). PRISMA Reporting Guidelines for Meta-analyses and Systematic Reviews. *JAMA surgery*.

Ashcroft, M. (2014). *The veterans' transition review*: Biteback Publishing.

Atkinson, L. (2012). Strategic decisions: Life history, interpersonal relations, intergenerational neurobiology, and ethics in parenting and development. *Parenting, 12*(2-3), 185-191.

Baker, C. (2020). Mental health statistics for England: prevalence, services and funding.

Banneyer, K. N., Koenig, S. A., Wang, L. A., & Stark, K. D. (2017). A review of the effects of parental PTSD: A focus on military children. *Couple and Family Psychology: Research and Practice, 6*(4), 274.

Baptist, J., Barros, P., Cafferky, B., & Johannes, E. (2015). Resilience Building Among Adolescents From National Guard Families: Applying a Developmental Contextual Model. *Journal of Adolescent Research, 30*(3), 306-334.

Barker, L. H., & Berry, K. D. (2009). Developmental issues impacting military families with young children during single and multiple deployments. *Military Medicine, 174*(10), 1033-1040.

Barnett, B., & Parker, G. (1998). The parentified child: early competence or childhood deprivation? *Child Psychology and Psychiatry Review, 3*(4), 146-155.

Bartholomew, K. (1997). Adult attachment processes: Individual and couple perspectives. *British Journal of Medical Psychology, 70*(3), 249-263.

Becker. (2007). Global perspectives on children's unpaid caregiving in the family: Research and policy on 'young carers' in the UK, Australia, the USA and Sub-Saharan Africa. *Global social policy, 7*(1), 23-50.

Becker, F., & Becker, S. (2008). Young Adult Carers in the UK. *Experiences, needs and services for carers aged*, 16-24.

Becker, S. (2000). The health and well-being of young carers. *Social Care Institute of Excellence (2005)*.

Becker, S. (2005). Young carers: evidence and messages from UK and Australian research. *Carers: The Next Generation, Adelaide, Carers South Australia*.

Becker, S. (2007). Global perspectives on children's unpaid caregiving in the family: Research and policy on 'young carers' in the UK, Australia, the USA and Sub-Saharan Africa. *Global social policy, 7*(1), 23-50.

Becker, S., Dearden, C., & Aldridge, J. (2002). Children's labour of love?: Young carers and care work. In *Hidden Hands* (pp. 86-104): Routledge.

Beks, T. (2016). Walking on Eggshells: The Lived Experience of Partners of Veterans with PTSD. *Qualitative Report, 21*(4), 645-660.

Bello-Utu, C. F., & DeSocio, J. E. (2015). Military deployment and reintegration: a systematic review of child coping. *J Child Adolesc Psychiatr Nurs, 28*(1), 23-34.

Belsky, J., & Isabella, R. (1988). Maternal, infant, and social-contextual determinants of attachment security. *Clinical implications of attachment*, 41-94.

Benzies, K. M., & Allen, M. (2001). Symbolic interactionism as a theoretical perspective for multiple method research. *Journal of advanced nursing, 33*(4), 541-547.

Berardini, Y., Chalmers, H., & Ramey, H. (2021). Unfolding what self-compassion means in young carers' lives. *Child and Adolescent Social Work Journal, 38*(5), 533-545.

Berger, R., & Weiss, T. (2009). The posttraumatic growth model: An expansion to the family system. *Traumatology, 15*(1), 63-74.

Bernard, H. R. (2017). *Research methods in anthropology: Qualitative and quantitative approaches*: Rowman & Littlefield.

Bjornestad, A. G., Schweinle, A., & Elhai, J. D. (2014). Measuring Secondary Traumatic Stress Symptoms in Military Spouses With the Posttraumatic Stress Disorder Checklist Military Version. *Journal of Nervous and Mental Disease, 202*(12), 864-869.

Blamey, H., Phillips, A., Hess, D. C., & Fear, N. T. (2019). The impact of parental military service on child well-being. In: University of Toronto Press.

Bleakley, A. (2005). Stories as data, data as stories: making sense of narrative inquiry in clinical education. *Medical education, 39*(5), 534-540.

Blos, P. (1979). The Adolescent Passage New York: Int. In: Univ. Press.

Blumer, H. (1962). Society as symbolic interaction. *Contemporary Sociological Thought*, 91.

Blumer, H. (1981). George Herbert Mead: Self, Language, and the World. In: JSTOR.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*: Univ of California Press.

Boss, P. (2004). Ambiguous loss research, theory, and practice: Reflections after 9/11. *Journal of Marriage and Family, 66*(3), 551-566.

Bowlby, J. (1951). Maternal care and mental health, Geneva, 1951. *World Health Organization*.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International journal of psycho-analysis, 39*, 350-373.

Bowlby, J. (1973). Attachment and loss: Volume II: Separation, anxiety and anger. In *Attachment and loss: Volume II: Separation, anxiety and anger* (pp. 1-429): London: The Hogarth press and the institute of psycho-analysis.

Bowlby, J. (1980). Attachment and loss: Volume III: Loss, sadness and depression. In *Attachment and Loss: Volume III: Loss, Sadness and Depression* (pp. 1-462): London: The Hogarth press and the institute of psycho-analysis.

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American journal of Orthopsychiatry, 52*(4), 664.

Braun-Lewensohn, O., & Bar, R. (2017). Coping and quality of life of soldiers' wives following military operation. *Psychiatry research, 254*, 90-95.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental psychology, 28*(5), 759.

Bride, B. E., & Figley, C. R. (2009). Secondary Trauma and Military Veteran Caregivers. *Smith College Studies in Social Work, 79*(3-4), 314-329.

Briggs, E. C., Fairbank, J. A., Tunno, A. M., Lee, R. C., Corry, N. H., Pflieger, J. C., . . . Murphy, R. A. (2020). Military life stressors, family communication and satisfaction: Associations with children’s psychosocial outcomes. *Journal of child & adolescent trauma, 13*(1), 75-87.

Britt, T. W., Sipos, M. L., Klinefelter, Z., & Adler, A. B. (2019). Determinants of mental and physical health treatment-seeking among military personnel. *The British Journal of Psychiatry*, 1-7.

Brown, L. S., & Wright, J. (2001). Attachment theory in adolescence and its relevance to developmental psychopathology. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 8*(1), 15-32.

Bucci, M., Marques, S. S., Oh, D., & Harris, N. B. (2016). Toxic stress in children and adolescents. *Advances in Pediatrics, 63*(1), 403-428.

Buchanan, C., Kemppainen, J., Smith, S., MacKain, S., & Cox, C. W. (2011). Awareness of posttraumatic stress disorder in veterans: A female spouse/intimate partner perspective. *Military Medicine, 176*(7), 743-751.

Burgh, T. D., White, C., Fear, N., & Iversen, A. . (2011). The impact of deployment to Iraq or Afghanistan on partners and wives of military personnel. . *International Review of Psychiatry, 23*, 192-200.

Burnett, G., Jones, R. A., Bliwise, N. G., & Ross, L. T. (2006). Family unpredictability, parental alcoholism, and the development of parentification. *The American journal of family therapy, 34*(3), 181-189.

Cameron, T. M., Walker, M. F., & Fisher, R. J. (2022). A Qualitative Study Exploring the Lives and Caring Practices of Young Carers of Stroke Survivors. *International Journal of Environmental Research and Public Health, 19*(7), 3941.

Carers Act. (1995). Carers (Recognition and Services) Act: Chapter 12. In: London: HMSO.

Carter, M. J., & Fuller, C. (2015). Symbolic interactionism. *Sociopedia. isa, 1*, 1-17.

Casey, D., & Houghton, C. (2010). Clarifying case study research: Examples from practice. *Nurse researcher, 17*(3).

Cassidy, J., & Shaver, P. R. (2016). *Handbook of attachment: Theory, research, and clinical applications* (Third ed.): Rough Guides.

Cavanagh, S. E. (2008). Family structure history and adolescent adjustment. *Journal of Family Issues, 29*(7), 944-980.

Cavanagh, S. E., Schiller, K. S., & Riegle-Crumb, C. (2006). Marital transitions, parenting, and schooling: Exploring the link between family-structure history and adolescents' academic status. *Sociology of education, 79*(4), 329-354.

Cederbaum, J. A., Gilreath, T. D., Benbenishty, R., Astor, R. A., Pineda, D., DePedro, K. T., . . . Atuel, H. (2014). Well-being and suicidal ideation of secondary school students from military families. *J Adolesc Health, 54*(6), 672-677. :10.1016/j.jadohealth.2013.09.006

Cesur, R., Sabia, J. J., & Tekin, E. (2013). The psychological costs of war: Military combat and mental health. *Journal of Health Economics, 32*(1), 51-65.

Chandra, A., Burns, R. M., Tanielian, T., Jaycox, L. H., & Scott, M. M. (2008). Understanding the impact of deployment on children and families.

Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the Homefront: The Experience of Children From Military Families. *Pediatrics, 125*(1), 16-25

Chandra, A., Martin, L. T., Hawkins, S. A., & Richardson, A. (2010). The Impact of Parental Deployment on Child Social and Emotional Functioning: Perspectives of School Staff. *Journal of Adolescent Health, 46*(3), 218-223.

Charles, G., Stainton, T., & Marshall, S. (2009). Young carers: Mature before their time. *Reclaiming children and youth, 18*(2), 38.

Chartrand, M. M., Frank, D. A., White, L. F., & Shope, T. R. (2008). Effect of Parents' Wartime Deployment on the Behavior of Young Children in Military Families. *Archives of Pediatrics & Adolescent Medicine, 162*(11), 1009-1014.

Chen, C. Y.-C., & Panebianco, A. (2020). Physical and psychological conditions of parental chronic illness, parentification and adolescent psychological adjustment. *Psychology & Health, 35*(9), 1075-1094.

Chikhradze, N., Knecht, C., & Metzing, S. (2017). Young carers: growing up with chronic illness in the family-a systematic review 2007-2017. *Journal of Compassionate Health Care, 4*(1), 12.

Children Act 1989. (1989). *Legislation.gov.uk*. Retrieved from http://www.legislation.gov.uk/ukpga/1989/41

Children and Families Act 2014. (2014). *Legislation.gov.uk*. Retrieved from http://www.legislation.gov.uk/ukpga/2014/6/section/96/enacted

Chou, M.-J., Tu, Y.-C., & Huang, K.-P. (2013). Confucianism and character education: a Chinese view. *Journal of Social Sciences, 9*(2), 59.

Clandinin, & Connelly. (2006). *Handbook of narrative inquiry: Mapping a methodology*: Sage Publications.

Clandinin, & Rosiek, G. (2007). *Mapping a landscape of narrative inquiry: Borderland, spaces and tensions. In. Clandinin, DJ Handbook of narrative inquiry: mapping a methodology*: Thousand Oaks. CA Sage.

Clandinin, D., & Connelly, F. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, 2-14.

Clandinin, D. J. (2016). *Engaging in narrative inquiry*: Routledge.

Clandinin, D. J., & Connelly, F. M. (2000). Narrative inquiry. In: San Francisco: Jossey-Bass.

Clandinin, J., & Connelly, M. (1994). Personal experience methods.

Clay, D., Connors, C., Day, N., Gkiza, M., Aldridge, J., Cheesbrough, S.,Taylor, L. (2017). The lives of young carers in England.

Close, H. (2007). The use of photography as a qualitative research tool. *Nurse researcher, 15*(1).

Cobos, A. (2020). “Shelter from the Storm”: Military Service Member Spousal Caregiver Challenges and Barriers to Resources in the Midst of Enduring Conflicts. *Journal of Veterans Studies, 6*(1).

Cocks, A. (2006). ‘The Ethical Maze: Finding and inclusive path towards gaining. *Childhood, 13*(2), 247-266.

Cohen, E., Zerach, G., & Solomon, Z. (2011). The implication of combat-induced stress reaction, PTSD, and attachment in parenting among war veterans. *Journal of Family Psychology, 25*(5), 688.

Coleman, M., Ganong, L., & Fine, M. (2000). Reinvestigating remarriage: Another decade of progress. *Journal of Marriage and Family, 62*(4), 1288-1307.

Collins, T. (2018). Military parent's PTSD and children's mental health: A scoping review. *The Qualitative Report, 23*(5), 1237-1255.

Collins, W. A. (1997). Relationships and development during adolescence: Interpersonal adaptation to individual change. *Personal Relationships, 4*(1), 1-14.

Collins, W. A., & Laursen, B. (2004). Parent-adolescent relationships and influences. *Handbook of adolescent psychology, 2*, 331-362.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational researcher, 19*(5), 2-14.

The Convention of the Rights of a Child. (1989). *UNICEF.org*.

Cooklin, A. (2010). ‘Living upside down’: being a young carer of a parent with mental illness. *Advances in psychiatric treatment, 16*(2), 141-146.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative inquiry, 9*(3), 335-354.

Corbin, J., Strauss, A., & Strauss, A. L. (2014). *Basics of qualitative research*: sage.

Cozza, C. S. J., & Lerner, R. M. (2013). Military children and families: Introducing the issue. *The Future of Children, 23*(2), 3-11.

Cozza, S. J., Chun, R. S., & Polo, J. A. (2005). Military families and children during Operation Iraqi Freedom. *Psychiatric Quarterly, 76*(4), 371-378.

Cozza, S. J., Holmes, A. K., & Van Ost, S. L. (2013). Family-centered care for military and veteran families affected by combat injury. *Clin Child Fam Psychol Rev, 16*(3), 311-321.

Cramm, H., Norris, D., Schwartz, K. D., Tam-Seto, L., Williams, A., & Mahar, A. (2020). Impact of Canadian Armed Forces veterans’ mental health problems on the family during the military to civilian transition. *Military Behavioral Health, 8*(2), 148-158.

Cree, L., Brooks, H. L., Berzins, K., Fraser, C., Lovell, K., & Bee, P. (2015). Carers’ experiences of involvement in care planning: a qualitative exploration of the facilitators and barriers to engagement with mental health services. *BMC Psychiatry, 15*(1), 208.

Cree, V. E. (2003). Worries and problems of young carers: issues for mental health. *Child & Family Social Work, 8*(4), 301-309.

Creech, S. K., & Misca, G. (2017). Parenting with PTSD: A review of research on the influence of PTSD on parent-child functioning in military and veteran families. *Frontiers in Psychology, 8*, 1101.

Creswell, J. W. (2009). Research Design, Qualitatif, Quantitative, and Mixing Approaches. In: London: Sage.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health, 2013*, 541-545.

De Pedro, K. T., Astor, R. A., Gilreath, T. D., Benbenishty, R., & Berkowitz, R. (2018). School climate, deployment, and mental health among students in military-connected schools. *Youth & Society, 50*(1), 93-115.

De Wolff, M. S., & Van Ijzendoorn, M. H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child development, 68*(4), 571-591.

Dearden, C., & Becker, S. (2003). *Young carers and education*: Carers UK London.

Dearden, C., & Becker, S. (2005). Growing up caring: young carers and vulnerability to social exclusion. *Youth policy and social inclusion: Critical debates with young people*, 251-266.

Dekel, R., & Monson, C. M. (2010). Military-related post-traumatic stress disorder and family relations: Current knowledge and future directions. *Aggression and violent behavior, 15*(4), 303-309.

Denzin. (2008). *Symbolic interactionism and cultural studies: The politics of interpretation*: John Wiley & Sons.

Denzin, K. L., S. (2011). *The Sage handbook of qualitative research*: sage.

Denzin, N. K. (1984). On Understanding Emotion, San Francisco: Josey-Bass. In: Inc.

Denzin, N. K. (1989). *Interpretive biography* (Vol. 17): Sage.

DeVoe, E. R., Kritikos, T. M., Emmert-Aronson, B., Kantor, G. K., & Paris, R. (2018). Very young child well-being in military families: a snapshot. *Journal of Child and Family Studies, 27*(7), 2138-2148.

DeVoe, E. R., Ross, A. M., Spencer, R., Drew, A., Acker, M., Paris, R., & Jacoby, V. (2020). Coparenting across the deployment cycle: Observations from military families with young children. *Journal of Family Issues, 41*(9), 1447-1469.

Dewey, J. (1938). Experience and education: the Kappa Delta Phi lecture series. *New York, NY: Kappa Delta Pi*.

Dewey, J. (1989). *The Later Works of John Dewey, 1949-1952: 1949-1952, Essays, Typescripts, and Knowing and the Known* (Vol. 16): SIU Press.

Diaz, N., Siskowski, C., & Connors, L. (2007). *Latino Young Caregivers in the United States: Who are they and what are the Academic Implications of this Role?* Paper presented at the Child & Youth Care Forum

DOH. (1996c). *Carers (Recognition and Services) Act 7995: Policy Guidance and Practice Guide*. London

DoH. (2005). *Research Governance Framework for Health and Social Care.* London

Doyle, M. E., & Peterson, K. A. (2005). Re-entry and reintegration: Returning home after combat. *Psychiatric Quarterly, 76*(4), 361-370.

Drummet, A. R., Coleman, M., & Cable, S. (2003). Military families under stress: Implications for family life education. *Family Relations, 52*(3), 279-287.

Duax, J. M., Bohnert, K. M., M. Rauch, S. A., & Defever, A. M. (2014). Posttraumatic stress disorder symptoms, levels of social support, and emotional hiding in returning veterans. *Journal of Rehabilitation Research & Development, 51*(4), 571-578.

DuMont, K. A., Widom, C. S., & Czaja, S. J. (2007). Predictors of resilience in abused and neglected children grown-up: the role of individual and neighborhood characteristics. *Child Abuse Negl, 31*(3), 255-274.

Earley, L., & Cushway, D. (2002). The parentified child. *Clinical child psychology and psychiatry, 7*(2), 163-178.

Easterbrooks, M. A., Ginsburg, K., & Lerner, R. M. (2013). Resilience among military youth. *The Future of Children*, 99-120.

Eeden-Moorefield, B. v., & Pasley, B. K. (2013). Remarriage and stepfamily life. In *Handbook of marriage and the family* (pp. 517-546): Springer.

Einarsdóttir, J. (2007). Research with children: Methodological and ethical challenges. *European early childhood education research journal, 15*(2), 197-211.

Ender, M. G. (2002). *Military brats and other global nomads: Growing up in organization families*: Praeger Publishers.

Esin, C. (2011). Narrative analysis approaches. *Qualitative research methods in psychology*, 92-118.

Esposito-Smythers, C., Wolff, J., Lemmon, K. M., Bodzy, M., Swenson, R. R., & Spirito, A. (2011). Military youth and the deployment cycle: emotional health consequences and recommendations for intervention. *J Fam Psychol, 25*(4), 497-507.

Evans, D. T., & Watson, P. (2015). Spotlight on sexual health and education for military, veterans and families. *Education and Health Journal, 33*(2), 47-51.

Faber, A. J., Willerton, E., Clymer, S. R., MacDermid, S. M., & Weiss, H. M. (2008). Ambiguous absence, ambiguous presence: A qualitative study of military reserve families in wartime. *Journal of Family Psychology, 22*(2), 222.

Farrimond, H. (2012). *Doing ethical research*: Macmillan International Higher Education.

Fear, N. (2017). *Understanding the Impact of Having a Military Father with Post Traumatic Stress Disorder (PTSD) on Adolescent Children*. Retrieved from

Fear, N. T., Jones, M., Murphy, D., Hull, L., Iversen, A. C., Coker, B., . . . Wessely, S. (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *Lancet, 375*(9728), 1783-1797.

Felitti, V. J. (2009). Adverse childhood experiences and adult health. *Academic Pediatrics, 9*(3), 131.

Fielding, N., & Thomas, H. (2008). Qualitative interviewing.

Fingerson, L. (2009). Children's bodies. In *The Palgrave handbook of childhood studies* (pp. 217-227): Springer.

Finnegan, A., Di Lemma, L., McGhee, S., & Watson, R. (2021). Evaluating serious stress in military veterans, their carers and families: a protocol. *BMJ Mil Health*.

Finnegan, A., Finnegan, S., Thomas, M., Deahl, M., Simpson, R. G., & Ashford, R. (2014). The presentation of depression in the British Army. *Nurse Education Today*, *34*(1), 83-91.

Fitton, V. A. (2012). Attachment theory: History, research, and practice. *Psychoanalytic social work, 19*(1-2), 121-143.

Fitzsimons, V. M., & Krause-Parello, C. A. (2009). Military Children: When Parents Are Deployed Overseas. *Journal of School Nursing, 25*(1), 40-47.

Flanagan, C. (2003). Trust, identity, and civic hope. *Applied Developmental Science, 7*(3), 165-171.

Flittner O'Grady, A. E., Whiteman, S. D., Cardin, J. F., & MacDermid Wadsworth, S. M. (2018). Changes in parenting and youth adjustment across the military deployment cycle. *Journal of Marriage and Family, 80*(2), 569-581.

Floersch, J., Longhofer, J. L., Kranke, D., & Townsend, L. (2010). Integrating thematic, grounded theory and narrative analysis: A case study of adolescent psychotropic treatment. *Qualitative Social Work, 9*(3), 407-425.

Foran, H. M., Eckford, R. D., Sinclair, R. R., & Wright, K. M. (2017). Child mental health symptoms following parental deployment: The impact of parental posttraumatic stress disorder symptoms, marital distress, and general aggression. *Sage open, 7*(3),

Forbes, H., Reaf, N., Iversen, A., & Dandeker, C. (2011). The mental health of UK Armed Forces personnel. The impact of Iraq and Afghanistan. *RUSI Journal, 156*(2), 14-20.

Fraser, E., & Pakenham, K. I. (2009). Resilience in children of parents with mental illness: relations between mental health literacy, social connectedness and coping, and both adjustment and caregiving. *Psychol Health Med, 14*(5), 573-584.

Freedman, D. X., & Arieti, S. (1975). *American handbook of psychiatry. 5. Treatment*: Basic books.

Freeman, M. (1998). The sociology of childhood and children's rights. *The International Journal of Children s Rights, 6*(4), 433-444.

Gall, J. P., Gall, M. D., & Borg, W. R. (1999). *Applying educational research: A practical guide*: Longman Publishing Group.

Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and violent behavior, 9*(5), 477-501.

Ganong, L. H., Coleman, M., & Jamison, T. (2011). Patterns of stepchild–stepparent relationship development. *Journal of Marriage and Family, 73*(2), 396-413.

Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books, Inc.

Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of consulting and clinical psychology, 78*(5), 599.

Gillick V West Norfolk and Wisbech Area Health Authority. (1984). Retrieved from London:

Given, L. (2008). The SAGE Encyclopedia of Qualitative Research Methods.

Glenn, D. M., Beckham, J. C., Feldman, M. E., Kirby, A. C., Hertzberg, M. A., & Moore, S. D. (2002). Violence and hostility among families of Vietnam veterans with combat-related posttraumatic stress disorder. *Violence and victims, 17*(4), 473.

Goddard, W., & Melville, S. (2004). *Research methodology: An introduction*: Juta and Company Ltd.

Goffman, E. (1961). *Encounters: Two studies in the sociology of interaction*: Ravenio Books.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of child psychology and psychiatry, 38*(5), 581-586.

Göran Svedin, C., & Priebe, G. (2008). The Strengths and Difficulties Questionnaire as a screening instrument in a community sample of high school seniors in Sweden. *Nordic Journal of Psychiatry, 62*(3), 225-232.

Gough, G., & Gulliford, A. (2020). Resilience amongst young carers: Investigating protective factors and benefit-finding as perceived by young carers. *Educational Psychology in Practice, 36*(2), 149-169.

Gray, B., Robinson, C., & Seddon, D. (2008). Invisible Children: Young Carers of Parents with Mental Health Problems-The Perspectives of Professionals. *Child and Adolescent Mental Health, 13*(4), 169-172.

Gray, M. R., & Steinberg, L. (1999). Unpacking authoritative parenting: Reassessing a multidimensional construct. *Journal of Marriage and the Family*, 574-587.

Great Britain, P. (2000). Carers and Disabled Children Act 2000. In: London: Stationery Office.

Gribble, R., Wessley, S., Klein, S., Alexander, D. A., Dandeker, C., & Fear, N. T. (2015). British Public Opinion after a Decade of War: Attitudes to Iraq and Afghanistan. *Politics, 35*(2), 128-150.

Hall, S. (1990). Cultural identity and diaspora.

Hambrick, E. P., Brawner, T. W., & Perry, B. D. (2019). Timing of early-life stress and the development of brain-related capacities. *Frontiers in behavioral neuroscience, 13*, 183.

Harkness, L. L. (1991). The effect of combat-related PTSD on children. *National Center for PTSD Clinical Newsletter, 2*(1), 12-13.

Harper, N. S. (2019). Trauma-Informed Care for Children and Adolescents. In: Slack Incorporated Thorofare, NJ.

Harris, J. R. (2011). *The nurture assumption: Why children turn out the way they do*: Simon and Schuster.

Harrison, D., & Albanese, P. (2012). The “parentification” phenomenon as applied to adolescents living through parental military deployments. *Canadian Journal of Family and Youth/Le Journal Canadien de Famille et de la Jeunesse, 4*(1), 1-27.

Hartup, W. W., & Laursen, B. (1999). Relationships as developmental contexts: Retrospective themes and contemporary issues. In *Relationships as developmental contexts* (pp. 27-50): Psychology Press.

Harvey, S. B., Hatch, S. L., Jones, M., Hull, L., Jones, N., Greenberg, N., . . . Wessely, S. (2011). Coming Home: Social Functioning and the Mental Health of UK Reservists on Return From Deployment to Iraq or Afghanistan. *Annals of Epidemiology, 21*(9), 666-672.

Hatch, S. L., Harvey, S. B., Dandeker, C., Burdett, H., Greenberg, N., Fear, N. T., & Wessely, S. (2013). Life in and after the Armed Forces: social networks and mental health in the UK military. *Sociology of health & illness, 35*(7), 1045-1064.

Hayes, J., Wakefield, B., Andresen, E. M., Scherrer, J., Traylor, L., Wiegmann, P., . . . DeSouza, C. (2010). Identification of domains and measures for assessment battery to examine well-being of spouses of OIF/OEF veterans with PTSD. *Journal of Rehabilitation Research & Development, 47*(9), 825-840.

Heidegger, M. (1996). *Being and Time*. New York: University of New York Press.

Hisle-Gorman, E., Eide, M., Coll, E. J., & Gorman, G. H. (2014). Attention deficit hyperactivity disorder and medication use by children during parental military deployments. *Military Medicine, 179*(5), 573-578.

Holmes, A. K., Rauch, P. K., & Cozza, S. J. (2013). When a Parent Is Injured or Killed in Combat. *Future of Children, 23*(2), 143-162.

Hooper, L. M., Moore, H. M., & Smith, A. K. (2014). Parentification in military families: Overlapping constructs and theoretical explorations in family, clinical, and military psychology. *Children and Youth Services Review, 39*, 123-134.

Horton, D. (2005). Consultation with military children and schools: A proposed model. *Consulting Psychology Journal: Practice and Research, 57*(4), 259.

Hosek, J., Kavanagh, J. E., & Miller, L. L. (2006). *How deployments affect service members*: Rand Corporation.

Houston, J. B., Pfefferbaum, B., Sherman, M. D., Melson, A. G., Jeon-Slaughter, H., Brand, M. W., & Jarman, Y. (2009). Children of deployed National Guard troops: Perceptions of parental deployment to Operation Iraqi Freedom. *Psychiatric Annals, 39*(8).

Howard, D. (2010). Number of child carers "four times previous estimate". *BBC News, 16*.

Hubbard, G., Backett-Milburn, K., & Kemmer, D. (2001). Working with emotion: issues for the researcher in fieldwork and teamwork. *International journal of social research methodology, 4*(2), 119-137.

Huebner, A., Mancini, J., Wilcox, R., & Grass, S. G. (2007). Parental Deployment and Youth in Military Families: Exploring Uncertainty and Ambiguous Loss. *Family Relations*(56), 112-122.

Huebner, C. R. (2019). Health and mental health needs of children in US military families. *COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD FAMILY HEALTH, 143*(1), e20183258.

Hynes, C., Scullion, L., Lawler, C., Steel, R., & Boland, P. (2021). The impact of in-service physical injury or illness on the mental health of military veterans. *BMJ Mil Health*.

Ireland, M. J., & Pakenham, K. I. (2010). Youth adjustment to parental illness or disability: The role of illness characteristics, caregiving, and attachment. *Psychology, Health & Medicine, 15*(6), 632-645.

Iversen, A. C., Fear, N. T., Simonoff, E., Hull, L., Horn, O., Greenberg, N., . . . Wessely, S. (2007). Influence of childhood adversity on health among male UK military personnel. *British Journal of Psychiatry, 191*, 506-511.

Järkestig-Berggren, U., Bergman, A. S., Eriksson, M., & Priebe, G. (2019). Young carers in Sweden—A pilot study of care activities, view of caring, and psychological well-being. *Child & Family Social Work, 24*(2), 292-300.

Johnson, H. L., & Ling, C. G. (2013). Caring for military children in the 21st century. *J Am Assoc Nurse Pract, 25*(4), 195-202.

Joseph, S., Sempik, J., Leu, A., & Becker, S. (2019). Young carers research, practice and policy: an overview and critical perspective on possible future directions. *Adolescent Research Review*, 1-13.

Jurkovic, G. J., Thirkield, A., & Morrell, R. (2001). Parentification of adult children of divorce: A multidimensional analysis. *Journal of Youth and Adolescence, 30*(2), 245-257.

Kallander, E. K., Weimand, B., Ruud, T., Becker, S., Van Roy, B., & Hanssen-Bauer, K. (2018). Outcomes for children who care for a parent with a severe illness or substance abuse. *Child & Youth Services, 39*(4), 228-249.

Kalmijn, M. (2013). Adult children's relationships with married parents, divorced parents, and stepparents: Biology, marriage, or residence? *Journal of Marriage and Family, 75*(5), 1181-1193.

Kaplow, J. B., Layne, C. M., Saltzman, W. R., Cozza, S. J., & Pynoos, R. S. (2013). Using Multidimensional Grief Theory to Explore the Effects of Deployment, Reintegration, and Death on Military Youth and Families. *Clinical child and family psychology review, 16*(3), 322-340.

Karre, J. K., Perkins, D. F., & Aronson, K. R. (2018). Research on Fathers in the Military Context: Current Status and Future Directions. *Journal of Family Theory & Review, 10*(3), 641-656.

Kavanaugh, M. S., Stamatopoulos, V., Cohen, D., & Zhang, L. (2016). Unacknowledged caregivers: A scoping review of research on caregiving youth in the United States. *Adolescent Research Review, 1*(1), 29-49.

Keller, M. M., & Decoteau, G. T. (2000). *The Military Child: Mobility and Education. Fastback 463*: ERIC.

Kelley, P. W., Kenny, D. J., Gordon, D. R., & Benner, P. (2015). The Evolution of Case Management for Service Members Injured in Iraq and Afghanistan. *Qualitative Health Research, 25*(3), 426-439.

Kelly, N., Horrocks, C., Milnes, K., Roberts, B., & Robinson, D. (2005). Introduction-Narrative, Memory & Everyday Life. In: University of Huddersfield.

Kerns, K. A., & Barth, J. M. (1995). Attachment and play: Convergence across components of parent-child relationships and their relations to peer competence. *Journal of Social and Personal Relationships, 12*(2), 243-260.

Kim, J.-H. (2015). *Understanding narrative inquiry: The crafting and analysis of stories as research*: Sage publications.

King, N., & Smith, A. (2016). Exploring the impact of parental post-traumatic stress disorder on military family children: A review of the literature. *Nurse Education Today, 47*, 29-36.

King, V. (2006). The antecedents and consequences of adolescents' relationships with stepfathers and nonresident fathers. *Journal of Marriage and Family, 68*(4), 910-928.

King, V., Thorsen, M. L., & Amato, P. R. (2014). Factors associated with positive relationships between stepfathers and adolescent stepchildren. *Social Science Research, 47*, 16-29.

Kleinman, S. (2002). Emotions, fieldwork and professional lives. *Qualitative research in action*, 375-394.

Klostermann, K., Mignone, T., Kelley, M. L., Musson, S., & Bohall, G. (2012). Intimate partner violence in the military: Treatment considerations. *Aggression and violent behavior, 17*(1), 53-58.

Kobak, R., & Duemmler, S. (1994). Attachment and conversation: Toward a discourse analysis of adolescent and adult security.

Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*: Simon and Schuster.

Kudler, H., & Porter, R. I. (2013). Building communities of care for military children and families. *The Future of Children*, 163-185.

Lagrone, D. M. (1978). Military Family Syndrome. *American Journal of Psychiatry, 135*(9), 1040-1043.

Lahav, Y., Renshaw, K. D., & Solomon, Z. (2019). Domestic abuse and forgiveness among military spouses. *Journal of Aggression, Maltreatment & Trauma, 28*(2), 243-260.

Lamb, M. E. (2013). The changing faces of fatherhood and father-child relationships: From fatherhood as status to father as dad.

Lamb, M. E., & Oppenheim, D. (1989). Fatherhood and father-child relationships. *Fathers and their families*, 11-26.

Lambert, J. E., Engh, R., Hasbun, A., & Holzer, J. (2012). Impact of Posttraumatic Stress Disorder on the Relationship Quality and Psychological Distress of Intimate Partners: A Meta-Analytic Review. *Journal of Family Psychology, 26*(5), 729-737.

LaMotte, A. D., Taft, C. T., Reardon, A. F., & Miller, M. W. (2015). Veterans' PTSD symptoms and their partners' desired changes in key relationship domains. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(5), 479.

Landi, G., Boccolini, G., Giovagnoli, S., Pakenham, K. I., Grandi, S., & Tossani, E. (2020). Validation of the Italian Young Carer of Parents Inventory-Revised (YCOPI-R). *Disability and rehabilitation*, 1-12.

LaRossa, R., & Reitzes, D. C. (1993). Symbolic Interactionism and Family Studies. In P. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and Methods: A Contextual Approach* (pp. 135-166). Boston, MA: Springer US.

Le Menestrel, S., & Kizer, K. W. (2019). High-Stress Events, Family Resilience Processes, and Military Family Well-Being. In *Strengthening the Military Family Readiness System for a Changing American Society*: National Academies Press (US).

Leen-Feldner, E. W., Feldner, M. T., Bunaciu, L., & Blumenthal, H. (2011). Associations between parental posttraumatic stress disorder and both offspring internalizing problems and parental aggression within the National Comorbidity Survey-Replication. *Journal of Anxiety Disorders, 25*(2), 169-175.

Legion, T. (2005). Profile of the Ex-service community in the UK. *The Royal British Legion, London*.

Leightley, D., Williamson, V., Darby, J., & Fear, N. T. (2019). Identifying probable post-traumatic stress disorder: applying supervised machine learning to data from a UK military cohort. *Journal of Mental Health, 28*(1), 34-41.

Lerner, R. M., & Steinberg, L. (2009). *Handbook of adolescent psychology, volume 1: Individual bases of adolescent development* (Vol. 1): John Wiley & Sons.

Lester, P., Peterson, K., Reeves, J., Knauss, L., Glover, D., Mogil, C., . . . Wilt, K. (2010). The long war and parental combat deployment: Effects on military children and at-home spouses. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(4), 310-320.

Lester, P., Peterson, K., Reeves, J., Knauss, L., Glover, D., Mogil, C., . . . Beardslee, W. (2012). The Long War and Parental Combat Deployment: Effects on Military Children and At-Home Spouses (vol 49, pg 310, 2011). *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(3), 337-337.

Leu, A., & Becker, S. (2017). A cross-national and comparative classification of in-country awareness and policy responses to ‘young carers’. *Journal of Youth Studies, 20*(6), 750-762.

Leu, A., Frech, M., Wepf, H., Sempik, J., Joseph, S., Helbling, L., . . . Jung, C. (2019). Counting young carers in Switzerland–a study of prevalence. *Children & Society, 33*(1), 53-67.

Lincoln, A., Swift, E., & Shorteno-Fraser, M. (2008). Psychological adjustment and treatment of children and families with parents deployed in military combat. *Journal of Clinical Psychology, 64*(8), 984-992.

Lindeke, L., Hauck, M., & Tanner, M. (2000). Practical issues in obtaining child assent for research. *Journal of Pediatric Nursing, 15*(2), 99-104.

Lively, K. J., & Heise, D. R. (2014). Emotions in affect control theory. In *Handbook of the Sociology of Emotions: Volume II* (pp. 51-75): Springer.

Lloyd, K. (2013). Happiness and well-being of young carers: Extent, nature and correlates of caring among 10 and 11 year old school children. *Journal of Happiness Studies, 14*(1), 67-80.

Loignon, A., Ouellet, M.-C., & Belleville, G. (2020). A systematic review and meta-analysis on PTSD following TBI among military/veteran and civilian populations. *The Journal of Head Trauma Rehabilitation, 35*(1), E21-E35.

Louie, A. D., & Cromer, L. D. (2014). Parent–child attachment during the deployment cycle: Impact on reintegration parenting stress. *Professional Psychology: Research and Practice, 45*(6), 496.

Lunneborg, C. E. (2007). Convenience sample. *The Blackwell Encyclopedia of Sociology*.

MacManus, D., Jones, N., Wessely, S., Fear, N. T., Jones, E., & Greenberg, N. (2014). The mental health of the UK Armed Forces in the 21st century: resilience in the face of adversity. *Journal of the Royal Army Medical Corps, 160*(2), 125-130.

Maholmes, V. (2012). Adjustment of Children and Youth in Military Families: Toward Developmental Understandings. *Child Development Perspectives, 6*(4), 430-435.

Mansfield, A. J., Kaufman, J. S., Engel, C. C., & Gaynes, B. N. (2011). Deployment and mental health diagnoses among children of US Army personnel. *Arch Pediatr Adolesc Med, 165*(11), 999-1005.

Margaret Gowen, S., Sarojini Hart, C., Sehmar, P., & Wigfield, A. (2021). ‘.. It takes a lot of brain space’: Understanding young carers’ lives in England and the implications for policy and practice to reduce inappropriate and excessive care work. *Children & Society*.

Marsiglio, W. (2004). When stepfathers claim stepchildren: A conceptual analysis. *Journal of Marriage and Family, 66*(1), 22-39.

Matthews, M. H. (1992). *Making sense of place: Children's understanding of large-scale environments*: Barnes & Noble Books.

Matzka, M., & Nagl-Cupal, M. (2020). Psychosocial resources contributing to resilience in Austrian young carers—A study using photo novella. *Research in Nursing & Health, 43*(6), 629-639.

Mayall, B. (2000). Conversations with children: working with generational issues in P. Christensen and A. James (Eds) Research with children: perspectives and practices. In: London: Falmer Press.

McAndrew, S., Warne, T., Fallon, D., & Moran, P. (2012). Young, gifted, and caring: A project narrative of young carers, their mental health, and getting them involved in education, research and practice. *International Journal of Mental Health Nursing, 21*(1), 12-19.

McCormack, C. (2000a). From interview transcript to interpretive story: Part 1—Viewing the transcript through multiple lenses. *Field Methods, 12*(4), 282-297.

McCormack, C. (2000b). From interview transcript to interpretive story: Part 2—Developing an interpretive story. *Field Methods, 12*(4), 298-315.

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *International journal of social research methodology, 7*(3), 219-236.

McDonald, J., Cumming, J., & Dew, K. (2009). An exploratory study of young carers and their families in New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online, 4*(2), 115-129.

McDonald, J. R., Liang, S. Y., Li, P., Maalouf, S., Murray, C. K., Weintrob, A. C., . . . Bradley, W. (2018). Infectious complications after deployment trauma: following wounded US military personnel into veterans affairs care. *Clinical infectious diseases, 67*(8), 1205-1212.

McDougall, E., O'Connor, M., & Howell, J. (2018). "Something that happens at home and stays at home": An exploration of the lived experience of young carers in Western Australia. *Health & social care in the community, 26*(4), 572-580.

McFadyen, J., & Rankin, J. (2016). The Role of Gatekeepers in Research: Learning from Reflexivity and Reflection. *GSTF Journal of Nursing and Health Care (JNHC), 4*(1).

McFarlane, A. C. (2009). Military deployment: the impact on children and family adjustment and the need for care. *Current Opinion in Psychiatry, 22*(4), 369-373.

McKinzie Jr, O. (2022). *The Impact of Reintegration on Families of Reserve and National Guard Combat Veterans Returning From War: Findings and Clinical Implications* (Doctoral dissertation, Virginia Tech)

McGaw, V. E., Reupert, A. E., & Maybery, D. (2020). Partners of Veterans With PTSD: Parenting and Family Experiences. *Families in Society, 101*(4), 456-468.

McGibbon, M., Spratt, T., & Davidson, G. (2019). Young carers in Northern Ireland: Perceptions of and responses to illness and disability within the family. *The British Journal of Social Work, 49*(5), 1162-1179.

McGill, G., Wilson, G., Caddick, N., Forster, N., & Kiernan, M. D. (2020). Rehabilitation and transition in military veterans after limb-loss. *Disability and rehabilitation*, 1-8.

McNulty, P. (2010). Adaptability and resiliency of military families during reunification: Initial results of a longitudinal study. *Federal Practitioner, 3*, 18-27.

Meadows, S. O., Tanielian, T., Karney, B., Schell, T., Griffin, B. A., Jaycox, L. H., . . . Ramchand, R. (2017). The deployment life study: Longitudinal analysis of military families across the deployment cycle. *Rand health quarterly, 6*(2).

Melcer, T., Sechriest, V. F., Walker, J., & Galarneau, M. (2013). A comparison of health outcomes for combat amputee and limb salvage patients injured in Iraq and Afghanistan wars. *Journal of Trauma and Acute Care Surgery, 75*, S247-S254.

Mello, R. A. (2002). Collocation analysis: A method for conceptualizing and understanding narrative data. *Qualitative Research, 2*(2), 231-243.

Mental Capacity Act. (2005). Retrieved from London:

Milardo, R. M. (2009). *The forgotten kin: Aunts and uncles*: Cambridge University Press.

Miller, H. B., Miller, L., & Bjorklund, D. (2010). Helping military children cope with parental deployment: Role of attachment theory and recommendations for mental health clinicians and counselors. *International journal of emergency mental health, 12*(4), 231.

Mishler, E. G. (2006). Narrative and identity: The double arrow of time.

Misra, P., & Singh, V. (2014). Exploring the impact of parental military deployment/field posting on adolescents in Indian military families. *Psychological Studies, 59*(1), 36-43.

Mmari, K., Roche, K. M., Sudhinaraset, M., & Blum, R. (2009). When a parent goes off to war: Exploring the issues faced by adolescents and their families. *Youth & Society, 40*(4), 455-475.

Mmari, K. N., Bradshaw, C. P., Sudhinaraset, M., & Blum, R. (2010). Exploring the Role of Social Connectedness Among Military Youth: Perceptions from Youth, Parents, and School Personnel. *Child & Youth Care Forum, 39*(5), 351-366.

Montalvo, B., Guerney, B. G., Rosman, B. L., Schumer, F., & Minuchin, S. (1967). *Families of the slums: An exploration of their structure and treatment*: Basic Books.

Montgomery, R. J. K., J. (2008). TCARE: Tailored Caregiver Assessment and Referral. *American Journal of Nursing, 108*(9), 54-57.

Morley, D., & Jenkinson, C. (2016). Children's and young people's response to parental illness: introduction and overview. In *Children and Young People's Response to Parental Illness* (pp. 11-14): CRC Press.

Morris, D. B. (2001). Narrative, ethics, and pain: Thinking with stories. *Narrative, 9*(1), 55-77.

Mulholland, E., Dahlberg, D., & McDowell, L. (2020). A Two-Front War: Exploring Military Families' Battle with Parental Deployment. *Journal of Pediatric Nursing, 54*, 34-41.

Murphy, D., Palmer, E., Hill, K., Ashwick, R., & Busuttil, W. (2017). Living alongside military PTSD: a qualitative study of female partners' experiences with UK Veterans. *Journal of Military, Veteran and Family Health, 3*(1), 52-61.

Musil, D. (2005). *Brats: Our journey home*: Brats Without Borders, Incorporated.

Nagy, I. B., & Spark, G. M. (1973). Invisible loyalties. *New York*.

Narendorf, S. C., Munson, M. R., & Floersch, J. (2015). Perspectives on psychotropic medication treatment among young adults formerly served in public systems of care: A thematic and narrative analysis. *Journal of the Society for Social Work and Research, 6*(1), 121-143.

Neville, F., & Reicher, S. (2011). The experience of collective participation: Shared identity, relatedness and emotionality. *Contemporary social science, 6*(3), 377-396.

Newman, T. (2002). 'Young carers' and disabled parents: time for a change of direction? *Disability & Society, 17*(6), 613-625.

Nursing and Midwifery Council. (2015). *Social Media Guaidance - the Code*.

Office of National Statistics (2021). *Census 2011*. London

O'Grady, A. E., Wadsworth, S. M., Willerton, E., Cardin, J. F., Topp, D., Mustillo, S., & Lester, P. (2015). Help seeking by parents in military families on behalf of their young children. *Psychol Serv, 12*(3), 231-240.

O'Neil, J. (2013). *The Service Children report*. London

O'Neill, J. (2017). Veterans' children. In *Military Veteran Psychological Health and Social Care* (pp. 67-83): Routledge.

Okri, B. (2014). *A way of being free*: Head of Zeus.

Pakenham, K. I., Chiu, J., Bursnall, S., & Cannon, T. (2007). Relations between social support, appraisal and coping and both positive and negative outcomes in young carers. *Journal of health psychology, 12*(1), 89-102.

Paley, B., Lester, P., & Mogil, C. (2013). Family systems and ecological perspectives on the impact of deployment on military families. *Clinical child and family psychology review, 16*(3), 245-265.

Park, N. (2011). Military children and families: strengths and challenges during peace and war. *American Psychologist, 66*(1), 65.

Parsons, A., Knopp, K., Rhoades, G. K., Allen, E. S., Markman, H. J., & Stanley, S. M. (2018). Associations of Army Fathers' PTSD Symptoms and Child Functioning: Within-and Between-Family Effects. *Family process, 57*(4), 915-926.

Pauline, B., & Boss, P. (2009). *Ambiguous loss: Learning to live with unresolved grief*: Harvard University Press.

Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: a systematic review of service user, clinician, and carer perspectives across clinical settings. *The Lancet Psychiatry, 5*(9), 747-764.

Phelan, S. M., Griffin, J. M., Hellerstedt, W. L., Sayer, N. A., Jensen, A. C., Burgess, D. J., & van Ryn, M. (2011). Perceived stigma, strain, and mental health among caregivers of veterans with traumatic brain injury. *Disability and Health Journal, 4*(3), 177-184.

Phillips, R. D., Wilson, S. M., Sun, D., VA Mid-Atlantic MIRECC Workgroup, & Morey, R. (2018). Posttraumatic stress disorder symptom network analysis in US military veterans: Examining the impact of combat exposure. *Frontiers in psychiatry*, *9*, 608.

Phoenix, C., Smith, B., & Sparkes, A. C. (2010). Narrative analysis in aging studies: A typology for consideration. *Journal of Aging Studies, 24*(1), 1-11.

Pidgeon, A. M., & Sanders, M. R. (2009). Attributions, parental anger and risk of maltreatment. *International journal of child health and human development*.

Pincus, S. H., House, R., Christenson, J., & Adler, L. E. (2001). The emotional cycle of deployment: A military family perspective. *US Army Medical Department Journal, 4*(5), 6.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International journal of qualitative studies in education, 8*(1), 5-23.

Possemato, K., Pratt, A., Barrie, K., & Ouimette, P. (2015). Family functioning in recent combat veterans with posttraumatic stress disorder and alcohol misuse. *Traumatology, 21*(4), 267.

Prasad, B. D., Khasgiwala, A., & Vaswani, T. (2009). Families in difficult situations. *Indian Journal of Social Work, 70*(2), 191-218.

Solomon, Z., Horesh, D., & Ginzburg, K. (2021). Trajectories of PTSD and secondary traumatization: A longitudinal study. *Journal of psychiatric research*, *138*, 354-359.

Qasir, N., Hassan, N., Marsh, A. N., & Cox, L. J. (2022). Kids at home. In *Not Just Bad Kids* (pp. 327-347): Elsevier.

Rafferty, L., Cawkill, P., Stevelink, S., Greenberg, K., & Greenberg, N. (2018). Dementia, post-traumatic stress disorder and major depressive disorder: a review of the mental health risk factors for dementia in the military veteran population. *Psychological medicine, 48*(9), 1400-1409.

Randall, W. L. (1999). Narrative intelligence and the novelty of our lives. *Journal of Aging Studies, 13*(1), 11-28.

Ramchand, R., Tanielian, T., Fisher, M. P., Vaughan, C. A., Trail, T. E., Epley, C., ... & Ghosh-Dastidar, B. (2014). Hidden Heroes: America's military caregivers—executive Summary. *Rand health quarterly*, *4*(2).

Ray, S. L., & Heaslip, K. (2011). Canadian military transitioning to civilian life: A discussion paper. *Journal of Psychiatric and Mental Health Nursing, 18*(3), 198-204.

Reger, M. A., Brenner, L. A., & du Pont, A. (2022). Traumatic brain injury and veteran mortality after the war in Afghanistan. *JAMA network open*, *5*(2), e2148158-e2148158.

Renshaw, K. D., Allen, E. S., Carter, S. P., Markman, H. J., & Stanley, S. M. (2014). Partners' Attributions for Service Members' Symptoms of Combat-Related Posttraumatic Stress Disorder. *Behaviour Therapy, 45*(2), 187-198.

Renshaw, K. D., Rodebaugh, T. L., & Rodrigues, C. S. (2010). Psychological and marital distress in spouses of Vietnam veterans: importance of spouses' perceptions. *Journal of Anxiety Disorders, 24*(7), 743-750.

Rentz, E. D., Marshall, S. W., Loomis, D., Casteel, C., Martin, S. L., & Gibbs, D. A. (2007). Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *American Journal of Epidemiology, 165*(10), 1199-1206.

Riessman, C. K. (1993). *Narrative analysis* (Vol. 30): Sage.

Riessman, C. K. (2008). *Narrative methods for the human sciences*: Sage.

Riggs, S. A., & Riggs, D. S. (2011). Risk and resilience in military families experiencing deployment: the role of the family attachment network. *Journal of Family Psychology, 25*(5), 675.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*: sage.

Ritchie, J., & Spencer, L. (2002). Qualitative data analysis for applied policy research. In *Analyzing qualitative data* (pp. 187-208): Routledge.

Rivera, J. C., Krueger, C. A., & Johnson, A. E. (2015). Female combat amputees have higher rates of posttraumatic stress disorder disability. *U.S. Army Medical Department journal*, 74-79.

Robison, O., Egan, J., & Inglis, G. (2017). Young carers in Glasgow: health, wellbeing and future expectations. *Glasgow: Glasgow Centre for Population Health*.

Rodriguez, P., Holowka, D. W., & Marx, B. P. (2012). Assessment of posttraumatic stress disorder-related functional impairment: A review. *Journal of Rehabilitation Research and Development, 49*(5), 649-666.

Rona, R. J., Hooper, R., Jones, M., Hull, L., Browne, T., Horn, O., . . . Wessely, S. (2006). Mental health screening in armed forces before the Iraq war and prevention of subsequent psychological morbidity: follow-up study. *British Medical Journal, 333*(7576), 991-994a.

Rosenbaum, T. Y. (2009). Applying theories of social exchange and symbolic interaction in the treatment of unconsummated marriage/relationship. *Sexual and Relationship Therapy, 24*(1), 38-46.

Rowley, J. (2002). Using case studies in research. *Management research news*.

Ruscio, A. M., Weathers, F. W., King, L. A., & King, D. W. (2002). Male war-zone veterans' perceived relationships with their children: The importance of emotional numbing. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 15*(5), 351-357.

Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & health sciences, 12*(3), 369-374.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students*. Pearson education.

Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry, 70*(2), 163.

Schaffer, H. R., & Emerson, P. E. (1964). The development of social attachments in infancy. *Monographs of the society for research in child development*, 1-77.

Schneider Rosen, K., & Burke, P. B. (1999). Multiple attachment relationships within families: Mothers and fathers with two young children. *Developmental psychology, 35*(2), 436.

Schutz, A., & Luckmann, T. (1973). *The structures of the life-world* (Vol. 1): northwestern university press.

Seery, B. L., & Crowley, M. S. (2000). Women's emotion work in the family: Relationship management and the process of building father-child relationships. *Journal of Family Issues, 21*(1), 100-127.

Sharpley, J., Fear, N., Greeberg, N., Jones, M., & Wessley, S. (2008). Pre-deployment stress briefing: does it have an effect? *Occupational Medicine, 58*(1), 30-34.

Shepherd-Banigan, M., Sherman, S. R., Lindquist, J. H., Miller, K. E., Tucker, M., Smith, V. A., & Van Houtven, C. H. (2020). Family caregivers of veterans experience high levels of burden, distress, and financial strain. *Journal of the American Geriatrics Society, 68*(11), 2675-2683.

Sheridan, S., & Samuelsson, I. P. (2001). Children's conceptions of participation and influence in pre-school: A perspective on pedagogical quality. *Contemporary Issues in Early Childhood, 2*(2), 169-194.

Sherman, M. D., Gress Smith, J. L., Straits-Troster, K., Larsen, J. L., & Gewirtz, A. (2016). Veterans' perceptions of the impact of PTSD on their parenting and children. *Psychological Services, 13*(4), 401.

Sherman, W. T. (1864). Letter to the city of Atlanta.

Silverman, I. (2000). *Doing Qualitative Research: A Practical Handbook*. London: London: Sage.

Siva, N. (2020). Loneliness in children and young people in the UK. *The Lancet Child & Adolescent Health, 4*(8), 567-568.

Smith-MacDonald, L., Raffin-Bouchal, S., Reay, G., Ewashen, C., Konnert, C., & Sinclair, S. (2020). Transitioning fractured identities: A grounded theory of veterans' experiences of operational stress injuries. *Traumatology, 26*(2), 235.

Smith, A. (2011). Respecting children's rights and agency: Theorectical insights into ethical reseach proceedures. In *Researching youth children's perspectives: Debating the ethics and dilemmas of educational research with children* (pp. 11-25). London/New York: Routledge.

Smith, C., Perou, R., & Lesesne, C. (2002). Parent education. *Handbook of Parenting. Vol. 4. Social Conditions and Applied Parenting*, 389-409.

Smith, M. (2004). Relationships of children in stepfamilies with their non-resident fathers. *Family Matters*(67), 28-35.

Søndergaard, S., Robertson, K., Silfversten, E., Anderson, B., Meads, C., Schaefer, A., & Larkin, J. (2016). Families Support to Transition.

Speziale, H. S., Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative Research in Nursing: Advancing the Humanistic Imperative*: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Stake, R. E. (2008). Qualitative case studies.

Stamatopoulos, V. (2015). One million and counting: The hidden army of young carers in Canada. *Journal of Youth Studies, 18*(6), 809-822.

Stamatopoulos, V. (2018). The young carer penalty: Exploring the costs of caregiving among a sample of Canadian youth. *Child & Youth Services, 39*(2-3), 180-205.

Stepka, P., & Callahan, K. (2016). The Impact of Military Life on Young Children and Their Parents. In *Parenting and Children's Resilience in Military Families* (pp. 11-26): Springer.

Stewart, S. D. (2002). The effect of stepchildren on childbearing intentions and births. *Demography, 39*(1), 181-197.

Stewart, S. D. (2005). How the birth of a child affects involvement with stepchildren. *Journal of Marriage and Family, 67*(2), 461-473.

Stewart, S. D. (2006). *Brave new stepfamilies: Diverse paths toward stepfamily living*: Sage Publications.

Strauss, A. (1959). Mirrors and Masks (Glencoe, Ill. In: Free Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research*. Sage publications.

Stryker, S. (1964). The interactional and situational approaches. *Handbook of marriage and the family*, 125-170.

Sullivan, R. M., Cozza, S. J., & Dougherty, J. G. (2019). Children of military families. *Child and Adolescent Psychiatric Clinics, 28*(3), 337-348.

Sumner, J., Boisvert, D., & Andersen, J. P. (2016). The effects of stress and social support on externalizing behaviors among children in military families. *Deviant Behavior, 37*(3), 246-262.

Sundin, J., Fear, N. T., Iversen, A., Rona, R. J., & Wessely, S. (2010). PTSD after deployment to Iraq: conflicting rates, conflicting claims. *Psychological Medicine, 40*(3), 367-382.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative research journal*.

Svetlicky, V. (2013). Elaboration on posttraumatic stress disorder diagnostic criteria: A factor analytic study of PTSD exposure to war or terror. *Israel Journal of Psychiatry, 50*(2), 84.

Swedean, S. K., Gonzales, M. V., Zickefoose, B. A., Bush, A. C., Davis, J. M., Elrod, D. C., & Hsieh, D. T. (2013). Recurrent headache in military-dependent children and the impact of parent deployment. *Mil Med, 178*(3), 274-278.

Sweeney, M. M. (2010). Remarriage and stepfamilies: Strategic sites for family scholarship in the 21st century. *Journal of Marriage and Family, 72*(3), 667-684.

Tams, F. A. (2000). *A Trenchard'brat'*: Pentland Press.

Tanielian, T., Haycox, L. H., Schell, T. L., Marshall, G. N., Burnam, M. A., Eibner, C., . . . Vaiana, M. E. (2008). *Invisible wounds of war. Summary and recommendations for addressing psychological and cognitive injuries*.

The Children's Society, (2013). *Hidden From View*

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*: penguin UK.

Verey, A., & Smith, P. K. (2012). Post-combat adjustment: Understanding transition. *Journal of Aggression, Conflict and Peace Research*.

Veri, S., Muthoni, C., Boyd, A. S., & Wilmoth, M. (2021). *A Scoping Review of the Effects of Military Deployment on Reserve Component Children.* Paper presented at the Child & Youth Care Forum.

Waddell, E., Lawn, S., Roberts, L., Henderson, J., Venning, A., Redpath, P., & Godwin, T. S. (2020). "Their pain is our pain": The lived experience of intimate partners in Veteran recovery from PTSD. *Journal of Military, Veteran and Family Health, 6*(2), 40-49.

Waddell, E., Pulvirenti, M., & Lawn, S. (2016). The Lived Experience of Caring for an Australian Military Veteran With Posttraumatic Stress Disorder. *Qualitative Health Research, 26*(12), 1603-1613.

Waliski, A., Bokony, P., & Kirchner, J. E. (2012). Combat-related Parental Deployment: Identifying the Impact on Families with Preschool-age Children. *Journal of Human Behavior in the Social Environment, 22*(6), 653-670.

Warren, D., & Edwards, B. (2017). Young carers. *Annual statistical report 2016*, 85.

Watson, P. (2016). Embedding the ethos of identifying military young carers. *British journal of community nursing, 21*(Sup3), S42-S42.

Watson, P., & Osborne, A. (2020). SSOP Annual Camp 2019 Narrative Evaluation: A critical investigation of the impact of a military veteran parent with mental health issues or PTSD upon childhood biography.

Weaver, S. E., & Coleman, M. (2010). Caught in the middle: Mothers in stepfamilies. *Journal of Social and Personal Relationships, 27*(3), 305-326.

Werner, E. E. (2012). Children and war: risk, resilience, and recovery. *Dev Psychopathol, 24*(2), 553-558.

Wertsch, M. E. (2006). *Military brats: Legacies of childhood inside the fortress*: Brightwell Publishing.

Wilkerson, J. M., Iantaffi, A., Grey, J. A., Bockting, W. O., & Rosser, B. S. (2014). Recommendations for internet-based qualitative health research with hard-to-reach populations. *Qualitative health research, 24*(4), 561-574.

Williams, K. C., & Mariglia, L. (2002). Military brats: Issues and associations in adulthood. *Military brats and other global nomads: Growing up in organization families*, 67-82.

Williamson, E., & Matolcsi, A. (2019). Domestic violence and abuse (DVA) in military families.

Williamson, E., & Price, N. (2009). Pilot Project: Domestic abuse and military families. *Bristol: University of Bristol.*

Williamson, V., Stevelink, S. A., Da Silva, E., & Fear, N. T. (2018). A systematic review of wellbeing in children: a comparison of military and civilian families. *Child and adolescent psychiatry and mental health, 12*(1), 1-11.

Wilson, J. (2014). *Essentials of business research: A guide to doing your research project*: Sage.

Wilson, S., Cunningham-Burley, S., Bancroft, A., Backett-Milburn, K., & Masters, H. (2007). Young people, biographical narratives and the life grid: young people's accounts of parental substance use. *Qualitative Research, 7*(1), 135-151.

Wooten, N. R., Brittingham, J. A., Sumi, N. S., Pitner, R. O., & Moore, K. D. (2019). Behavioral health service use by military children during Afghanistan and Iraq Wars. *The journal of behavioral health services & research, 46*(4), 549-569.

WORK, M. F. S., & WELFARE, C. (2018). Domestic Violence Postdeployment. *Rural Child Welfare Practice: Stories from the Field*.

Working Together to Safeguard Children. (2018).

Working together to support young carers and their families: a template for a local memorandum of understanding between Statutory Directors of Children's Service and Adult Services. (2012). *ADCS*.

Yablonsky, A. M., Barbero, E. D., & Richardson, J. W. (2016). Hard is normal: Military families' transitions within the process of deployment. *Research in Nursing & Health, 39*(1), 42-56.

Yambo, T. W., Johnson, M. E., Delaney, K. R., Hamilton, R., Miller, A. M., & York, J. A. (2016). Experiences of military spouses of veterans with combat-related posttraumatic stress disorder. *Journal of Nursing Scholarship, 48*(6), 543-551.

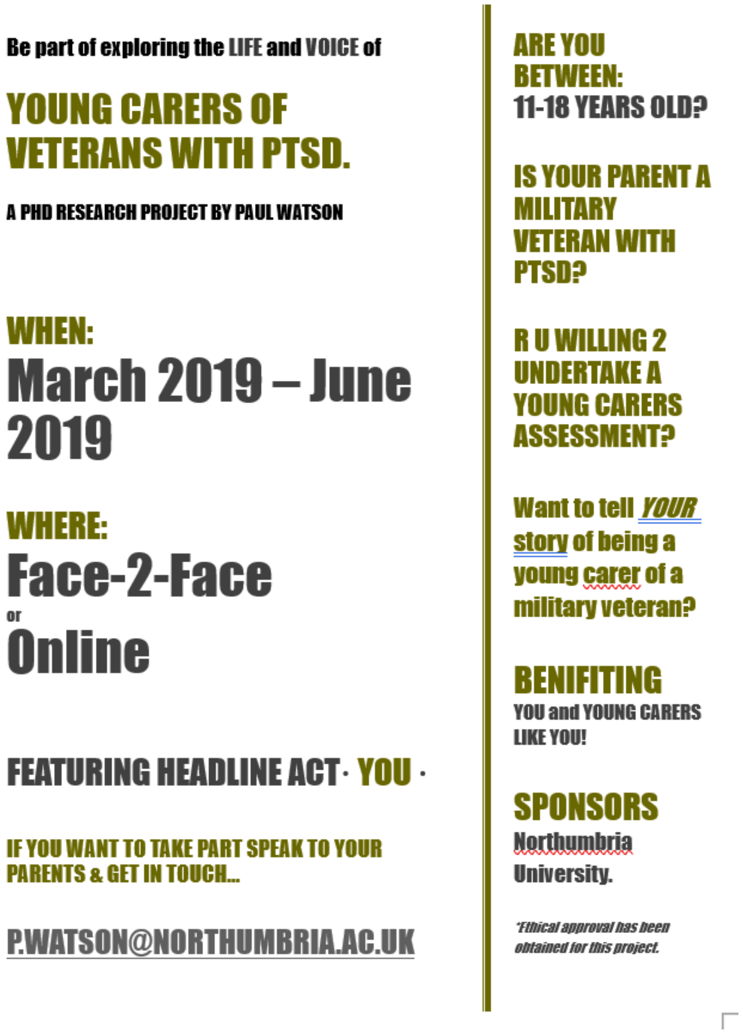
Yin, R. (1984). case study research. Beverly Hills. In: ca: Sage.

Yin, R. K. (1994). Case study research: Design and methods, applied social research. *Methods series, 5*.

Zhang, J., Palmer, A., Zhang, N., & Gewirtz, A. H. (2020). Coercive parenting mediates the relationship between military fathers' emotion regulation and children's adjustment. *Journal of abnormal child psychology*, 1-13.

9 Appendices

9.1 Appendix: 1 Advert for Study



Be part of exploring the LIFE and VOICE of

YOUNG CARERS OF VETERANS WITH PTSD.

A PHD RESEARCH PROJECT BY PAUL WATSON

WHEN:

March 2019 – June 2019

WHERE:

Face-2-Face

or

Online

FEATURING HEADLINE ACT · YOU ·

IF YOU WANT TO TAKE PART SPEAK TO YOUR PARENTS & GET IN TOUCH...

P.WATSON@NORTHUMBRIA.AC.UK

ARE YOU BETWEEN: 11-18 YEARS OLD?

IS YOUR PARENT A MILITARY VETERAN WITH PTSD?

R U WILLING 2 UNDERTAKE A YOUNG CARERS ASSESSMENT?

Want to tell *YOUR* story of being a young carer of a military veteran?

BENIFITING

YOU and YOUNG CARERS LIKE YOU!

SPONSORS

Northumbria University.

'Ethical approval has been obtained for this project.

9.2 Appendix: 2 Participant Information Document

Experience of being a Young Carer to a Military Veteran Parent with PTSD: A Narrative Inquiry'.

Re: Young Carers of Veteran Research

Thank you for taking the time to reply to my advert. My name is Paul Watson. I am a Postgraduate Researcher at Northumbria University, currently researching the subjective experience of a young carer's internal and external emotional response of the child, and the impact the role of carer has on the relationship with a parent with combat related diagnosis of PTSD.

As a military child and having served in the Armed forces myself, I am empathetic towards military families and understand the culture of what it is like to serve. I also know what it is like to be a young carer within a military family.

As a mental health and School Nurse, I have extensive experience of working with children, young people and young carers, and have the skills to carry out interviews, in a sympathetic and understanding manner, with the ability to notice when you may become destressed or begin to feel anxious.

Your parent or guardian has identified your family meet the criteria of this study: as being one with a modern veteran with combat related Post-Traumatic Stress Disorder (PTSD) and a young person between the age of 11 and 18 years, supports this veteran; and that you might be interested in sharing your life's story.

I am writing to ask if you would be willing to formally take part in my research. A consent form (which has to signed by your parent/guardian and yourself) and further information you may find useful has been attached.

The research will take place at intervals over the course of one academic year and will involve interviews in person at a veteran partner organisations property.

I hope you agree to participating, as this is the first research of its kind in trying to understand what it is like for you, a young carer, living with a parent with combat related PTSD.

If you are willing to participate and later change your mind at any given time during the research process, you can withdraw, without question and support can be offered if required.

I would welcome the opportunity to discuss this further and explain your role in more depth. Please feel free to contact me on the address or email below.

Ethical approval has been granted by the Northumbria Research Ethics Committee.

9.3 Appendix: 3- Parent Information Document

The Experience of being a Young Carer to a Military Veteran Parent with PTSD: A Narrative Inquiry'.

Dear Parent/Guardian

You are being invited to consent to your child taking part in a research study. Before you decide to allow your child to participate in the study it is important for you to understand the part you will play should you choose to do so.

As the parent of a young carer, you must give parental consent to your child taking part in this research. Additionally, you will act as the gatekeeper in the safety and well-being of your child, and bridge the relationship between your child and myself as the researcher. I have your child's best interests at heart and will not cause them any unintentional psychological harm.

As a military child and having served in the Armed forces myself, I am empathetic towards military families and understand the culture of what it is like to serve. As a mental health and School Nurse, I have extensive experience of working with children, young people and young carers, and have the skills to carry out interviews, in a sympathetic and understanding manner, with the ability to notice when a child is in destress or feeling anxious.

You are under no obligation to allow your child to participate in the study; non-participation will not affect your role as gatekeeper. However, if you do allow your child to take part it will be very much appreciated. If you allow your child to participate, you will be asked to sign a consent form so that any data collected can be published. **You and your child are free to leave the study and withdraw your consent at any time** without giving an explanation. The study will be confidential and the names of those taking part will not be used.

This research intends to explore how parental combat related Post-Traumatic Stress Disorder (PTSD) affects the emotional health of a young carer, and the impact the role of being a young carer and PTSD has on the relationship to their parent; placing the young carer at the centre of the research.

A young carer of a military veteran, is defined as: (adapted from the Children and Family Act 2014)

> "is someone between the ages of 5-18 years of age, who helps to look after a relative who has a condition, such as a disability, illness, mental health condition, or a drug or alcohol problem and holds veteran status"

The study will be examining the following points:

- To critically explore the impact of the carer role upon the emotional health of young carers;
- To identify and critically investigate the impact of the caring role upon family dynamics and relationships;
- To identify a typology of biographical life stories of these young carers;
- To privilege the voice of young carers in relation to the caring experience; and,
- To tentatively identify interventions that my act in support of military young carers.

You are being asked to give your consent for your child to be interviewed at a partner organisations property, to be decided nearer the time of interviews.

You will be consenting to allow your child to be involved in the main study at set intervals during the academic year, running from 10.2017 – 10.2018.

You will be consenting for your child to be voice recorded when online and in person; and for the researcher to use any drawings or blog’s and for the researcher to talk to your child.

Your child will be interviewed in person.

> Each interview will take approximately 60 minutes to complete at home and a minimum of 2 sessions will take place.
>
> N.B – all interviews will have a minimum of 2 sessions.

I wish to remind you any identifying information which could identify you as a research candidate will be amended to a generic character or code name of your choice.

In accordance with the Data Protection Act, information you and your child provide will be kept secure and will be destroyed upon completion of the research study.

Should you wish your child to take part in the study please return the consent form within 3 weeks of receipt.

9.4 Appendix: 4 Formal Invitation Letter

The Experience of being a Young Carer to a Military Veteran Parent with PTSD: A Narrative Inquiry'.

Thank you for taking the time to reply to my advert. My name is Paul Watson. I am a Postgraduate Researcher at Northumbria University, currently researching the subjective experience of a young carer's internal and external emotional response of the child, and the impact the role of carer has on the relationship with a parent with combat related diagnosis of PTSD.

You have identified your family meet the criteria of this study: as being one with a modern veteran with combat related Post-Traumatic Stress Disorder (PTSD) and a young person between the age of 11 and 18 years, supports this veteran.

I am writing to ask if you would formally like to take part in my research as a parent of a young carer. A consent form and further information you may find useful has been attached.

The research will take place at intervals over the course of one academic year and will involve interviews in person at a veteran partner organisations property.

I hope you agree to participating, as this is the first research of its kind in trying to understand what it is like for a young carer, living with a parent with combat related PTSD.

If you agree to participate and later change your mind at any given time during the research process, you can withdraw at any time, without question and support can be offered if required. Please feel free to contact me on the address or email below.

Ethical approval has been granted by the Northumbria Research Ethics Committee.

9.5 Appendix: 5 Consent Form

INFORMED CONSENT FORM

Taking part in a study which may cause psychological distress.

Please tick or initial where applicable and sign on page 2

I have carefully read and understood the Information sheet provided by Charlotte Watson	
I have had an opportunity to ask questions prior to my interview starting, to discuss this study and I have received satisfactory answers.	
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	
I agree to being recorded as a part of the interviews.	
I understand that by taking part in this study I (participant) may be exposed to recalling situations that may generate some psychological distress that may become apparent during and/or after the interview has finished (If this is the case the interview will stop immediately – and support will be given the gatekeepers).	
I agree to any information/data collected (which will be anonymised) to be used for this research/ journal articles/ conferences.	
I agree to take part in this study.	

Signature of participant.. Date .....………………..

(NAME IN BLOCK LETTERS) ....………………………

Signature of parent/guardian..

Date....………………..

(NAME IN BLOCK LETTERS) ....……………………….

9.6 Appendix: 6 Participant Debrief

PARTICIPANT DEBRIEF

Name of Researcher: Paul Watson
Name of Supervisor: Matthew Kiernan
Project Title: *"How being a young care provider to a military veteran with PTSD affects my emotional health" - Using narratives to explore the experiences of young carers from military families.*

- **What was the purpose of the project?**

The purpose of this project is to understand the following:

- How being a young carer affects your emotional health and well-being?
- How being a young carer affects your activities of daily living?
- How being a young carer affects your relationship with your parent?

- **How will I find out about the results?**

I (the researcher will keep you informed of the findings within this research via email or letter. It is important that you (the participant) inform me (the researcher) the best method of providing you with the results.

Once the research findings have been written, then ratified by the university, I envisage the results to be you within three months. N.B – this research will be completed January 2023

- **Have I been deceived in any way during the project?**

There has been no intent to deceive you in any way. However, if you feel you have been deceived then please do contact me – Email: P.Watson@northumbria.ac.uk

- **If I change my mind and wish to withdraw the information I have provided, how do I do this?**

If you decide to take part, please remember that you can withdraw your involvement at any time, without telling me the reasons why. You are completely free to make your own decision to take part or not, or to take part then retract your consent before the completion of the study, again without an explanation.

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed **36** months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual’s personal information, nor any data provided by them, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

If you wish to receive feedback about the findings of this research study then please contact the researcher at **P.Watson@northumbria.ac.uk**

This study and its protocol have received full ethical approval from Faculty of Health and Life Sciences Research Ethics Committee. If you require confirmation of this, or if you have any concerns or worries concerning this research, or if you wish to register a complaint, please contact the Chair of this Committee (Dr Nick Neave: nick.neave@northumbria.ac.uk), stating the title of the research project and the name of the researcher.

9.7 Appendix: 7 Support Services

Military Specific Support:

Army Families Foundation http://www.aff.org.uk/

ABF The Soldiers Charity:
020 7901 8900
www.soldierscharity.org

Combat Stress:
0800 138 1619 - 24hr helpline
www.combatstress.org.uk

Help for Heroes: Get Support

http://www.helpforheroes.org.uk/get-support/

Scotty's Little Soldiers

www.scottyslittlesoldiers.co.uk/

SSAFA Forces Line:
0845 241 7141
www.ssafa.org.uk/help-you/forcesline

Royal Air Forces Association
0800 0182 361
www.rafa.org.uk

Royal British Legion:
0808 802 8080
www.britishlegion.org.uk

Royal Naval Benevolent Trust:

023 9269 0112

www.rnbt.org.uk

Veterans Agency Helpline:
0808 1914 218
www.veterans-uk.info

Children and Young People's National Support Services:

National Self Harm Network
Self Harm Support
0800 6226000

Anxiety UK
Anxiety disorder information/links
0844 4775774

Papyrus
Confidential Young Suicide Prevention Advice for young people.
HOPELineUK: 0800 068 41 41
email: pat@papyrus-uk.org
Text support: 07786 209697

CALM
Preventing suicide in young males
0800 585858 (7 days a week, 5pm until midnight)
Textline: 07537 404717

Cruse Bereavement Care / **RD4U**
Advice, information and support to anyone bereaved, whenever or however the death occurred.
Freephone helpline: 0808 808 1677
email: helpline@cruse.org.uk

Childline
Free, confidential service for young people up to the age of 19.
call 0800 1111 for 1-to-1 chat
www.childline.org.uk/get-support/contacting-childline/

Get Connected
Live webchat on the site from 1pm - 11pm every day advising how to get the best help.
0808 808 4994 (1pm-11pm every day)
email: help@getconnected.org.uk (usually be answered within 24 hours)
Text FREE on 80849 (usually be answered within 24 hours)

MindFull
Support, information and advice about mental health and emotional wellbeing for 11-17 year olds

Young Minds
Mental health and emotional support for young people.
Young Minds Parent helpline - 0808 802 5544

Student Minds
Also - check your university's Student Union Welfare pages/Nightline service (all night student listening service) for local support. For a list of local NightLine services click here.

Samaritans
Confidential emotional support for people experiencing feelings of distress or despair.
Telephone: 08457 90 90 90 (24 hours a day)
Email: jo@samaritans.org

Mind Infoline
Confidential mental health information service.
Telephone: 0300 123 3393 (9am-5pm Monday to Friday)
Text: 86463 (open from 11am-4pm)
Email: info@mind.org.uk

Rethink Mental Illness Advice Line
Expert advice and information to anyone experiencing mental health problems and those who care for them.
Telephone: 0300 5000 927 (10am-2pm Monday to Friday)
Email: info@rethink.org

Frank
Confidential drugs information and resources
0800 776600

NHS Direct
Health advice 24 hours a day, 365 days a year.
0845 4647

NHS Choices
Mental Health advice and local service information.

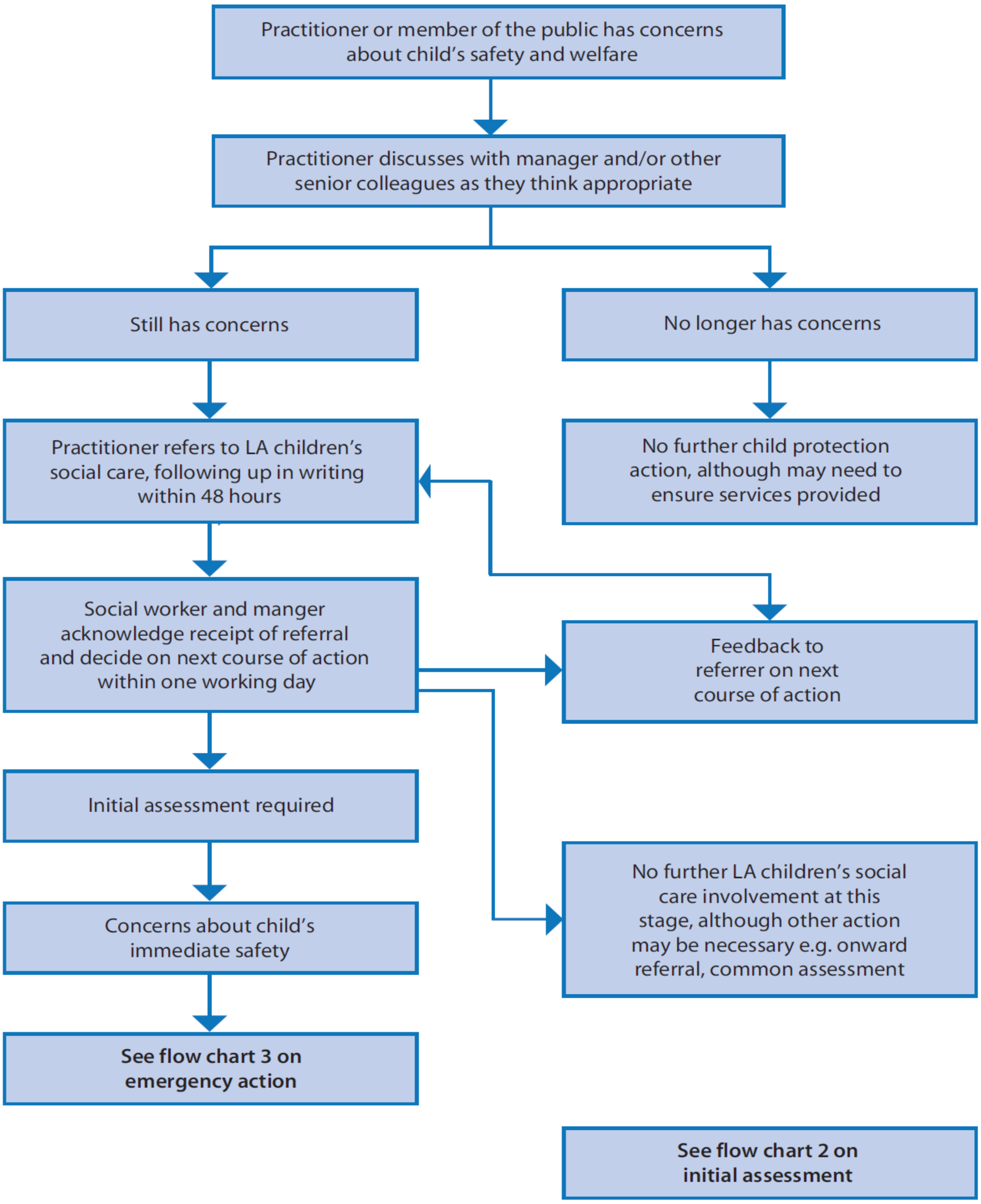
www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx

9.8 Appendix: 8 Safeguarding Children

The principles and parameters of a good assessment

186 Working Together to Safeguard Children

Flow chart 1: Referral



9.9 Appendix: 9 Literature Table

Reference	Purpose of Study	Sample	Study Design	Findings Reported
McDougall, O'Connor et al., (2018)	Much of the young carer research has focussed on service provisions and policy and has not focused on the perspectives of young carers. Hence, there is a need for qualitative research in this area to explore why young carers remain hidden and struggle with their role. This study aimed to explore the lived experiences of young carers.	13	A qualitative descriptive design using a phenomenological framework was adopted, which allows for exploratory research and the lived experiences of participants to emerge. Phenomenology attempts to understand how an individual constructs meaning from their experiences through their perception of events. An interpretivist framework emphasises individuals' unique experiences and aims to explore each participant's perspective. This aligns with our epistemology that each person has a constructed version of reality, there are multiple realities that have equal value, and that individual experience is context bound.	A thematic analysis of the transcribed interview data revealed four key themes. "Lessons from the experience" articulates the perceived benefits of the role and the themes: "navigating competing demands," "desire for normalcy" and "lost in the system" capture the struggles and complexities associated with being a young carer. Although there are challenges to being a young carer, it is something that young carers report can be beneficial and something that is done for those they love.
Stamatopoulos (2018)	The purpose of this research intends to contribute a first-hand account of the experiences of youth's substantial unpaid familial caregiving in the	15	A qualitative focus group methodology explored the benefits and challenges of youth's caregiving	The findings reveal evidence for a unique "young carer penalty," a term coined by this research to build upon the gendered "care penalty" experienced by adult

	context of long-term illness, disability or problems related to alcohol and/or other drugs.			women (especially mothers) when performing care work.
Järkestig-Berggren, Bergman et al., (2019)	So far, little is known about children in Sweden who are at risk of becoming young carers. The aim of this article is therefore to explore the extent and impact of children's caring activities as reported in a pilot study by a sample of children in Sweden.	30	Mixed Methods A number of international questionnaires measuring the number of caring activities, impact of caring, quality of life, and psychological well-being were translated and combined into a survey. Also, when completing the survey, the children were interviewed concerning their experiences of caregiving.	The participants report on a group level emotional symptoms such as fear and nervousness above the clinical cut-off value. They also rate a lower level of caring compared with findings from the United Kingdom, but they report a higher degree of negative impact of caring than young carers in the United Kingdom.
McGibbon, Spratt et al., (2019)	The study examined the protective and risk factors, which might help to promote or challenge the resilience of young carers. It was found that knowledge of and response to both the nature and trajectory of illness or disability contributed to young carers' capacity for resilience.	22	A Qualitative design. Each young carer participated in an in-depth semi-structured interview containing open-ended questions, using thematic analysis.	The research confirms that the nature of caring relationships is complex, with the psychological impact appearing to be the most challenging aspect of young carers' roles.
Matzka and Nagl-Cupal (2020)	Little research applying nonretrospective designs, however, has been done from the perspective of young carers regarding the psychosocial resources that enable them to handle the responsibility of caring for	10	Ten children and adolescents (aged 9–17) took photographs to illustrate their everyday lives. The photographs were then used to guide subsequent interviews. Data were analysed following the principles of directed qualitative content analysis and using the theoretical lens of resilience.	We identified two sets of psychosocial resources: (1) Personal resources comprising (a) being able to spend leisure time and (b) finding distraction from sorrows and problems. (2) Interpersonal resources comprising (a) fostering meaningful friendships, (b)

	chronically ill or disabled family members. The aim of the present study, therefore, was to identify psychosocial resources used by young carers in Austria.			receiving support from the family, and (c) bonding with the ill or disabled family member. Young carers largely have the same repertoire of resources as other children and can use them specifically to respond to the care burden. Interventions to support young carers must focus on promoting peer contact and cohesion within the nuclear family as well as bonding with the ill or disabled relative.
Berardini, Chalmers et al., (2021)	The purpose of this qualitative study was to gain a better understanding of what compassion and self-compassion meant for YCs and whether they saw themselves as self-carers in addition to being caregivers.	33	A qualitative design was use comprising of Six focus groups with YCs ages 12 to 18 years (*n* = 33) were conducted. Eight boys and 26 girls were divided into younger and older focus groups.	A constant comparison analysis yielded three major themes: characteristics of compassion, self-compassion in YCs, and supports for self-compassion. Overall, YCs showed continual compassion for their loved ones, but despite understanding the value of self-care and self-compassion in one's lives, very few YCs displayed self-compassion. Some reported conflicts and tensions within them and between them and their family member(s). The role of parents and YC programs were addressed as a possibility for supporting self-compassion.

Gowen, Sarojini Hart et al., (2021)	To explore young carers' perspectives on the nature of their caring responsibilities.	21	A qualitative approach was used. Each young carer in our sample participated in one of four focus groups, each lasted 3 h with breaks.	The findings raise key questions regarding effective implementation of contemporary child policy, duties of care towards children in caring roles and priorities for child protection and family support policy and practices, with the potential to inform thinking around child's well-being in wider contexts.

9.10 Appendix: 10 Creation of a storied Story

Storying Stories

Scenario: Living with PTSD

Title: You can just see the difference.

Abstract:

It wasn't scary it was more like, you still had to be good you just had to be cautious I would say.

Orientation:

I was a bit older then, so I Knew what it was. He came back so it was fine. I was worried [PTSD presentation] but I got used to it after a while.

Evaluation:

Things like he started to get angry more and more often, to other people and us. He snapped more quickly. If something frustrated him, he would get really angry.

Then what…

So, you had to be a bit careful and stuff, not to annoy him too much, because we were still quite young then. It was really scary when he would shout at you because he got upset quite easy then. We had to be good. We could be naughty every now and then, but not too naughty otherwise we set him off.

Coda:

It's PTSD

Theorizing:

I can't remember but I remember my mum going to see him. Because I wanted me and my sister to go and see him and mum was like "no". I don't know how long it was and I can't remember him coming back to the house.

I think he was in an impact explosion, and it broke his cheek bone, and he got some nerve damage. He is a bit deaf now.

She [mum] said dad had been injured so I am going to see him. That's when I started to get worried. Obviously, we cried a lot when mum went, because we wanted to see him, but we couldn't.

We hadn't seen him for a while, so we were like we wanted to go and see him really badly. When we got told we couldn't see him it was upsetting. He was in the country, but we can't go and see him.

Annotation within Transcript

Interesting to understand the participant is reflecting on what they know now and being reflective on the point of I knew he was going to come back...I thought (at the time) it was normal. I did not know what it was - was there any explanation from the family as to what the build-up was and what it was for? The participant then moves on to explaining they understand now what the build-up was for. Can an 8 year old really understand the complexities of the military aside from the military fairs and playing with friends from their community? it is hard to comprehend - "i just thought he would be alright!"

This extract starts to explore a change in behaviour and presentation of the participant. Moreover, there is a change in behaviour from the participant. This could be for a number of reasons. Looking back at the literature, the military father instils the discipline/ values within the context of the military and home environment. However, there is the complexities of the participant knowing his father is away and becoming anxious, or highly stressed presenting with misbehaviour, disruption of the relationship between their mother and sister (also stages of life). There is also identified good parts of the parents' deployment. The remainder of the family would sit together and talk (connecting) - also connecting with friends (going through the same thing?)

9.12 Appendix: 11 Northumbria Ethics Documentation

Professor Dianne Ford

Executive Dean

This matter is being dealt with by:

Associate Professor Peter McMeekin

Ethics Lead

Department of Nursing, Midwifery and Health

Faculty of Health and Life Sciences

Coach Lane Campus

Newcastle upon Tyne

NE7 7XA

Tel: 0191 2156368

Email: *peter.mcmeekin@northumbria.ac.uk*

October 2017

Dear Paul,

Faculty of Health and Life Sciences Research Ethics Review

Title: The Experience of being a young carer to a military veteran parent with PTSD: A narrative Inquiry.

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link: https://www.northumbria.ac.uk/research/ethics-and-governance/

You may now also proceed with your application (if applicable) to:

- NHS R&D organisations for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).
- IRAS (please see guidance attached. A ‘favourable opinion’ must be obtained prior to commencing your research. You must notify the University of the date of that favourable opinion.

You must not commence your research until you have obtained all necessary external approvals.

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Associate Professor Peter McMeekin

On behalf of Faculty Research Ethics Review Panel