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Department of Family Studies and Gerontology

Spousal Support and Post-traumatic Growth (PTG) among Canadian Armed Forces (CAF) Veteran Couples

by

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Abstract

Post-traumatic growth (PTG), positive psychological change developed through managing highly stressful experiences, is gaining empirical attention in the military context. This complements well-established research showing a negative psychosocial impact of military service-related post-traumatic stress disorder (PTSD) on Canadian Armed Forces (CAF) Veterans and their family, particularly spouses/partners. Three salient limitations exist in PTG research among CAF Veteran couples living with military service-related PTSD. First, PTG research is scarce in the Canadian military context; thus, little is known about this phenomenon among CAF Veterans and their spouses/partners. Second, spouses/partners have been identified as a valuable social resource in the development of PTG; however, the spousal support mechanisms involved in this process are unclear. Third, international research suggests that military spouses/partners may experience PTG as a result of living with PTSD in a couple relationship, yet this possibility has remained unexplored in a Canadian military context. The purpose of this study, informed through interpretive theory, is twofold: (1) to learn how PTG has been experienced among CAF Veteran couples who are living with service-related PTSD and (2) to examine the role of spousal support in the development of PTG among CAF Veteran couples.

Two questions guided this qualitative study: (1) how has PTG been experienced within the couple relationship for CAF Veterans living with PTSD and their spouse/partner? (2) how have social processes within the spousal support system fostered PTG? Narratives of nine spouses/partners of CAF Veterans, living with service-related PTSD, were collected individually through in-depth, semi-structured interviews. Interviews were taped, transcribed and thematically analyzed using open, axial and selective coding techniques adopted from grounded theory methodology. This analysis was supported by MAXQDA computer software.

Results showed that formal support resources at the community level are necessary for PTSD healing among CAF Veterans couples at the home level. Spouses/partners were vital for facilitating access and continued engagement with community level resources through their provision of emotional, instrumental, informational and appraisal support enacted through three key roles, caregiving, managing and cultivating, over the course of healing. Adaptive processes within the spouse/partner, such as positive outlook and determination, helped maintain the spousal support process; in turn, adaptive processes within the couple relationship, such as problem solving and communication skills, ensued from the spousal support process. Together, these personal and dyadic adaptive processes reinforced the relationship between spousal support and the development of PTG in spouses/partners and the couple relationship.

As understandings of PTSD evolve, this inquiry is both timely and essential as it expands the focus of research to include positive outcomes for CAF Veteran couples. These perspectives hold significance for the advancement of strength-based programs and services that will foster optimal social health and well-being for CAF Veterans and their families. Furthermore, these programs/services should target spouses/partners more directly given the crucial role they play in the healing process for CAF Veterans living with PTSD and to ensure spouses/partners can maintain their own well-being throughout their supportive role.

Acknowledgments

Many thanks to the nine women who graciously volunteered their time to allow me a glimpse into their world. My time speaking with them was truly meaningful, and their stories moved me in many ways as I found myself inspired both academically and personally. I have much reverence for their incredible strength, determination and positive viewpoints as they negotiate and redefine family life to meet the challenges of living with PTSD. I hope in some way my work will contribute to supporting these admirable women and the community they are part of.

I am grateful to have been surrounded by a supportive thesis committee throughout the development of my research. I appreciate that each of them offered me a unique viewpoint as I conceptualized my findings. Dr. Deborah Norris, aside from being my steady anchor in her role as thesis supervisor, enthused me to consider how families' experiences are impacted by socio-cultural ideologies, Dr. Maya Eichler impacted me with her view and efforts toward social innovation, and Dr. John Whelan inspired me to one day situate myself to work with families in a clinical capacity.

As I discuss my work on family support, I am reminded of the tremendous amount that I have received from members of my own family. They have helped me realize a potential that would not have been possible without their patience, love and generosity – thank you for aiding and encouraging me on this journey. A special mention to my two amazing children, Cole and Raeya, who continually drive me to reach my goals.

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Chapter 1: Introduction

It is well known that service in the Canadian Armed Forces (CAF) demands a large amount of dedication from its members and, traditionally, it was assumed to be a "single-man's occupation" (Albano, 1994). However, as the military culture has changed over time, members now combine family life with the military lifestyle (Vanier Institute of the Family, 2012), and approximately 54,000 military families reside in Canada (Battams, 2016). The military institution now acknowledges, "when one person joins, the whole family serves" (Park, 2011).

Reuben Hill's (1949) pivotal study on the impact of war stress on military families prompted military scholars to consider the role that families play in military service members' career course. One key piece of evidence supporting this claim is the finding that positive family functioning contributes to higher morale, retention and operational readiness and effectiveness among military service members (Park, 2011; Segal & Harris, 1993). As such, military families are commonly referred to as "strength behind the uniform" (Directorate of Military Family Support [DMFS], 2004).

Military families experience stressors across the lifespan that are both similar to and distinct from those of civilian families. The unique stressors faced by military families are typically attributed to service-related obligations and duties such as frequent home re-locations and prolonged separations for military operations and training. Some military duties, such as deployment for combat and peacekeeping missions, jeopardize the safety of service members and put them at risk for acquiring work-related injuries (Blaisure, Saathoff-Wells, Pereira, MacDermid Wadsworth, & Dombro, 2012; National Defence and Canadian Forces Ombudsman, 2013). Post-traumatic stress disorder

(PTSD), understood as an operational stress injury (OSI) in the Canadian military context, is one such injury that has become increasingly prevalent among military families (Nelson Goff, Crow, Reisberg, & Hamilton, 2009; Veterans Affairs Canada (VAC), 2006).

The deleterious effects of PTSD among military families are well established (Monson, Taft, & Fredman, 2009; Ray & Vanstone, 2009; Tsai et al., 2015). However, another aspect of experiencing traumatic stress that is gaining empirical attention is post-traumatic growth (PTG) (Figley & Figley, 2009; Moran, Schmidt, & Burker, 2013; Tsai et al., 2015; Zoellner & Maercker, 2006). PTG is described as "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p.1).

Empirical literature investigating PTG among military Veterans and their families is limited and further study is warranted. Three salient reasons support this contention. First, while explicit PTG research has taken place on military service members/Veterans in the United States, it is scarce in the Canadian military context. Thus, little is known about this phenomenon among CAF Veterans and their families. Second, social support constitutes a key resource facilitating the development of PTG (Calhoun & Tedeschi, 2006; Tedeschi, 2011), and spouses/partners represent a valuable source of this support (Figley & Figley, 2009; Sudom, 2010; Tedeschi & Calhoun, 2004). However, it is unclear how social processes within the couple relationship foster a PTG outcome. Third, PTG may not be limited to the primarily injured partner among couples; their spouse/partner may also experience PTG (Berger & Weiss, 2009; Wick & Nelson Goff,

2014), yet this possibility has remained largely unexplored in a Canadian military context.

An interpretive interactionist framework provided the theoretical and methodological groundwork to address these research limitations. Two broad questions guided this project: (1) How has PTG been experienced within the couple relationship for CAF Veterans living with PTSD and their spouse/partner? and (2) How have social processes within the spousal support system fostered PTG? This study has been undertaken to address these questions, and subsequently add to emerging literature on PTG and military families. It commences with a review of the literature depicting the experience of PTSD among military families and a potential for PTG, followed by details relating to the study's theoretical framework, methodology, measures taken to enhance reliability, validity and trustworthiness and ethical considerations. The current study's findings are presented and, subsequently, interpreted within literature relevant to the subject matter. The thesis concludes by noting limitations of the research design, potential avenues for future research and implications of findings.

Chapter 2: Literature Review

Military Culture and Family

There are many reported motivations for enlisting in the military, some of which include a chance to serve and protect our country, a steady income, access to educational benefits, early retirement and the opportunity for travel (Blaisure et al., 2012; Hall, 2011). In addition, some military members enlist as part of a family tradition, as an escape, or because they identify with the "warrior mentality" (Hall, 2011).

More than half of all military members and Veterans have family responsibilities for spouses, children, or other dependents (MacDermid Wadsworth & Southwell, 2011; Thompson et al., 2014). For example, population data on CAF Veterans from the 2013 *Survey on Transition to Civilian Life* showed that 74% of Regular Force, 72% of Reserves Class C, and 56% of Reserves Class A or B were married or living common law (Thompson et al., 2014). Westphal and Woodward (2010) succinctly define the military family as, "an interdependent group of individuals who have shared experiences that are influenced by world events, national policy, military culture, and one or more parents who have a commitment that requires self and family sacrifice" (p. 100).

Military families are now more diverse than ever before. Formerly, a military family was traditional in structure and function, consisting of a military husband and a civilian wife living on a military base among other military families in Permanent Married Quarters (PMQs)(Hall, 2011). Although these scenarios still exist, military families no longer exclusively fit this mold (Snyder, 2013). For example, 85% of Canadian military families now choose to live "off-base" within the civilian population (Battams, 2016), and there are increased numbers of women, single parents and dual-

service families serving in the CAF (Vanier Institute of the Family, 2012).

The reference to military as a "culture" aims to distinguish it from the civilian lifestyle. As such, an understanding of this military cultural identity, including its unique worldview based on the military institution's ideological backdrop, is integral for investigating and framing the lived experiences of families within this context (Hall, 2011). The military doctrine of operational readiness and effectiveness is a prime ideological premise engrained in military culture (Savitsky, Illingworth, & DuLaney, 2009). This often translates into a "duty first" principle for military service members and their families (Rothrauff, Cable & Coleman, 2004). That is, military service requires its members to frequently prioritize their military duties and missions over competing demands such as family roles and obligations (Rothrauff et al., 2004; Segal, 1986). In turn, family members are often required to sacrifice personal activities and goals to maintain the military lifestyle (Battams, 2016). However, the military institution also recognizes the interdependence between family functioning and operational readiness and effectiveness. This recognition evolved as family-support programs and policies were developed and implemented by the CAF through the Directorate of Military Family Support (DMFS, 2004).

Our contemporary understanding of Canadian military culture includes three primary factors that distinguish family life within this context from that within a civilian context: mobility, separation and risk (National Defence and Canadian Forces Ombudsman, 2013; Savitsky et al., 2009). It is noteworthy that these facets of a military lifestyle may also be experienced within a civilian lifestyle. However, it is less common for civilian occupations to demand frequent, enduring exposure to all three of these

factors over the span of a career (National Defence and Canadian Forces Ombudsman, 2013). For example, whereas some civilian careers demand *a degree* of mobility, family separation and risk, it is expected that most military careers will *frequently* and *recurrently* involve all of these characteristics throughout their span. Indeed, many military service members and their families are accustomed to numerous instances of mobility, family separation and risk throughout the career in addition to lengthy, sometimes sporadic, duty hours. (National Defence and Canadian Forces Ombudsman, 2013; Park, 2011).

Mobility, commonly in the form of home re-locations for duty postings, impacts Canadian military families almost four times as often as Canadian civilian families and these moves are largely at the discretion of the CAF (Cramm, Norris, Tam-Seto, Eichler, & Smith-Evans, 2015). Specifically, the CAF decides when, where and for how long a serving member will be posted. Although the posting preferences of service members are considered, organizational need takes priority, and military families are often posted with little choice in location or timeframe (National Defence and Canadian Forces Ombudsman, 2013).

It is common for family members to accompany a service member for his or her postings, but other facets of a CAF career necessitate periodic family separation (Hall, 2011; Savitsky et al., 2009; Snyder, 2013). In particular, many CAF members are repeatedly required to be away from home for routine training exercises and/or operational duties. During times of war, the possibility of a service member's deployment for dangerous missions is a fact of life for military families (National Defence and Canadian Forces Ombudsman, 2013). The recent conflicts in Iraq, Afghanistan and

neighboring countries have resulted in increased operational tempo leading to the most frequent military deployments and longest absences from family since the Vietnam War (Sayers, 2011; Sayer, Carlson & Frazier, 2014). Specific characteristics of the recent Global War on Terror, such as the risk for service-related injury or death, mark particularly high stressors for these families (National Defence and Canadian Forces Ombudsman, 2013).

Service-Related Traumatic Stress

In the Canadian military context, service-related traumatic stress is deemed an operational stress injury (OSI) (VAC, 2006). An OSI is defined as "any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Forces (CF) or as a member of the Royal Canadian Mounted Police (RCMP)" (VAC, 2006, p. 1). An estimated 1000 CAF personnel medically release from service each year; of those, approximately 40% have released due to mental health issues (Manser, 2015). OSIs have important implications for military and Veteran organizations. For example, service-related mental health issues are associated with reduced work productivity, reduced retention rates and increased absenteeism among active duty service members (Tanielian et al., 2008; VAC, 2008). In addition, OSIs may compound issues related to a service member's transition to civilian life (Savitsky et al., 2009). For example, OSIs have a direct impact on benefits and services available to Veterans (Boulos & Zamorski, 2013; Savitsky et al., 2009).

Combat exposure has been widely cited as a risk factor for the development of PTSD among Veterans, a recognized form of OSI in the military sphere (Nelson Goff et al., 2009; VAC, 2006). In particular, military deployment to hostile environments puts

service members at risk for undergoing potentially traumatic experiences such as being ambushed or attacked, handling dead bodies, witnessing injuries and/or death of unit members, or having killed someone (VAC, 2006). Indeed, Pearson, Zamorski, and Janz (2014) showed that CAF Regular Force members who deployed to Afghanistan were twice as likely to experience PTSD as those who had not deployed to Afghanistan.

In addition to experiences associated with combat, military service members may encounter other traumatic situations outside of direct combat, such as completing peacekeeping missions, disaster recovery missions, harassment, and sexual assault (Fontana & Rosenheck, 1998; Kimerling et al., 2010; VAC, 2008). These experiences sometimes have a long-lasting effect on Veterans, leaving them vulnerable to the development of PTSD symptoms (VAC, 2008).

It is important to note that exposure to traumatic events in the military context does not always result in the development of PTSD and many active service members and Veterans do not experience symptoms (VAC, 2006). Notably, OSIs may present as other medical conditions other than PTSD symptoms, such as anxiety, depression and traumatic brain injury (VAC, 2006). However, the scope of the current research will focus a discussion only on OSIs transpiring in the form of PTSD.

PTSD. The formal inclusion of PTSD within the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association [APA], 2013) officially marked it as a mental disorder. This provided the impetus for broadening knowledge on trauma and its effects across different contexts (Schnurr, 2010). Among military populations, it is estimated that up to 10% of CAF Veterans exposed to war zones will develop symptoms associated with PTSD (VAC, 2008).

As a form of OSI in the military context, PTSD symptoms are still recognized as those outlined in the DSM. The most recent, fifth edition of the DSM (i.e., DSM-V) (APA, 2013) classifies PTSD into four main clusters of symptoms: (a) presence of intrusion symptoms, (b) persistent avoidance of stimuli associated with the traumatic event, (c) negative alterations in cognitions and mood, and (d) alterations in arousal and reactivity. These clusters include such behavioral, cognitive, and emotional symptoms as hypervigilance, irritability, anger outbursts with little or no provocation, sleep disturbances, avoidance of people and activities, emotional numbness, persistent negative beliefs about oneself, distorted cognitions about the cause or consequence of the traumatic event, feelings of detachment, and re-experiencing the traumatic event (i.e., "flashbacks") (APA, 2013). Biological symptoms typically manifest in the form of somatic complaints for trauma survivors such as aches, pains, increased heart rate, tension, and faintness (Schwerdtfeger et al., 2008). In addition, literature notes a pervasive comorbidity between PTSD and other mental health issues such as depression and substance abuse (Weiss et al., 2012).

Initial research that has investigated the psychosocial impact of OSIs in the form of PTSD focuses chiefly on the experience of the injured military service member or Veteran. However, more recent studies have extended their focus beyond the injured party to additionally include family members, such as spouses/partners (Badr, Barker, & Milbury, 2011; Figley & Figley, 2009). Research focused on these considerations largely highlights the negative sequelae of PTSD on military families, such as decreased family functioning and decreased marital satisfaction (Lambert, Engh, Hasbun, & Holzer, 2012; Monson et al., 2009; Norris, Cramm, Eichler, Tam-Seto, & Smith-Evans, 2015).

Spouses/partners of military Veterans may be particularly vulnerable to the detrimental effects of PTSD symptoms given they often assume a supportive role during the healing process (Badr et al., 2011; Nelson Goff & Smith, 2005).

PTSD and spousal impact. The literature regarding the impact of PTSD on spouses brings into view three salient themes: secondary traumatic stress (STS) reactions, caregiver burden, and decreased marital relationship quality and/or functioning (Lambert et al., 2012; Norris et al., 2015). STS reactions occur when the psychological, emotional, behavioral and/or cognitive symptoms associated with PTSD spread beyond the directly injured individual to others in close, repeated contact with him or her (Dekel & Monson, 2010). STS reactions have been noted among spouses of Veterans diagnosed with PTSD where the spouse experiences symptoms that mirror those of the Veteran such as insomnia, fatigue, irritability, avoidance of activities, headaches, and increased use of alcohol and drugs (Baird & Kracen, 2006; Bride, Robinson, Yegidis, & Figley, 2004; Frančišković, Stevanović, Jelušić & Roganović, 2007). For example, Herzog, Everson, and Whitworth (2011) found that military spouses experienced STS symptoms that were similar to the PTSD symptoms experienced by his or her partner who had been deployed to Iraq. They found that these military spouses experienced cognitive, behavioral, and emotional avoidance symptoms, as well as intrusive thoughts and images, which were related to the negative experiences of the service member with PTSD.

Sometimes a Veteran's PTSD symptoms necessitate a role shift among family members as a means of coping to maintain positive family functioning (Badr et al., 2011; Figley & Kiser, 2013). In particular, a spouse might adopt a more instrumental role in the trauma survivor's healing process by shifting his or her role from "partner" to "caregiver"

(Dekel & Monson, 2010; Manser, 2015). In these cases, a caregiving spouse/partner may be required to manage and compensate for the emotional and behavioral difficulties experienced by the partner with PTSD. For example, spouses/partners may attempt to prevent violent episodes prompted by PTSD symptoms, assume sole responsibility for household duties and act as a "social buffer" for the injured Veteran (Blalock Henry et al., 2011; Chapin, 2011; Nelson & Wright, 1996). This role shift may overwhelm the caregiving spouse (i.e., role strain) and lead to caregiver burden (Baptist et al., 2011; Chapin, 2011; Dekel & Monson, 2010; Herzog & Everson, 2011). Caregiver burden often manifests as psychological distress in a spouse/partner such as a general increase in anxiety and depression (Badr et al., 2011; Dekel & Monson, 2010). In a Canadian study, Fast, Yacyshyn, and Keating (2008) interviewed 115 family members who provided primary support to a CAF Veteran living with a physical disability or mental health problem (94% of whom were spouses/partners) and found a significant impact on the supportive family member's well-being as they experienced less sleep and time for personal activities, and increased overall exhaustion.

Existing literature on the association between PTSD symptoms and marital relationship quality commonly cites a hindrance in trauma survivors' capacity to relate to close others, including spouses/partners (Monson et al., 2009). This barrier sometimes reduces feelings of closeness and intimacy, satisfaction, cohesion and expressiveness within these Veterans' marital relationship (Herzog & Everson, 2011; Lambert et al., 2012). In particular, the PTSD symptoms of emotional numbing, avoidance and withdrawal appear to be especially detrimental to marital intimacy, martial satisfaction and general family functioning (Erbes, Meis, Polusny & Compton, 2011; Evans,

Cowlishaw, & Hopwood, 2009; Lambert et al., 2012; Monson et al., 2009; Ray & Vanstone, 2009). Consequently, these factors may impede the PTSD healing process (Ray & Vanstone, 2009). Sleep and sexual disturbance-related symptoms can also negatively impact military couples' relationship satisfaction and intimacy within the marital relationship in some cases (Dirkzwager, Bramsen, Adèr, van der Ploeg, 2005; Nelson Goff, Crow, Reisbig, & Hamilton, 2007). Symptoms of anger and agitation can contribute to a reduced sense of safety within the relationship or instances of intimate partner violence (IPV) (Chapin, 2011; Lambert et al., 2012; Sayer et al., 2014).

To date, most research examining the relationship between a Veteran's PTSD symptoms and his or her spouse/partner has emphasized a unidirectional trajectory where a Veteran's PTSD symptoms exert an effect on the health and well-being of his or her spouse/partner (Norris et al., 2015). More recently, research is exploring the potential for a bi-directional relationship between Veterans living with PTSD and their family by examining the role that family members play in the healing process (Evans, Cowlishaw, Forbes, Parslow, & Lewis, 2010; Evans et al., 2009; Monson et al., 2009; Norris et al., 2015). Paralleling this shift, research is also emerging that examines positive changes following trauma (Norris et al., 2015) that might also be facilitated through this bi-directional relationship (Berger & Weiss, 2009).

Research that considers bi-directionality in the relationship between traumatic stress and family members offering support often focuses on the couple system as the unit of analysis. The term "system" is important in this regard because it implies that the couple relationship is comprised of interdependent, interactional processes between members of the dyad (Figley & Kiser, 2013) that impact the course of PTSD healing

(Nelson Goff & Smith, 2005). To this end, research has suggested a reciprocal effect occurs as family members interact throughout the healing process, which leads to either equilibrium or disequilibrium within the family system (Cozza, Holmes, & Van Ost, 2013). Indeed, just as a Veteran's PTSD symptoms impact his or her spouse/partner, relational qualities and behaviors within the couple relationship may, likewise, impact the course of a Veteran's healing process (Evans et al., 2010).

PTSD and the couple system. Literature identifies risk and protective factors implicated in the capacity of military couples to adapt to acute and chronic stress (Riggs & Riggs, 2011). Risk factors are generally understood as influences (e.g., psychological, genetic, or environmental) in an individual's life that *decrease* the likelihood of positive outcomes. Conversely, protective factors are generally understood as influences that *increase* the likelihood of positive outcomes (Benzies & Mychasiuk, 2009; Walsh, 2003). Figure 1 depicts the Couple Adaptation to Traumatic Stress (CATS) model (Nelson Goff & Smith, 2005), a framework for depicting how each couple member's levels of functioning, predisposing factors and resources (i.e., risk and protective factors, respectively), and relational functioning within the couple system interact to shape a couple's experience with traumatic stress. This model emphasizes the role that members of a dyad play in increasing or decreasing positive outcomes following traumatic stress. Specifically, the CATS model proposes that an interactional, reciprocal relationship exists within the dyad, which systemically influences both negative and positive adaptation to traumatic stress.

Examples of risk factors that may compound current stressors include pre-trauma influences such as previous stress or trauma exposure (e.g., in childhood), mental illness,

age, and sex (Nelson Goff & Smith, 2005). In military families, deployment may also function as a risk factor given that spouses/partners of service members who have been deployed often perceive higher levels of stress than spouses/partners of service members who have not been deployed (Burton, Farley, & Rhea, 2009; Schlomer et al., 2012). However, it is important to note a distinction between deployment in general and deployment where service has led to an OSI such as PTSD. For example, literature has shown equivocal support for a negative impact on marital outcomes and family functioning for deployment in general; there is more evidence substantiating negative impacts on family functioning and relational adjustment when the service member has incurred an OSI during deployment (Allen, Rhoades, Stanley & Markman, 2010; de Burgh, White, Fear, & Iversen, 2011; Dirkzwager et al., 2005; Erbes et al., 2011).

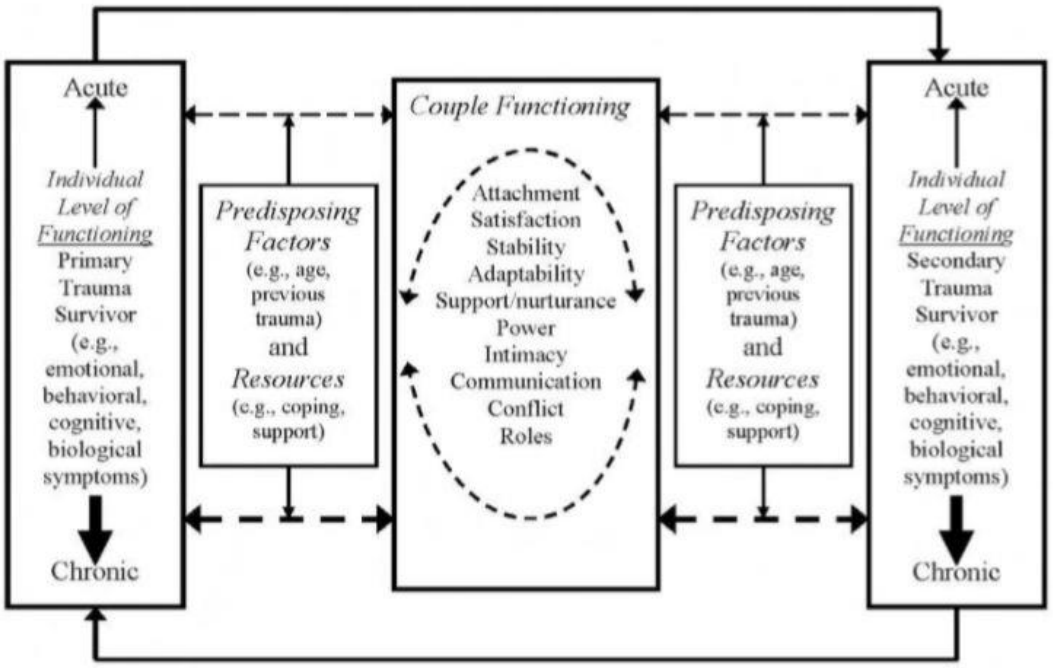
In terms of protective factors, the CATS model suggests that resources at the individual level (e.g., physical and mental health, self-esteem, positive coping strategies, financial resources) and resources at the couple level (e.g., cohesion, social support, shared views) may buffer couples' negative adaptation to traumatic stress (Nelson Goff & Smith, 2005). In the military context, family schemas, such as identifying as a "military family", can provide a sense of meaning for the risks associated with a military lifestyle, including risk for OSIs (e.g., PTSD), which can positively impact the course of a Veteran's treatment and healing (Chapin, 2011). Similarly, a shared understanding among family members of the traumatic experience via open communication, as well as a shared perception of PTSD symptom severity, seem to protect family members against negative outcomes (Figley & Figley, 2009; Johnson, 2011).

Certain demographic resources, such as a spouse/partner's employment status and education level, have also been identified as protective factors for military couples. For example, Frančišković et al. (2007) found that STS was more common among spouses/partners who were unemployed. They suggested that this might be because unemployed spouses/partners potentially spend more time in contact with the partner who has PTSD (i.e., if they are both at home together for prolonged periods) or they might be more likely to have assumed a caregiving role (potentially leading to caregiver burden) due to greater availability. Lev-Wiesel & Amir (2001) found in another study that higher levels of education among Holocaust survivor spouses were linked to lower levels of STS. It appears that employment and education provide military spouses with a buffer to the negative effects of PTSD by helping them maintain their self-identity separate from their caregiving role (Frančišković et al., 2007).

Finally, the CATS model emphasizes how relational factors such as relationship satisfaction, communication, intimacy, attachment, roles and nurturance play a role in the systemic nature of couples' traumatic stress responses (Nelson Goff & Smith, 2005). Like individual factors, the relational nature of these elements may either exacerbate or buffer the effects of PTSD within the couple system (Basham, 2008; Campbell & Renshaw, 2012; Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010). Froma Walsh (2003) advocates specific social (relational) processes within a family context that can promote traumatic stress healing and growth, many of which are consistent with the CATS model. These relational processes involve shared perspectives and behaviors that underlie interactions between family members in times of crisis. Specifically, Walsh outlines three areas of family functioning that encompass these processes: family belief systems

(making meaning of adversity, positive outlook, transcendence and spirituality), organizational patterns (flexibility, connectedness, social and economic resources), communication/problem-solving (clarity, open emotional expression, collaborative problem-solving). Considering Walsh's conceptions in light of the CATS model provides a good basis for understanding how traumatic stress manifests in a dyadic context for couples living with PTSD.

Figure 1. Couple Adaptation to Traumatic Stress (CATS) Model (Nelson Goff & Smith, 2005)



It also appears that positive or negative relations between members of a dyad set the tone for family functioning as a whole. Specifically, positive relations between couple members can contribute to strength within the family, whereas negative relations between couple members may put the family at risk for negative outcomes, such as interpersonal

violence or divorce (Figley & Kiser, 2013; Herzog & Everson, 2011). Research focusing specifically on protective relational factors among military couples managing traumatic stress emphasizes processes such as attachment mechanisms, open communication, effective coping skills, healthy family functioning and social support from an intimate partner (Norman, 2000; Wick & Nelson Goff, 2014).

Social support received from a Veteran's spouse/partner warrants particular attention because it has been depicted as a critical protective variable impacting the overall well-being of military service members (Ponder, Aguire, Smith-Osborne, & Granvold, 2012; Sudom, 2010; Therrien, Richer, Lee, Watkins, & Zamorski, 2016) and it is a strong predictor of healing from trauma and PTSD symptoms (Badr et al., 2011). Namely, it has been highlighted in military family literature for its role in facilitating positive adaptation to acute and chronic stressors by acting as a psychosocial buffer against traumatic stress among combat Veterans (Basham, 2008; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Pietrzak et al., 2010). In addition, social support has been associated with salutogenic effects following traumatic stress, such as the development of PTG (Tedeschi & Calhoun, 2004). A closer examination of PTG, and the role of couples' relational support processes that foster this outcome, is timely for contributing to the expanding body of literature that considers a bi-directional relationship between an injured Veteran and his or her close family members, as well as for strengthening our understanding of positive effects associated with trauma healing. Further, PTG outcomes may not be limited to the injured Veteran – their spouse/partner may experience growth through the spousal support process (Berger & Weiss, 2009), yet this possibility has remained largely unexplored in a Canadian military context. However,

three international studies do support this prospect. Specifically, Dekel (2007) and Lahav, Kanat-Maymon and Solomon (2017) both documented the development of PTG among wives of former Israeli combat veterans and/or prisoners of war (POWs) during the 1973 Yom Kippur War and McCormack, Hagger and Joseph (2011) found growth among wives of Vietnam War Veterans from Australia.

Post-traumatic Growth (PTG)

The general concept of PTG is not new. It has been documented in ancient Greek writings, as well as some religious teachings (e.g., Hebrew, early Christians, Hinduism, Buddhism, Islam) that emphasize the potential for transformation through suffering. However, contemporary and secular interest in PTG evolved through the 1980s and gained momentum in the 1990s (Tedeschi & Calhoun, 2004). Scholars have used many different terms to describe this experience including "stress-related growth", "finding benefits", "thriving", or "adversarial growth" (Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). Richard Tedeschi and Lawrence Calhoun coined the term "posttraumatic growth" in 1995 (Tedeschi & Calhoun, 1995). Their development of the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) ensued in 1996, which aimed to measure the positive changes experienced by some individuals following their exposure to highly stressful or traumatic life events (Tedeschi & Calhoun, 2004). It is important to note that some scholars describe PTG as an outcome (e.g., Tedeschi & Calhoun, 2004), whereas others view it as a process (e.g., Affleck & Tennen, 1996). For the purposes of this study, I examined PTG as an outcome, potentially mobilized through CAF Veteran couples' spousal support process while living with PTSD.

The phenomenon of PTG depicts, not only an individual's positive adaptation to a stressful event, but fundamentally his or her developmental and psychological progression *beyond* his or her state prior to the stressful event (Tedeschi & Calhoun, 2004). Tedeschi and Calhoun (1995) identified three broad domains of PTG: changes in perception of self, changes in relationships with others, and changes in general philosophy of life. Subsequently, they delineated five dimensions of PTG within these three domains: greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development (Tedeschi & Calhoun, 2006; Zoellner & Maercker, 2006).

Specific to war Veterans, research has delineated two main aftereffects of exposure to traumatic events in addition to growth: decline (characterized by the development of an impediment to positive adaptation and functioning) and resilience (characterized by a capacity to remain relatively unscathed) (Lepore & Revenson, 2006). Decline sometimes presents as mental health issues that bear a psychological (e.g., PTSD, depression, substance abuse) or social (e.g., decreased family functioning, distress in spouse) impact on military families. It is noteworthy that a PTG outcome typically follows a period of decline (Larner & Blow, 2011). The concepts of PTG and resilience share commonality (e.g., some descriptions of resilience include PTG's transformational aspect), yet studies have suggested they are inversely related. For example, it appears that highly resilient individuals seem to experience less PTG (Lepore & Revenson, 2006; Tedeschi & McNally, 2011).

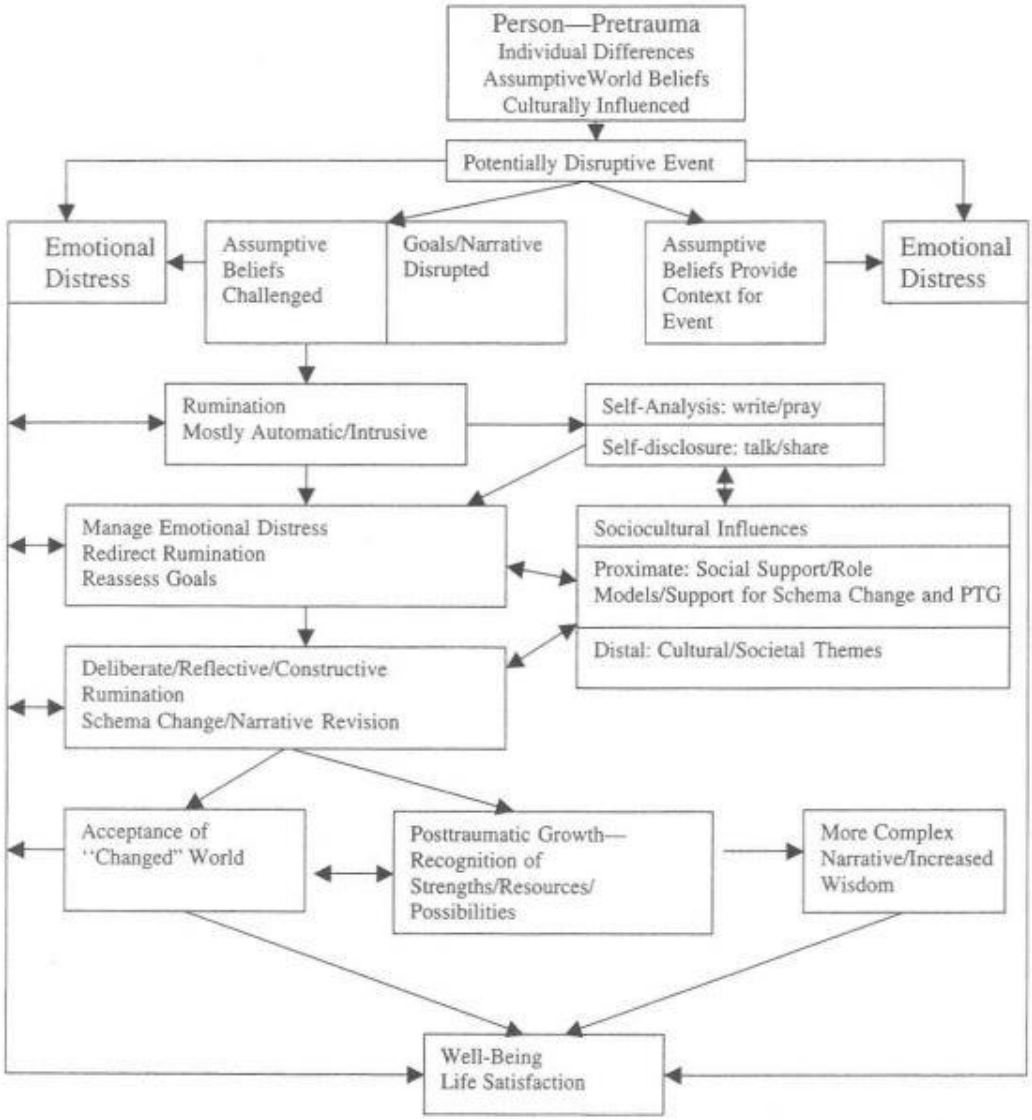
The meanings ascribed to trauma and its effects are integral to the experience of PTG (Larner & Blow, 2011). It is suggested that those who are effectively able to cope and adapt to PTSD symptoms are those who have found positive meaning in the traumatic experience, such as "translating the experience into survivorship" (Norman, 2000, p. 305). Alternatively, those individuals who persistently view themselves as a victim, blame others and hold negative worldviews tend to cope and adapt less effectively (Norman, 2000). As such, meaning-making comprises a form of coping for some that may help shift or "transform" negative effects of trauma into more positive outcomes (Figley & Kiser, 2013; Larner & Blow, 2011; Tedeschi & Calhoun, 2004). According to researchers and practitioners that adopt a systems perspective, the family represents an important context for meaning-making coping because it enables members to co-construct experiences as they interact with each other, such as through a social support process (Figley & Figley, 2009)

In addition to meaning-making coping, a specific form of cognitive processing, "rumination", has been highlighted as a key factor in the development of PTG (Calhoun &Tedeschi, 1998). Two types of rumination styles have been highlighted in conceptualizations of PTG: brooding rumination and reflective rumination (Tedeschi & Calhoun, 2004). Brooding rumination, recognized as a passive form of cognitive processing, is often associated with negative outcomes such as distress and the development of depressive symptoms. Alternatively, reflective rumination, recognized as an active form of cognitive processing, is associated with a reduction in depressive symptoms and the development of growth (Moran et al., 2013; Tedeschi, 2011). Reflective rumination is regarded as a constructive process that facilitates PTG by

enabling individuals to relinquish previously held worldview assumptions and goals (pre-trauma) in favor of building new schemas, meanings and goals that better match changes imposed by challenging circumstances (post-trauma) (Tedeschi & Calhoun, 2004). Reflective rumination also enables the "trauma narrative", another ostensibly crucial component to the development of PTG. A trauma narrative is an individual's account of the pre-trauma and post-trauma states, where the trauma itself bridges the "before and after" components (Tedeschi & Calhoun, 2004). Various models have been proposed to depict this process, as well as the development of PTG in general.

Models of PTG. Figure 2 portrays a well-regarded model of PTG following traumatic stress (Calhoun, Cann, & Tedeschi, 2010), which has evolved over the years since the 1990s to its current framework. The general concept of this model states that individuals develop a general set of beliefs and assumptions (schemas) about the world that both guide behaviors and provide feedback about life events as they are experienced (Tedeschi & Calhoun, 2004). This has been referred to as the "assumptive world". An individual's assumptive world provides a framework for understanding that allows individuals to gain meaning from experiences (Parkes, 1971). Calhoun and Tedeschi (2006) assert that highly stressful life events, which they refer to as "seismic events", sometimes oppose our assumptive world and lead to psychological crisis; they refer to this as a "shattering" of the assumptive world. The effort ("struggle") to re-build the assumptive world purportedly mobilizes the development of PTG among some individuals. In this view, growth develops through struggle as an individual re-structures his or her life in a way that facilitates newfound strength and understanding (Tedeschi & Calhoun, 2004).

Figure 2. Comprehensive Model of PTG (Calhoun, Cann, & Tedeschi, 2010)



The model of PTG includes five broad components (pre-trauma characteristics, the seismic event, challenges, rumination, socio-cultural factors) that interact to develop the final, sixth component: post-traumatic growth (Calhoun & Tedeschi, 2006). The first component, pre-trauma characteristics, suggests that certain dispositional characteristics, such as openness to experience, extroversion and optimism, promote the development of PTG. In addition, personal resources, such as income, education and

spirituality/religiosity appear to encourage the development of PTG (Berger & Weiss, 2009; Tedeschi & Calhoun, 2004). The second component, the seismic event, involves characteristics of the stressor such as its magnitude (Berger & Weiss, 2009). That is, the stressor should be perceived as intense enough to disrupt the status quo to a degree that it threatens an individual's assumptive world (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004). The third component, challenges, involves managing emotional distress and threats to beliefs, goals and personal narratives (Calhoun & Tedeshi, 2006; Tedeschi & Calhoun, 2004). Factors in this component are impacted by the fourth component, the process of rumination, including self-disclosure, and support from others (Tedeschi & Calhoun, 2004). For example, over time the cognitive processing involved in reflective rumination apparently helps individuals disengage from previously held beliefs and goals, which allows for the emergence of new perspectives. Self-disclosure, through writing or talking to supportive others, appears to help construct a trauma narrative that incorporates the changes that have occurred following the stressful event (Tedeschi & Calhoun, 2004). The fifth component, socio-cultural factors, involves elements within an individual's social context that influence a growth trajectory (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006). To this end, Calhoun and Tedeschi discuss how proximate and distal factors contribute to growth. Proximate factors refer to environmental influences that an injured individual interacts with on a regular basis, such as family, friends, and spiritual affiliations. Distal factors refer to environmental aspects that impact an injured individual on a broader level, such as through societal institutions and cultural ideologies (Calhoun & Tedeschi, 2006). This component emphasizes the role of "primary reference groups" as proximate factors. These are individuals who share

general attitudes and assumptions with a trauma survivor; namely, their social support system. Importantly, these supportive reference groups co-engage in the cognitive process to help re-shape and construct new narratives, beliefs and assumptions (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006). For example, disclosure of traumatic experiences to supportive others (e.g., counselors, family members, other trauma survivors) often enables an individual to construct a trauma narrative by receiving both validation of the trauma survivor's emotional experience and potential new perspectives that can be integrated into an individual's trauma narrative (Calhoun & Tedeschi, 2006). It stands to reason that co-engagement with spouses/partners should provide a context or "reference group" for this transformative cognitive process given they represent a valuable source of social support.

Historically, PTG models have focused an examination of this experience at the individual level. At the family level, Hill (1949) originally advanced the possibility of growth as one trajectory that could emerge within the family system as a result of traumatic stress management (e.g., World War II-related "crises"). Specifically, Hill suggested that the impact of traumatic stress on family functioning would present in one of three ways: deterioration, return to pre-crisis baseline, or surpassing pre-crisis baseline. However, exploration of these assumptions was dormant for many years. Recently, with growing awareness of the central role of families in facilitating healing from traumatic stress, research is now exploring the possibility that PTG may expand to close family members who support the injured individual (Berger & Weiss, 2009; Wick & Nelson Goff, 2014). Vicarious PTG (i.e., development of PTG in supportive others) has been documented among clinicians who work in close contact with trauma survivors

throughout their course of healing. It is speculated that this occurs through the process of disclosure and trauma narrative formation that this occurs (Arnold, Calhoun, Tedeschi, & Cann, 2005; Tedeschi & Calhoun, 2004).

The research of Berger and Weiss (2009) expands upon Calhoun and Tedeschi's (2006) model of PTG by incorporating understandings of the ways in which family members experience it. Although the general functioning of Calhoun and Tedeschi's model remains the same, Berger and Weiss modify each component to match a family context. For example, the first component now considers family characteristics such as cohesion, shared power, role flexibility, collaborative problem solving, and family resources such as a positive history of managing normative stressors. The view of stressors in the second component includes a consideration of how these events disrupt family equilibrium in a way that impedes decision making, problem solving and role performance within the family system. Challenges in the third component include family role shifts, reduced intimacy, attachment and communication, interference in the family narrative and threats to family beliefs and goals. The process of rumination extends to family relational processes including family reminiscing, communication to make shared meaning and shared problem solving. In the fifth component, the social context includes extended family members as proximate factors and community, including cultural beliefs and norms, as distal factors – together these impact a family's rumination process. If PTG emerges in the family context, new qualities such as positive changes in family identity, beliefs, legacy, relationships with other family members and friends and life priorities are proposed (Berger & Weiss, 2009).

The military couple context is a viable option for exploring the development of family PTG given the link between a military lifestyle and the possibility of traumatic stress injuries. Further, including the experience of spouses/partners should offer a more comprehensive perspective on how social context contributes to a shift from struggle to strength for families living with PTSD. For example, spouses/partners' role as spousal support provider affords a different view of the experience than the Veteran holds, which contributes to a wider understanding of the experience.

PTG and PTSD. Research that has investigated the association between PTG and PTSD yields mixed results (see Zoellner & Maercker, 2006 and Pietrzak et al., 2010 for review). For example, inconsistency is shown in the literature where some studies indicate a positive relationship, some studies indicate a negative relationship and other studies indicate no relationship at all between PTG and PTSD (Zoellner & Maercker, 2006). It has been acknowledged that, whereas there is a wide range of equivocal results, there is also a wide range of assessment measures and samples employed in these studies. Recently, a curvilinear, inverted U-shaped relationship between PTSD symptoms and PTG has received support (e.g., Shakespeare-Finch & Lurie-Beck, 2014; Tsai et al., 2015). This type of relationship suggests that moderate levels of PTSD symptoms are associated with the greatest levels of PTG (Tsai et al., 2015).

What is clear about the relationship between PTG and PTSD is that growth and distress are not necessarily mutually exclusive – trauma survivors can concurrently experience distress and PTG, and both of these may endure for a lifetime (Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). Zoellner and Maercker (2006) note an important clarification about the relationship between PTG and PTSD: "PTG and PTSD are distinct, independent constructs representing separate but in either case continuous

dimensions. Both concepts are not regarded as two ends of the same continuum of, for example, adaptation to trauma" (p. 629). That is, the emergence of PTG does not always mark an end to emotional distress (Zoellner & Maercker, 2006). For example, it is possible that a Veteran with service-related PTSD might still suffer from symptoms such as sleep disturbances, anxiety and high startle responses while concurrently experiencing closer interpersonal relationships and a greater appreciation of life following the trauma. It is precisely from managing these circumstances that PTG emerges (Moran et al., 2013; Tedeschi, 2011).

Empirical research examining factors associated with PTG in Veterans is limited, but growing, particularly following the amount of combat exposure in the most recent conflicts in Iraq and Afghanistan and the potential link between combat exposure and PTSD (see Pietrzak et al., 2010 for studies). It has been suggested that growth may actually be a more common outcome of trauma than PTSD (Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). However, research on the deleterious effects of combat-related deployment has dominated recent literature in the military context (Norris et al., 2015). Some early studies (e.g., Casella & Motta, 1990) examining the development of PTSD among combat Veterans revealed that despite the negative associations of the exposure to combat situations, some Veterans reported positive outcomes from these experiences (Tedeschi, 2011).

Recent studies of PTSD and PTG among military service members and Veterans have largely been conducted in the United States, leaving room for advancing empirical research in the Canadian military context. For example, data from the National Health and Resilience in Veterans Study indicated that 72% of a nationally representative sample of US Veterans with PTSD experienced PTG (Tsai et al., 2015). Pietrzak et al. (2010)

similarly examined the relationship between PTSD and PTG among OEF-OIF Veterans. The most salient dimensions of PTG among these Veterans were a change in priorities about what is important in life, a better appreciation of each day, and more confidence in their ability to handle difficulties. Further, Veterans in their sample with PTSD showed a greater indication of PTG than Veterans without PTSD.

Overall, it appears that the relationship between PTG and PTSD is complex; some scholars speculate that a third variable, such as personality traits or coping skills, may moderate the relationship (Pietrzak et al., 2010). In particular, individuals engaging in adaptive coping strategies (e.g., positive appraisal, religion, acceptance of change) rather than maladaptive ones (e.g., social avoidance, worry, self-punishment) seem to enable a trajectory toward developing PTG (Moran et al., 2013; Pietrzak, 2010). Further, it appears that social support facilitates the adaptive coping that promotes PTG (Rajandram, Jenewein, McGrath, & Zwahlen, 2011). Yet, to my knowledge, this relationship has not been empirically investigated among CAF Veterans living with PTSD who receive social support from their spouse/partner. Also, social support is an interpersonal process (Badr et al., 2011; Figley & Kiser, 2013), yet research that has identified specific relational processes that potentially unite the relationship between social support, adaptive coping and PTG is sorely lacking (Berger & Weiss, 2009; Scrignaro, Barni, & Magrin, 2011; Tedeschi & Calhoun, 2004).

PTG and social/spousal support. As noted, social support has been described as a valuable environmental resource for facilitating PTG (Tedeschi & Calhoun, 2004). Although the concept of social support lacks clarity in scholarly literature, most researchers recognize it as a multidimensional, interpersonal process involving the

provision and receipt of informational (e.g., providing information to assist an individual in need to problem solve), emotional (e.g., providing comforting gestures, physical presence, sharing ideas, offering encouragement), instrumental (e.g., providing assistance through tangible goods and services such as transportation, financial aid, household duties) and/or appraisal (e.g., providing information that aids self-esteem and self-evaluation) support (Benzies & Mychasiuk, 2009; Cutrona & Russel, 1990; Finfgeld - Connett, 2005; Hinson Langford, Bowsher, Maloney, & Lillis, 1997). Many scholars and practitioners view social support as a dynamic, ongoing process that is context specific. In addition, scholars emphasize a perceived need, an available social network, and a willingness to accept and provide help as important antecedents to social support (Finfgeld-Connett, 2005; Hinson Langford et al., 1997).

The notion of social climate or environment is salient in social support literature. That is, an atmosphere in which the social support system is situated that includes qualities such as mutuality and protection (Finfgeld-Connett, 2005; Langford et al., 1997). Specific to a military context, Therrien, Richer, Lee, Watkins, and Zamorski (2016) demonstrated that CAF Regular Force Members' who were married or living common-law experienced more positive mental health than those who were single, and they associated this with a greater social support system for service members who were living with others.

A consideration of trauma survivors' social environment (e.g., family context) is pertinent to a discussion of adaptation to traumatic stress injuries because it helps bring to light the role that supportive others play in facilitating adaptive functioning (Lepore & Revenson, 2006). Furthermore, the type of support provided to trauma survivors in their

social environment appears to impact the development of PTG (Lepore and Revenson, 2006; Scrignaro et al., 2011). For example, Scrignaro et al. (2011) examined why some cancer patients experience more PTG than others; they found that an "autonomy-supportive environment" was most beneficial toward the development of PTG. This type of environment is characterized by instances of social support provided in a way that allows for trauma survivors to meet their basic needs of autonomy, competence and relatedness (Joseph & Linley, 2005). Scrignaro et al. suggested that this type of social support might additionally facilitate adaptive coping processes that are conducive to the development of PTG.

Most studies of PTG that have assessed both members of a dyad include cancer patients and their spouse/partner (e.g., Manne et al., 2004; Weiss, 2004; Zwahlen, Hagenbuch, Carley, Jenewein, & Buchi, 2010). These studies have indicated that strong marital support is associated with the development of PTG, but the pathway between social support and PTG may not be direct (Prati & Pietrantoni, 2009). One possibility is that social support moderates the relationship between adaptive coping processes and the development of PTG. This speculation resonates with a meta-analysis conducted by Prati and Pietrantoni (2009) wherein they found that, although a medium effect size existed between social support and PTG, a stronger relationship was found between coping responses and PTG.

The emphasis on examining PTG in a dyadic context among cancer patients inspires an exploration of PTG among other types of dyads, such as military couples. To this end, it remains to be clarified how social support processes within military couples living with PTSD facilitate the development of PTG. For example, does support provided

by a spouse/partner enable adaptive coping processes within the dyad, which may lead to the development of PTG?

Adaptive dyadic coping processes. Individuals and couples engage in a variety of behavioral, cognitive, and emotional responses to alleviate and manage symptoms associated with acute and chronic stress (Folkman & Moskowitz, 2004). As described by Karney and Crown (2007), adaptive processes in a dyadic context are "all the ways that spouses interact, communicate, resolve problems, provide support and understand each other" (p. 24). This definition resonates with Walsh's (2003) depiction of family processes wherein emphasis is placed on joint, family effort to manage day-to-day living

In addition to the meaning-making coping style previously discussed, two forms of coping processes are salient in the literature that may impact couples' adaptive functioning: problem-focused coping (actively working to solve problems associated with a stressor) and emotion-focused coping (attempting to manage and reduce negative emotions associated with a stressor) (Lazarus & Folkman, 1984). Problem-focused coping has widely been associated with adaptive outcomes and it involves strategies such as implementing steps to solve a problem after considering the pros and cons of different approaches (Baker & Berenbaum, 2007; Figley & Kiser, 2013; Lazarus & Folkman, 1984). Emotion-focused coping is a complex process that includes many different strategies under its umbrella, such as denial, avoidance, and releasing emotions. For this reason, emotion-focused coping has been associated with both adaptive and maladaptive functioning, and positive or negative adaptation may depend on the type of strategy adopted for managing stressors (Baker & Berenbaum, 2007).

It is noteworthy that social support might involve dyadic processes that relate to more than one form of coping. Some of these have been highlighted for their positive impact on couples' adaptation to stress. For example, a partner with PTSD might disclose his or her feelings about a stressful event to his or her spouse/partner (i.e., emotion-focused coping), while at the same time, part of the spouse/partner's supportive role might involve him or her recognizing challenging situations, which includes support in diffusing reactions associated with PTSD symptoms (i.e., problem-focused coping) (Blalock Henry et al., 2011; Nelson Goff et al., 2006; Schwertfeger et al., 2008). In addition, a shared understanding of PTSD between both members of a dyad, such as viewing it as an experience they will navigate together, as a unit (i.e., meaning-making coping), is associated with positive psychological and marital adaptation (Badr et al., 2011).

Specific to military couples, Wick and Nelson Goff (2014) found that open, supportive communication promoted marital satisfaction among military couples that were living with PTSD. Specifically, it fostered positive conflict management strategies and greater role satisfaction among couples who experienced low levels of PTSD symptoms. In turn, open communication between both partners appears to promote a supportive environment where they are receptive to sharing emotions and solving problems collaboratively (Nelson Goff et al., 2006). In another study of military couples, Creech, Benzer, Liebsack, Proctor and Taft (2013) found that dyads living with a service-related stress injury who actively attempted to modify the situation, or their view of it, experienced lower PTSD symptoms and improved family outcomes than those who attempted to avoid managing the traumatic stress.

Overall, various dyadic coping processes within the spousal support system are associated with adaptive functioning; however, it is unclear which of these, if any, specifically foster PTG for military couples living with PTSD. Although it has been suggested that social support may foster adaptive dyadic coping that, in turn, promotes PTG, the particular relational processes involved within the dyad are unclear and warrant empirical attention, particularly among military couples. Further, it may not only be the Veteran who benefits from the dyadic process of PTSD support – his or her spouse/partner might also experience growth through the provision of support. These points form the rationale for my two research questions noted at the beginning of this discussion, and the purpose of my study is twofold: (1) to investigate how PTG has been experienced in the day-to-day living for CAF Veteran couples living with PTSD, and (2) to delineate how spousal support processes have facilitated the development of PTG for these couples. The remaining discussion will outline the theoretical and methodological groundwork I chose to undertake this investigation, followed by a portrayal and discussion of this study's findings.

Chapter 3: Theoretical Framework

An interpretive interactionist framework provided the theoretical and methodological groundwork for my research. Norman Denzin (1989) originally put forth this theoretical stance as a specific form of interpretivism. Interpretive interactionism bears similarity to both phenomenology and symbolic interactionism. Expressly, like phenomenology, interpretive interactionism assumes that social phenomena are derived through human behavior based on how people interpret the world; like symbolic interactionism, it assumes that social interactions create symbolic meaning within particular contexts, and that this symbolic meaning guides individuals' perceptions and behavior (Bryman, 2012; Denzin, 1989; Neuman, 2006). Interpretive interactionism is distinguished, in part, by a specific focus on problematic events in people's lives, and it aims to illuminate how individuals interact with their social environment to bring meaning to challenging experiences (Denzin, 1989).

As with all interpretivist approaches, interpretive interactionism concerns itself with examining the context of social meanings (Neuman, 2006). Emphasis is placed on examining specific times, places and groups, which encompass individuals' experiences. This includes consideration of how psychological, social, historical and cultural aspects intersect to construct meanings that shape peoples' understanding of the world and, ultimately, guide their actions (Snape & Spencer, 2003). At the core, interpretive interactionist researchers concern themselves with identifying intricate interactional processes that are built and sustained through continuous communication and negotiation with others in social contexts. Consequently, these interactional processes form specific

underlying meanings, which construct individuals' and/or groups' unique social realities (Denzin, 1989).

Social researchers of the interpretive interactionist standpoint aim to understand social phenomena from the point of view of those who are directly situated within the experience of interest (i.e., emic perspective), and the uniqueness of each case is highly valued (i.e., ideographic approach) (Denzin, 1989; Schwandt, 1994). As such, interpretive interactionism is a naturalistic, biographic exploration wherein individuals' life stories of challenging events, and those social interactions that shape them, are of prime interest (Denzin, 1989).

There is an existential element to interpretive interactionism owing to a distinct focus on transformational moments in peoples' lives. This focus particularly sets interpretive interactionism apart from similar theoretical standpoints. These transformational moments are referred to as "epiphanies" and are, essentially, turning points in peoples' lives where there has been a shift from a crisis period to a new state of being or life perspective (Denzin, 1989). Denzin (1989) describes four forms of the epiphany: the major (abrupt, life-shattering experience that leads to profound life change), the cumulative (gradual accrual of negative experiences that eventually leads to life change), the minor and the illuminative (underlying situational problems are exposed), and the relived (a major life turning point is recurrently experienced). The interpretive interactionist researcher aims to reveal transformative life shifts by investigating those social processes that inform the construction and maintenance of epiphanies (Denzin, 1989). This aligns with the broader interpretivist approach, which states, "the inquirer must elucidate the process of meaning construction and clarify what

and how meanings are embodied in the language and actions of social actors" (Schwandt, 1994, p. 118).

Interpretive interactionism embraces the ontological and epistemological principles of relativism and subjectivism, respectively (Denzin, 1989). Relativism states that reality is the result of how social actors construct social phenomena through the meanings they attach to their experiences. Reality is thought to shift according to different experiences and different mental constructions of these experiences (Guba, 1990). Consequently, the idea of a single, shared social reality is precluded in interpretive interactionism in favor of accepting multiple realities as a viable route to knowledge (Denzin, 1989). Interplay between human agency and different contextual factors (e.g., psychological, social, cultural, historical) largely accounts for this variation in lived experiences among individuals and groups. The nature of reality is, thus, a product of how it is uniquely constructed by each and every individual within particular contexts (Guba, 1990; Snape & Spencer, 2003).

To establish how different individuals and groups construct reality, interpretive interactionists adopt a subjective viewpoint (Denzin, 1989). In its application to research, subjectivity involves a double interpretation of these "constructions" through an interactive process involving exchanges between the inquirer (e.g., researcher) and the individual or group that has directly experienced the topic of interest (e.g., participant) (Guba, 1990). According to interpretive interactionists, this interactive process is a vital tool for unearthing the underlying meaning that people use to construct their social realities (Denzin, 1989). This means that both the perspectives of participants and researchers are acceptable and valuable means of understanding an experience. Personal

values are accepted as resources in this double interpretation, and interpretive interactionists reject the notion of value-free research. Instead, they argue that values can be used as a resource for conducting research rather than an obstacle (Bryman, 2012; Denzin, 1989; Guba, 1990).

Methodologically, an interpretive interactionist standpoint rejects the position adopted by the natural sciences that the social world is objective, consistently governed by strict natural laws, and generalizable across contexts (Denzin, 1989; Guba, 1990). Instead, they are interested in demonstrating social phenomena that is contextually unique through biographic narratives rather than through statistics and probabilities (Guba, 1990). In addition, explanations of individuals' and/or groups' lived experiences are recounted at the level of meaning, not cause (Snape & Spencer, 2003). Therefore, the interpretive interactionist stance is methodologically antithetical to paradigms that apply natural science methods to social science inquiries (e.g., positivist or post-positivist paradigms), and it asserts that the social sciences require different methods of inquiry to examine human behavior than those methods of the natural sciences (Guba, 1990; Denzin, 1989).

Denzin (1989) explains that the interpretive interactionist research process occurs over five methodological phases: deconstruction, capture, bracketing or reduction, construction, and contextualization. Deconstruction is an overview and critical analysis of existing research on the topic of interest. It is akin to a literature review where previous research is examined, including relevant theories, definitions of constructs and overall findings. Capture is the phase where data is collected (e.g., interviews, observations) from naturalistic settings that represent the topic of interest. Bracketing is the phase where

naturalistic data is removed from the context in which it occurs for analysis. Key features of the construct are identified in the bracketing phase by breaking down data into smaller parts with little interpretation through existing relevant theories or researcher's preconceptions and values. Construction involves taking the smaller parts identified in the bracketing phase and re-building them. This is accomplished by organizing the smaller features of the phenomena through a process of listing, ordering, relating and integrating. Contextualization is the interpretation phase. This is where all the elements identified in the previous phases are situated back into the social environments in which they originated in a manner that provides meaning and understanding about the social phenomenon of interest.

An interpretive interactionist paradigm complemented my study's research design and questions in several ways. First, research question one (How has PTG been experienced within the couple relationship for CAF Veterans living with PTSD and their spouse/partner?) broadly examined couples' experiences of PTG, as described by CAF Veterans' spouses/partners. This entailed gleaning the mechanisms that shaped spouses/partners' worldviews based on how they attached meaning to evolving circumstances over the course of PTSD healing. Interpretive interactionism is aligned with this goal given its focus on revealing transformational moments (epiphanies) that, in this study, marked progression toward PTG.

Second, research question two (How have social processes within the spousal support system fostered PTG?) sought to uncover specific support processes within the couple relationship that facilitated the development of PTG. As previously noted, an interpretive interactionist lens focuses on how social interactions within particular

environments (e.g., the dyad) shape reality, and thus, was compatible for this undertaking. For example, this lens enabled me to discern specific dyadic processes that couples engaged in together that were beneficial to the PTSD healing process.

Third, Denzin (1989) advocates that the interpretive interactionist approach is suitable for research that seeks to examine "the relationship between personal troubles…and the public policies and public institutions that have been created to address those personal problems" (p. 10). Epiphanies may occur privately (e.g., at home, within an individual or family), but they might also have public implications to the extent that they are embedded within larger historical, cultural and institutional aspects of personal life (Denzin, 1989). This is particularly the case for couples with military history given their day-to-day living is entrenched within military culture ideologies, which persistently permeate all areas of life for CAF service members and their families (Hall, 2011). In addition, consideration of a military background applies to ex-service members as much as active service members given many Veterans access programs and services through VAC that impact their lives (Thompson et al., 2014). This makes it challenging to separate CAF Veteran couples' personal experiences from the military backdrop, necessitating a consideration of those "public experiences" (i.e., community/institutional level) that impact "private experiences (i.e., personal level). For example, as will be detailed in this study's findings, the experience of PTG principally transpires within the family sphere, in part through provision of informal (spousal) support, yet *formal* support programs and services, provided at the community level, also intersect this experience. Denzin (1989) further asserts, "the perspectives and experiences of those persons who are served by applied programs must be grasped, interpreted, and understood if solid,

effective, applied programs are to be created" (p. 12). As such, I deemed interpretive interactionism an appropriate basis for my research given that one of the goals for my research is to inform and enhance formal support programs and services for CAF Veterans and their families who are living with PTSD.

Chapter 4: Methodology

This chapter outlines my study's research design. It begins by describing the specific measures and procedures employed for data collection and analysis and concludes with an explanation of strategies implemented for increasing reliability, validity and trustworthiness, as well as precautions taken to address ethical considerations.

Data Collection

Participant inclusion criteria. Spouses/partners of CAF Veterans living with PTSD who perceived that positive changes had developed within the Veteran or within the couple relationship as a result of the PTSD healing process were invited to participate in this study. In addition, spouses/partners were eligible to participate if they met the following criteria:

- Spoke fluent English;
- Were at least 19 years old;
- Self-defined as being in a committed, long-term relationship with the Veteran and cohabitated with him or her for at least two years prior to the OSI;
- Remained in a committed relationship with the Veteran throughout the PTSD healing process;
- The Veteran had received (and may still be receiving) at least one year of professional treatment (e.g., medical, psychological) to manage his or her PTSD symptoms prior to participation in this study (not required that the spouse/partner was in attendance for any or all of the treatment sessions);

- Provided support to the Veteran throughout the PTSD healing process and perceived that it was beneficial to his or her healing.

Measures. Data was collected through in-depth, individual interviews with spouses/partners to gain an understanding of how PTG had developed within the couple system. Specifically, questions aimed to demarcate specific relational processes that contributed to healing from PTSD within the couple relationship in a way that fostered the development of PTG.

These interviews followed a three-part, semi-structured guide (Appendix A), consisting mainly of open-ended questions. Several close-ended questions were included at the beginning to collect background information and to help ease spouses/partners into the interview. Part one of the interview collected demographic information about spouses/partners and the Veteran's military service, part two contained OSI-related questions and part three comprised PTG-related questions.

The development of the interview guide was informed by salient themes in the literature and models relevant to couples living with traumatic stress (e.g., CATS model; Nelson Goff & Smith, 2005). In addition, some questions were adapted from the short form of the Posttraumatic Growth Inventory (PTGI-SF) (Cann et al., 2010) to encourage a comprehensive interview that captured the notion of PTG as conceptualized by Tedeschi and Calhoun (1996; 2004). I deemed this important to increase conceptual clarity given the overlap between resilience and growth following adversity in the literature. Also, examining PTG in a military couple context is a relatively novel research topic; incorporating Tedeschi and Calhoun's notions into the current interview guide offered a comparison point to non-military couple contexts that have documented

experiences of PTG aligned with this model. The PTGI-SF (Cann et al., 2010) is a 10-item quantitative assessment tool used to measure the five dimensions of positive change originally put forth by Tedeschi and Calhoun (relating to others, new possibilities, personal strength, spiritual change, and appreciation of life). The short form derived from an original scale of 21-items scale, the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996),

Keeping with the epistemology and methodology of an interpretive interactionist paradigm, this interview guide was tailored to enable a dialectical and hermeneutical exchange between participants and myself, as researcher. Dialectic and hermeneutic approaches are two complementary methods that often occur in tandem throughout the data collection process (Conroy, 2003). An elaboration of how I applied these techniques follows in my description of the interview process.

Procedure. Upon receiving ethics clearance from Mount Saint Vincent University's Research Ethics Board, I used a purposive sampling approach to recruit participants who met the above-noted inclusion criteria. Next, I interviewed eligible participants individually, drawing on techniques aligned with dialectical and hermeneutical approaches. A detailed description of this procedure follows.

Participant recruitment. My purposive sampling approach incorporated a combination of criterion and snowball sampling techniques. Criterion sampling involved seeking participants who met the above-specified inclusion criteria, and snowball sampling involved "branching out" from these initial participants (e.g., through "word of mouth") to establish contact with other potential participants.

I forwarded an information package about my study to leaders of groups/organizations (key contacts) that support injured Veterans and their families within the Maritime Provinces of Nova Scotia, New Brunswick and Prince Edward Island. This package, containing one letter addressed to the key contacts (see Appendix B) and another addressed to potential participants (see Appendix C) explained the purpose and nature of my study and requested that key contacts distribute information about the study to potential participants. In addition, I had the opportunity to meet directly with four of these key contacts, and I was invited to speak about my study at two support groups. A recruitment poster was also forwarded to two clinical facilities for display in waiting areas (see Appendix D). I also used this recruitment poster as the basis for a Facebook page I developed for participant recruitment purposes. This page was shared on Facebook networks trafficked by military and Veteran families across Canada.

Interview process. Spouses/partners that were interested in participating were directed to contact me to ensure they met the eligibility criteria. If satisfactory, I forwarded them an informed consent form (Appendix E), which was read, signed and returned to me prior to the interview. Spouses/partners opted to engage in the interview either in person, by telephone, or by Skype and an interview date and time was arranged. On the interview day, the informed consent process was reviewed with participants, questions were addressed, and an overview of the interview structure was provided before commencing.

Six spouses/partners opted for a telephone interview, two for an in-person interview and one for a Skype interview. At spouses/partners' discretion, both in-person interviews took place at Mount Saint Vincent University, where I undertake graduate

studies. Interviews lasted between one to two and a half hours in length. I advised spouses/partners at the outset of the interview that they were able to skip any questions they were uncomfortable answering, without penalty. In addition, I checked in with them periodically to discern their comfort level to see if they required a break or if they would like to continue. Interviews were audio-recorded with spouses/partners' permission and, later, transcribed verbatim.

The semi-structured design of the interviews allowed a flexible presentation of questions (e.g., variable ordering of questions, adding/omitting questions as appropriate), based on the unique progression of each interview, which facilitated the dialectic, hermeneutic flow. The hermeneutical spiral, in part, represents how a researcher's values and presumptions are an integral part of the data collection and interpretation process as they become intertwined into his or her understanding of social phenomena (Denzin, 1989). Therefore, the hermeneutic research process involved a continuous interaction and active dialogue between me and the spouses/partners that included a blending of personal values, beliefs, assumptions and reflections that shaped the interpretation of experiences over the span of the interview process (Conroy, 2003).

In a research milieu, a dialectic exchange essentially refers to an active, transactional dialogue between the researcher and participant(s) that seeks a unified account. This can be achieved by confronting and reconciling divergent participant-researcher views in order to reach an understanding that satisfies multiple viewpoints (Guba & Lincoln, 1994). A dialectic process is considered complete once relative consensus is reached for an explanation (Guba, 1990; Guba & Lincoln, 1994).

The interactional nature of the dialectic approach complements the underlying assumption of a hermeneutic approach that existence is a dynamic process, rather than a static entity (Conroy, 2003). Martin Heidegger originally described this dynamic process in his book *Being and Time* (1962) as the "hermeneutic circle" or "hermeneutic spiral" wherein individuals' interpretations are interdependent with others' interpretations over a period of time (Conroy, 2003; Taylor & de Vocht, 2011). This means that research findings are established based on how social phenomena is cooperatively created through this transactional exchange (Guba & Lincoln, 1994). For example, spouses/partners' experiences living with PTSD held meaning for them based on understandings they had reached over the course of healing. My interpretation of these experiences, and underlying meanings, was shaped throughout the interview as I continually interacted with the spouses/partners and sought clarification. Therefore a spiraling process occurred wherein my interpretations continuously built on my understanding of spouses/partners' accounts over time.

In my role as researcher, I facilitated hermeneutic spiraling through active listening that included periodically restating participants' responses to confirm my understanding of their accounts, and I used probes to elicit deeper detail, where necessary, to gain clarification of subject matter. By restating spouses/partners' accounts as I had understood them, they were able to confirm (i.e., agree with my understanding), supplement (i.e., add new information beyond that already provided to clarify) or correct (i.e., disagree with my understanding and revise) (Taylor & de Vocht, 2011; Valentine, 1999) my interpretation of their accounts as the interview progressed. This created a spiraling process aimed at negotiating and combining my perspective with that of the

spouses/partners to portray a unified, jointly constructed interpretation of dynamics that fostered PTG within the couple relationship.

Upon completion of the interviews, I asked participants if they were willing to connect me with other spouses/partners who were potentially eligible and interested in participating (i.e., snowball sampling). Before parting, I notified participants that their names would be entered into a draw for a $50.00 gift certificate for a local restaurant in appreciation of their time. Participants were thanked for their time and invited to contact me if any questions arose about the study.

Once the interviews were transcribed, spouses/partners were given the opportunity to read their transcripts to determine if they felt their perspective had been adequately captured or if there was anything else they would like to add. All participants were satisfied with their accounts as recorded in their transcript and did not elect to make any additions or changes.

Data Analysis

Data was thematically analyzed through a six-step process outlined by Braun and Clarke (2006) that incorporated techniques from grounded theory method (GTM) (Strauss, 1987; Strauss & Corbin, 1998) into its coding phases. Braun and Clarke define thematic analysis as "a method for identifying, analyzing and reporting patterns (themes) within data" (p. 79) and propose this can be accomplished through the following sequence: 1) Familiarizing with the data, 2) Coding, 3) Searching for themes, 4) Reviewing themes, 5) Defining and naming themes, and 6) Generating the report.

Braun and Clarke (2006) state that researchers become familiar with the data by "immersing" themselves in it, and propose reading the data (e.g., interview transcripts)

multiple times, while taking notes on preliminary thoughts and ideas for initial coding. The first phase of coding involves discretely sorting data according to preliminary ideas in order to create an organizational structure. A search for themes within this structure follows whereby researchers create broader themes comprised of specific codes devised in the first phase of coding. These themes are subsequently reviewed and either collapsed or separated, as needed, in order to refine emerging patterns in the data. The new, refined themes are conclusively defined by assembling them into fewer, more abstract themes that capture the core narrative of each as well as how they relate to the broader, overall storyline portrayed in the data. The resulting report aims to make an assertion from the data that relates to the study's research question(s). As such, it provides an account of data by presenting themes in a logical manner and incorporating rich exemplars from the data to demonstrate the validity of each theme.

Braun and Clarke (2006) distinguish between two thematic analysis approaches: inductive and theoretical. They explain that an inductive analysis involves generating an understanding of a topic that derives solely from the dataset, without theoretical preconception. As such, an inductive analysis avoids trying to fit data into a coding frame based on existing theories related to the subject matter at hand. Conversely, a theoretical analysis is guided by existing theories and models describing the topic of interest and data is organized within a coding frame that aligns with a researchers pre-conceived understandings of a concept. My study integrated elements of both theoretical and inductive analysis. On the one hand, my interview guide was partially informed by PTG models (e.g., Tedeschi & Calhoun, 1996; 2004; Calhoun & Tedeschi, 2006; Berger & Weiss, 2009) and the CATS model (Nelson Goff & Smith, 2005). This qualifies as

theoretical influence to my data collection process. Furthermore, because this is a relatively novel area of research in the military context, I followed information from these models for my analysis as I was interested in exploring their existing conceptualizations within this particular population. On the other hand, I employed an inductive approach to reveal how PTG was experienced specifically for CAF Veteran couples living with PTSD. To this end, I drew on spouses/partners' accounts to understand how it was distinctively experienced by them within the general areas of PTG outlined in the models (e.g., PTG emerged for many spouses/partners specifically as "better boundaries" in the general area of "self-perception" posited by Calhoun and Tedeschi).

Braun and Clarke (2006) additionally propose two types of themes associated with thematic analysis, based on a chosen level of data analysis: semantic or latent. Semantic themes take participants' accounts at face value without considering meaning behind their words, whereas latent themes unearth the underlying meaning of participants' accounts beyond the surface by linking data to ideas and assumptions that shape the semantic content. As such, semantic themes are generally descriptive and latent themes are explanatory. Given I sought to situate my data within a PTG framework, and to explain how social processes contributed to the development of PTG, I chose to analyze my data at a latent level. However, I did not completely depart from surface-level data as I incorporated participants' own words into some themes.

As previously noted, I drew on principles from GTM to support my thematic analysis. I adopted this approach to support steps 2 through 5 of Braun and Clarke's (2006) analysis structure. I chose to integrate GTM techniques because there is in-depth

literature available outlining concrete coding steps for this approach. Conversely, Braun and Clarke provide a broad, theoretical description of how it should be conducted, but less detail describing specific steps on how to do so.

GTM is a compatible integration for thematic analysis because they are ontologically and epistemologically aligned (i.e., both accept relativism and subjectivism, respectively) (Braun & Clarke, 2006; Glaser & Strauss, 2012); thus, researchers adopting either approach operate from similar standpoints to achieve their goals. In addition, GTM's coding phases, subsequently described, resemble aspects of interpretive interactionism's methodological phases of bracketing, capturing and contextualizing, making it compatible with my theoretical foundation.

I elected thematic analysis as the primary guide for my analysis over GTM due to my reliance on the PTG and CATS models in developing aspects of my interview guide and for informing my analysis. As such, my inquiry was not purely inductive, and I deemed thematic analysis, with some tolerance for theoretical influence, best suited for my purposes. In contrast, in its purest form, GTM largely rejects the use of the theory for data collection and analysis (Glaser & Strauss, 2012).

Brief description of GTM. The primary focus of GTM analyses is to capture and interpret meanings of constructs by identifying analytical categories emerging from data, their dimensions, and the relationships between them (Ritchie & Lewis, 2012). This is accomplished through a three-phase analytic process of open, axial and selective coding (Strauss, 1987; Strauss & Corbin, 1998). Collectively, these phases comprise a course of continually evaluating similarities and differences between categories, referred to as constant comparison.

Constant comparison operates slightly differently within each of GTM's three coding stages (Glaser & Strauss, 2012; LaRossa, 2005), which is outlined below in thematic analysis steps 2-5. This process continues until theoretical saturation is reached; that is, the point where reviewing data does not add anything novel to the developing concept or theory (Bryman, 2012; LaRossa, 2005; Glaser & Strauss, 2012; Ritchie & Lewis, 2012).

Thematic analysis step 1: Familiarizing with the data. I first acquainted myself with the data by listening back to audio-recordings of the interviews, taking notes on my initial thoughts about each spouse/partner's account and marking ideas for thematic categories. I then transcribed the interviews verbatim, while simultaneously noting any elaborations to my initial ideas that formed upon this second pass through the data.

Step 2: Initial coding. I uploaded interview transcripts into MAXQDA, computer software designed to support qualitative data analysis, and employed GTM's open coding technique for preliminary coding. I used MAXQDA's memo feature during this stage to define initial codes, which often included verbatim exemplars from spouses/partners' accounts. I supplemented these memos with a hand-written journal throughout my analysis.

Open coding (consistent with the "bracketing" phase in interpretive interactionism) refers to a process whereby data are broken down into distinct parts, or "incidents" (words or phrases that cluster together) (Glaser & Strauss, 2012). Specific incidents, within participants' narratives are relied on as indicators of social phenomena that help construct broader, abstract classifications of data (categories). Traditionally, open coding relies mainly on language directly from participants' narratives for creating

initial categories (Glaser & Strauss, 2012; LaRossa, 2005). However, I did draw on existing concepts of social support and PTG while devising my initial coding structure. For example, following Tedeschi and Calhoun's (2004) model, I grouped incidents reflecting PTG under "perception of self", "relationships", and "life philosophy".

During open coding, data is sorted into many categories and labeled using the constant comparison method. Specifically, each new coded incident is compared to previously coded incidents: incidents that are similar are grouped together in the same category and incidents that differ are grouped into another, separate category (LaRossa, 2005). In addition, constant comparison during GTM's open coding phase includes a comparison of incidents belonging to the same category. This enables different properties (e.g., dimensions, levels, groups) to emerge (Glaser & Strauss, 2012). For example, by comparing underlying incidents of a broad spousal support category, I was able to discern properties of emotional, instrumental, informational and appraisal support.

Steps 3 & 4: Searching for and reviewing themes. I applied GTM's axial coding strategy to begin forming, and subsequently, reviewing themes. Axial coding (consistent with the "capture" phase in interpretive interactionism) refers to the process of "putting data back together" by developing connections within and between categories to provide circumstantial details (i.e., when, where, why, who, how) (LaRossa, 2005).

In the axial coding phase, constant comparison involves moving beyond mere comparison of incidents to other incidents (within categories), to comparing incidents to the properties of the category they belong to. This facilitates linking categories together to depict how codes are connected to contexts, consequences, patterns of interaction and causes (Bryman, 2012; LaRossa, 2005). For example, by comparing the properties of

social support, I merged codes representing types (emotional, informational, instrumental, appraisal) and levels (high, medium, low) of support into broader themes of "caregiver", "manager" and "cultivator" to capture how spouses/partners provided spousal support in different ways to match the functional capacity of the Veteran as healing progressed. Similarly, I merged narratives of "then" and "now" to devise three turning points that spouses/partners experienced that put them on a growth trajectory.

Axial coding enables the researcher to begin theoretically interpreting the data as connections between categories are devised (Glaser & Strauss, 2012). For example, I examined the coded segments that comprised each theme and compared them to segments that formed other themes. I then adjusted by merging or separating themes in order to produce a more coherent account of the data. As a result, I formed contextual linkages across spouses/partners narratives that depicted linkages between support processes, dyadic coping and points of change that shaped PTSD healing and fostered PTG.

I used MAXQDA's memo feature for these steps to flesh out my notions regarding specific categories and of emerging relationships between categories as analyses progressed. I also tracked how I came to decisions when making these connections within the memos and my handwritten journal.

Step 5: Defining and naming themes. I drew on GTM's selective coding technique to define and name themes. Selective coding (consistent with the "contextualizing" phase in interpretive interactionism) refers to the process of identifying the core, theoretically saturated categories around which other categories are integrated (LaRossa, 2005). The aim of selective coding is to form a converging, "explanatory

whole" that depicts participants' main "story" underlying their accounts. Constant comparison supports this during selective coding by simultaneously elaborating on the most salient details and reducing unnecessary or repetitive details (LaRossa, 2005). This involves merging interrelated categories into fewer, higher-level concepts that best represent the emerging theory or model (Glaser & Strauss, 2012).

I reviewed MAXQDA memos at this stage, and collapsed themes depicting relationships between categories (devised in steps 2-4) into even more abstract, overarching themes. In this way, I was able to develop a more unified account of the data that integrated novel, inductively emergent themes with pre-existing theories and models that related to support processes, adaptive coping, and PTG. Specifically, I formed four overarching, abstract themes (outlined in chapter 5), with related sub-themes, to depict spouses/partners' stories of living with PTSD and how they grew personally and relationally as a result of the healing process.

Step 6: Writing the report. The results of my study are fully discussed in the ensuing chapter; however, I will take a moment to discuss "thick description", an important technique within an interpretive interactionist approach (Denzin, 1989).

Thick description involves a rich, detailed account of experiences from the viewpoint of those individuals who have lived them. The goal is to portray the experience in a manner that promotes an intimate glimpse into how these individuals have constructed the experience (Neuman, 2006). This is in contrast to thin descriptions that yield summaries and generalizations about social phenomena in an abstract manner (Denzin, 1989). The large amount of detail involved in thick description necessitates interchange between descriptive and explanatory accounts in order to clarify an

audience's understanding of social phenomena. That is, thick description must be balanced by thick interpretation (Janesick, 1994).

I provided exemplars throughout my results to support thick description. Exemplars are salient, first-hand accounts that are used to represent key constructs and themes in the data as they are situated in real-world experiences (Stake, 1994). Specifically, I extracted certain verbatim accounts from the data that I believed effectively represented and accentuated particular themes. I placed these extractions within my descriptions to support them.

Reliability, Validity and Trustworthiness

I applied the techniques of reflexivity, respondent validation, and triangulation to enhance reliability, validity, and trustworthiness in my study. Reflexivity is a frequently used technique in qualitative research. It is also consistent with a hermeneutical method wherein the researcher is actively involved in shaping the accounts of the participants (Conroy, 2003). Reflexivity serves to situate the researcher's theoretical stance, biases, and values within the study and to make explicit any implicit assumptions (Conroy, 2003; Denzin, 1989). In this way, a research design becomes both transparent and coherent, which, in turn, increases its rigor (Bryman, 2012). For example, I am a civilian academic researching an experience embedded within the military culture. As such, my mindset and values may differ from the spouses/partners to the extent that I have not lived day-to-day under the same cultural umbrella.

Methodologically speaking, at the outset of my study, I suspected that dyadic processes noted in Nelson Goff and Smith's (2005) CATS model would impact the development of PTG within the couple system. By explicitly declaring this, I am denoting

my initial stance and expectations for one possible outcome of the study. In addition, transparency is achieved in my study's methodology by openly noting how various theoretical influences guided my analyses. This transparency helps others more clearly understand the influences that impacted my decisions for data analyses and interpretation (Bryman, 2012).

Reflexivity is a continuous technique. As such, I kept a dated reflective journal throughout the process of data collection, analysis and interpretation. In addition to maintaining an awareness of my underlying assumptions and expectations, this journal (in conjunction with MAXQDA memos) simultaneously served as a log to track my general understandings, misunderstandings, and analytical decisions throughout my research. This helped incorporate my preconceptions of the experience with spouses/partners' narratives in order to better synthesize my interpretation with their verbatim accounts. This reflective journal aimed to maintain a clear, coherent account of my research process indicating how I reached my conclusions.

I used the technique of respondent validation both during the interview process and after the audio-recorded interviews were transcribed to enhance validity of the study (Bryman, 2012). During the interview process, I periodically restated spouses/partners' accounts, as I understood them, in order to confirm, supplement or correct my interpretation of their experiences (Taylor & de Vocht, 2011; Valentine, 1999). After the interview, spouses/partners were offered an opportunity to review their verbatim transcripts, again, with a view toward confirming, clarifying, or correcting their accounts.

A triangulation technique was applied to enhance trustworthiness in the proposed study. Triangulation is a research practice that draws on multiple means to aid in data

interpretation (Janesick, 1994). Specifically, this procedure serves as a method of confirmability by cross-checking knowledge. Denzin (1978) posited four types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation (Janesick, 1994). This study incorporated theory triangulation to help substantiate different types of information, which enabled a deeper, more comprehensive understanding of PTG in this context and the processes that fostered it. For example, I juxtaposed three main theories: Calhoun and Tedeschi's (2006) framework (see also Tedeschi & Calhoun, 2004 and Calhoun, Cann, & Tedeschi, 2010) for how PTG develops at the individual level, Berger and Weiss' (2009) expansion of this PTG model to the family level and Nelson Goff and Smith's (2005) model for how dyadic factors and processes impact couples' adaptation to stress. Together, these models converged to support an explanatory account of both process (dyadic support processes) and outcome (individual and/or family PTG), which qualifies as theory triangulation.

Ethical Considerations

I received ethical clearance for my study from Mount Saint Vincent University's Research Ethics Board prior to data collection, and I took several ethical precautions while conducting my study. First, as noted above, all spouses/partners completed and signed an informed consent form before participating in the interview. This form included a clear written account, in lay language, describing the purpose and nature of the study, expectations for participants' involvement, and all foreseeable risks and/or potential benefits of participating. The goal of the informed consent process was to provide adequate details about the study so that participants could make a well-informed decision about participating. Spouses/partners were given copy of the informed consent form,

signed by both me and the spouse/partner, to keep for themselves and I retained another copy. In addition, I verbally reviewed key details of the informed consent form prior to the interview to ensure that spouses/partners fully understood the information contained therein as well as their rights as participants, including the option to withdraw at any time without penalty.

Second, there was no expectation that spouses/partners would incur distress by participating in this study; however, I was aware that the nature of the interview questions had potential to inadvertently trigger an emotional reaction (e.g., instigation of upsetting memories). As mentioned, foreseeable risks of participating in the study were clearly outlined in the informed consent form, as well as discussed verbally, so as to minimize this risk for psychological harm. According to the second edition of *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2) (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010), the Principle of Concern for Welfare states that, "ultimately it is the individual who decides whether the risks justify the benefits in their decision to either consent or refuse to participate in the research".

I additionally checked in with spouses/partners in between each of the three interview sections, and any other times I felt were warranted, to gauge their comfort level throughout the interview. Following the interviews, I emailed each spouse/partner to thank them for their participation and I included contact information for military/Veteran family support services. Further, the inclusion criteria stipulating that the Veteran must "have received (and may still be receiving) at least one year of professional treatment

(e.g., medical, psychological) to manage his/her PTSD symptoms prior to recruitment for this study" was aimed at having ample distance from the most challenging phases of healing to minimize risk of distressing emotional reactions.

Third, military families comprise a relatively small, cohesive community, especially within close geographic proximity. Thus, I foresaw an increased potential for participants' identity to be inadvertently known to others in the same community. This risk was increased given that all but one spouse/partner resided in the same province. As such, to safeguard spouses/partners anonymity, I did not attach pseudonyms to excerpts of their accounts when used as exemplars in my results section. I did so to deter readers from noticing patterns in the data that could inadvertently lead to recognizing the speaker. Likewise, I chose to present participant characteristics in aggregate form only rather than within a table displaying details for each participant.

Finally, I managed issues related to privacy and confidentiality. In regards to privacy, my recruitment strategies were arranged such that I relied on spouses/partners coming to me if they were interested in participating (e.g., requesting "key contacts" to distribute recruitment packages at their discretion); therefore, I only acquired their identity if they chose to contact me. In addition, I gave spouses/partners the option of participating in the interview by telephone, by Skype, or in person partially for their convenience and partially for privacy purposes. As such, if potential participants were uncomfortable with meeting in person for privacy reasons, they had the option of a telephone interview. The two spouses/partners who elected in-person interviews decided where the interview took place and it was just the two of us in the room throughout the interview.

In regards to confidentiality, I was the only person throughout the study who had access to the raw data in audio-file format; these audio files were deleted as each interview was transcribed. I personally transcribed all interviews, including removal of all potentially identifying information such as names, locations, and organizations. As an added layer of security, each interview transcription file was password-protected. Another confidentiality consideration, related to the informed consent process, involved a verbal re-iteration of the limits of confidentiality for my study, as outlined in the informed consent form. That is, I explained to spouses/partners that I was legally obligated to report information to authorities that could pose a health or safety risk to the participant or another person (e.g., a verbalized threat to cause harm to self or another).

Chapter 5: Findings

Sample Description

Nine female spouses/partners of CAF Veterans (all male) living with service-related PTSD participated in my study. They provided first-hand accounts of how they lived with this experience as a spouse/partner providing support to a Veteran with PTSD and how they lived together, as a couple, throughout the healing process. All spouses/partners, aged between 42 and 65 years old, resided in Nova Scotia except one who resided on Prince Edward Island. They were involved in a long term, committed relationship with the Veteran, either married or common-law; relationships varied between 10 and 43 years in length. All couples except one had children and most were adult children at the time of the interview. A few spouses/partners themselves had family military history, such as parents who served in the military. More than half of the spouses/partners held work outside of the home – three had served or were serving in the CAF themselves and two spouses/partners were service providers within the military/Veteran community.

The Veterans' ages ranged from 45-69 years old. Their CAF service ranged from 11- 31 years, mostly as full-time regular force members. Two Veterans served in the reserves, one of which served as both regular force and reserve member. Four Veterans served in the Army environment, four in the Navy and two in the Air Force; one Veteran served in both Army and Navy environments. Veterans held a variety of ranks including sergeant, captain, master corporal, petty officer, master seaman, p1, and they were employed in a variety of trades including medic (Army), electronic sensor operator (Navy), and ATIS tech (Air Force), to name a few.

All spouses/partners had experienced separation from the Veteran due to deployment, often multiple times, and all Veterans were deployed at least once to a high conflict area (e.g., to support or participate in combat, for peacekeeping missions, for disaster clean-up) in locations such as Bosnia, Afghanistan, Egypt, and Kosovo. One spouse/partner made specific mention to the Veteran's involvement in Operation Apollo in 2003 and two noted involvement in the Swiss Air recovery mission in 1998.

Most spouses/partners described the Veteran's transition to civilian life as challenging for her and/or the Veteran, particularly because many expressed that the Veteran was not prepared to retire. Veterans' CAF release dates ranged between 1994 and 2014 (most between 2011 and 2016) and the majority of these were medical releases; however, not all medical releases were related to PTSD.

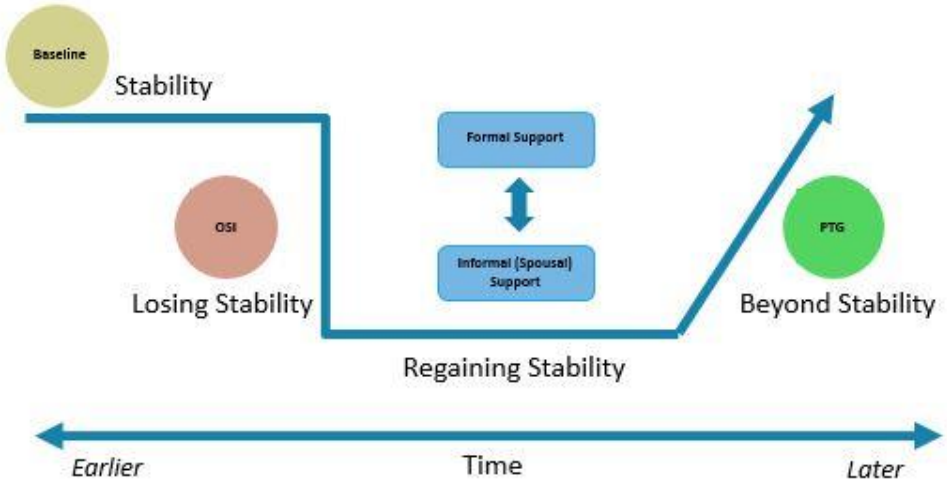
Introduction to Themes in the Data

A concept of "redefinition" emerged as a core, cohesive element linking all themes in spouses/partners' narratives. In the strict dictionary sense, redefinition means, "The action or process of defining something again or differently" (Oxford University Press, 2017b). In the context of my data, this concept emerged on a dyadic level as changing family roles, responsibilities, routines, relations, and support throughout the course of PTSD healing. On a personal level, spouses/partners continually redefined their supportive role to the Veteran and their overall expectations for family life, including how they viewed and attached meaning to living with PTSD. Together, redefining on dyadic and personal levels enabled couples to gradually build a "new normal" for family life as they came to conceptualize it in a different, more positive light as healing

progressed. This continual redefinition forged a transformative pathway for couples, culminating as personal and relational growth.

CAF Veteran couples' general PTSD healing and growth process is depicted in Figure 3 as a trajectory ranging from the pre-OSI period through to the PTG outcome. Although not as linear as the figure might suggest, the process involves moving through periods of stability, crisis/losing stability, regaining stability and moving beyond stability within the family system. At the dyadic level, varying points of stability mark how couples' level of family functioning shifts from low to high over the course of PTSD healing. At the personal level, couple's points of stability/instability, and their subsequent levels of family functioning, match the Veteran's level of PTSD healing, depicted as his increasing functional capacity over time. For example, on a spectrum, losing stability corresponds to the Veteran's lowest level of functional capacity, beyond stability corresponds to the Veteran's highest level of functional capacity (post-OSI) and regaining stability falls in between the two as the Veteran's functional capacity continually increases.

Figure 3. CAF Veteran couples' PTSD healing and growth process



At the most basic level, functional capacity is described by spouses/partners as the Veteran's ability to exert more control over managing PTSD symptoms in order to engage in routine activities, such as leaving the home independently: "The biggest thing that he's done is be able to, number one leave the house and number two, leave the house on his own." At a more complex level, the Veteran's personal functional capacity infiltrates couples' functioning, portrayed as changing relational patterns from partnering to parenting to re-partnering within the couple relationship. Partnering aligns with pre-OSI stability where family roles, responsibilities and power dynamics are relatively clear and egalitarian. Parenting aligns with a loss of stability following the OSI, where the spouse/partner assumes the Veteran's roles and responsibilities to compensate for his diminished functional capacity (due to PTSD symptoms), leading to a power dynamic resembling a parent-child relationship rather than a partner relationship. Re-partnering begins as couples learn to cope with PTSD symptoms together, allowing them to regain stability in their relationship. Partnering takes on a different form as couples adopt new ways of relational functioning to adapt to changes within the family system, helping them move beyond stability. Moreover, re-partnering coincides with the Veteran's increasing functional capacity, enabling the relational power dynamic to approach a more or less egalitarian state and the Veteran re-assumes many of his family roles and responsibilities.

Spousal support, enacted through three interconnected roles of caregiving, managing, and cultivating, provides the foundation for couples to regain and move beyond stability. Notably, this form of informal support interacts with formal supports at the community level to create a more inclusive social support network that enhances couples' proficiency in reestablishing family stability. Furthermore, individual and dyadic

adaptive processes develop through the interplay between informal and formal supports, which are closely connected to the development of PTG. Spouses/partners reach transformative junctures through the social support system that help them move across the different healing phases. The PTG outcome is situated within couples' efforts to continually move forward in their relationship as they strive toward a state of healing beyond stability.

Four superordinate themes and related subthemes emerged from spouses/partners' accounts describing couples' PTSD healing process, generally, and the role of spousal support in the development of PTG, specifically:

1) Couples lose stability as the OSI becomes the epicenter of family life

2) Couples regain stability through an interdependent relationship between informal and formal supports

a) Spouses/partners as linchpins throughout healing

b) Formal supports as channels for healing

c) Adaptive processes arise from the informal-formal support network

3) Couples move beyond stability as PTG develops at personal and relational levels through the social support system

4) Couples traverse healing phases as spouses/partners redefine what it means to live with PTSD

Theme 1: Couples lose stability as the OSI becomes the epicenter of family life

The OSI profoundly impacted all areas of life for the couples and became central to their day-to-day living. The word "epicenter" embodies how the Veteran's PTSD symptoms intersected the family system, making his well-being the focal point around

which all family interactions revolved early in the healing process. Specifically, changes in the Veteran related to PTSD became central as they pervaded family life, imposing stress and extensive changes in couples' routine family living.

Changes in Veteran. All spouses/partners stated that they were aware of a problem before receiving a formal PTSD diagnosis due to drastic behavior changes in the Veteran. They commonly expressed that following a particular event, typically deployment to a high conflict area, the Veteran did not come home as the same person, which was startling and confusing for spouses/partners.

> When my husband came home from his last, longest deployment in 2003, I didn't recognize the person who came home…at first I would say I felt like, because he was so different, there was such a drastic change in him and he was such in denial that there was anything wrong with him.
>
> The symptoms actually started when he came back [from deployment]. Whether he realized it or not, I did, I just, he wasn't the same.

Common behavioral changes in the Veteran included anger outbursts, impatience, reduced intimacy with the spouse/partner, difficulty connecting with others, substance abuse, sleep disturbances, decreased energy, hypervigilance, "flashbacks", reckless and/or secret money spending, withdrawal from previously enjoyed activities (e.g., hobbies, social events) and suicide ideation and/or attempts.

> I used to blame myself, "Ok, I'm doing something wrong," because he'd fly into these rages and he was suicidal. So I was terrified to go to work myself because I didn't know what I was going to come home to at one point.

In addition, all spouses/partners observed reduced self-esteem in the Veteran and shared that he commonly held negative self-perceptions such as "I'm not good enough, I don't measure up", as one spouse/partner recounted, or "There's something wrong with me. I'm not able to deploy, I'm a failure", as expressed by another.

Early attributions for changes in Veteran. Many spouses/partners did not suspect that the changes in the Veteran were military service-related. In fact, most initially attributed the changes in the Veteran to typical reintegration adjustment following deployment, "everyday" relational issues, or other events that had occurred while he was away: "I didn't know really where to point the finger and I never ever thought it was due to anything with the military. I always thought well it's all the stress in our life." Self-blame was an early sentiment for spouses/partners and many attributed changes in their relationship to something they were doing wrong or because they themselves had changed while the Veteran was deployed.

> We'd just spent almost seven months apart. I had changed while he was gone. There was a lot of changes leading up to him leaving. Like I didn't have a license before he left. I obtained a license before he left, like just the week before he left. I became more independent. I wasn't as reliant upon him, so he came home to someone who was like very much used to taking care of everything.

A few other spouses/partners noted that they had given birth to a child while the Veteran was deployed, or shortly upon his return, which they perceived as a large adjustment for anyone regardless of injury. In another case, a spouse/partner who lived with chronic health issues blamed herself for changes in the Veteran because she believed her own

healthcare needs were straining their relationship: "And I, obviously I couldn't fix my problem and I just thought, you know, I am just adding to his stress so much and there's nothing I can do. And I absolutely blamed myself. "

One spouse/partner who did think the changes were military service-related believed it was because the Veteran had become more cultured during his deployment overseas rather than because of an adverse experience related to military service.

> He was different but I just thought that was because he'd been away, or because of what he'd experienced while he was away, but not the negative things. You know he travelled while he was away. Like he'd have a bit of time off and he'd do the tourist things. You know different things and I thought, "Oh, it's because he's more worldly" and not, it didn't occur to me that it was because of things that he had seen. Things that he'd experienced.

When changes were attributed to a relational issue, some spouses/partners stated that they believed they simply needed to reconnect after being separated for a lengthy period of time, typical of a "normal" re-adjustment period following deployment. However, when issues did not eventually resolve, and tensions escalated in some cases, the spouse/partner realized there was another underlying issue.

> I just thought it was him adjusting to coming home and that things had changed between us because of my growth as an individual, becoming more, like, self-sufficient. But there was something still that was in him that I couldn't put my finger on.

Before the PTSD diagnosis, spouses/partners who realized the problem initiated outside of their relationship did not know how to manage it without knowing what was wrong, which placed strain on them as a couple.

> We didn't know what to call the mental health issues. We didn't know there was a name for it. We didn't understand. He was so medicated at that point with no definition of what was happening. It was really very stressful.

PTSD diagnosis. It often took years for the PTSD diagnosis to be formally specified and many couples lived for a prolonged period (over a decade in a few cases) with no precise understanding of the Veteran's behavioral changes. The absence of PTSD diagnosis perpetuated a state of confusion for spouses/partners, which encumbered the healing progress as they did not know how to manage the underlying issue.

> This whole issue is nothing new in our lives. This is something that he's carried for years and years and we had no idea what it was. And now when I look back, I can see things starting and snowballing and escalating but I had no idea what it was called.

In some cases, the diagnosis was given long after it had been labelled as another type of mental health issue (e.g., adjustment disorder, depression, anxiety), but only marginal improvement resulted from treatment for that particular diagnosis and, in some cases, the Veteran's symptoms worsened: "Our doctor had suggested that he see someone and he was on medication but it was for severe depression and mixed anxiety and things kept continuing to get worse and worse and worse."

The PTSD diagnosis was largely received by the spouse/partner as a beneficial piece of information: some expressed that it clarified why their partner had changed, others shared that it provided a sense of validation for what they already suspected. In addition, several spouses/partners explained how the diagnosis allowed them to access formal support programs that they were previously ineligible for: "It has eased the stress because of, you know, with Veterans Affairs, there's different programs that are available with that diagnosis." However, shortly after receiving the PTSD diagnosis, most spouses/partners felt an imperative to "fix" the problem, which typically preceded a complete understanding of what it meant to live with PTSD or denial of what it uniquely meant for them.

> I think initially, like after he was diagnosed, after Afghanistan, I think the way I looked at it was, I just wanted to know, "How long is this going to take?" Like, how much time do we need until, you know, this is fixed or better?

Many spouses/partners explained that, initially, the Veteran himself did not view the diagnosis as positive news. The diagnosis was especially not well received by the Veteran if he was still serving because he anticipated negative consequences for his military career related to stigma, as one spouse/partner described in her husband's initial reaction to the diagnosis: "He even got worse because then he said, 'Well I'm useless, I'm no good, nobody wants me.'" This commonly manifested for the Veteran in the work domain as tensions with co-workers or superiors, as one spouse/partner recounted:

> He had been having issues with other people at work in general and he just felt that he had no respect, like nobody respected him and that. He just felt

like everybody was coming at him. And everybody was attacking him.

And he felt really alone. And he felt very isolated.

In addition, many spouses/partners perceived stigma in the social domain as both the spouse/partner and the Veteran often became alienated from friends. For example, one spouse/partner described how they felt shunned by friends: "All these people that had been really good friends of ours absolutely refused to speak to us. So we lost our whole support system that was there because he was just considered a leper." Another spouse/partner described a sense of ignorance that led to friends avoiding them: "So kind of like a loss of family, loss of social. I think once he was off on medical leave, like people didn't know how to respond or react, so they just didn't. So that was hard."

OSI impact on Veteran. The OSI resulted in both intrapersonal and interpersonal challenges for the Veteran that infiltrated the family system. Spouses/partners described how the Veteran grappled with managing PTSD symptoms on a daily basis (intrapersonal level), which greatly reduced his functional capacity and impacted his relationships with others (interpersonal level). PTSD symptoms frequently interfered with the Veteran's ability to perform routine roles and responsibilities at home and were often assumed by the spouse/partner. Similarly, PTSD symptoms impacted his military work capacity, and sometimes formed the basis for a medical release if the diagnosis was already known. Other times, the Veteran might have released medically for other reasons, such as physical health issues related to military service, and was only diagnosed with PTSD post-release. However, in retrospect, and regardless of the reason for release (e.g., medical or voluntary), spouses/partners often made linkages between what they now recognized as PTSD symptoms and how they transpired in the Veteran's work

environment prior to release. For example, as previously noted, some Veterans developed issues with co-workers or commanding officers, which spouses/partners believed either occurred as a result of the symptoms or exacerbated the symptoms, but this connection was not made at the time. These workplace tensions concerned many spouses/partners as they simultaneously speculated both about the Veteran's well-being and the family's financial security if there were career consequences to these actions. For example, one spouse/partner disclosed how negative interactions between the Veteran and a senior officer had resulted in a harassment case, which led to an administrative hold on the Veteran's pay:

> It went on for a year. The wheels grind very slowly in a situation like that. [Veteran]'s pay was stopped because this was a senior officer and enlisted men versus senior officers, they don't win. And they were really blunt and said, "Like, if we pay you, you're only going to have to pay it back so we're basically doing you a favor by not paying you." So it was horrendously stressful. And I was the one on the phone trying to deal with people in [location] and people in [location], "Like, why have you stopped his pay? You know, like, hey, you need to pay us." And it was a nightmare. It was just a nightmare.

OSI impact on spouses/partners. All spouses/partners highlighted that living with the OSI was stressful. As one spouse/partner exemplified, those who worked outside the home experienced immense pressure to maintain the work-family balance: "I was working full time in a job with a lot of pressure and responsibility. And so between the two, it was, it was really extreme. It was very, very stressful." In addition, many alluded

to the fact that, even though they loved their partner, there was at least a temporary point where living with PTSD was a burden.

> I think if I knew 20 years ago, or 15 years ago, what I know today, I probably would have handled things a lot differently. If before we got married, if I knew this was going to be my lot in life, I'd be single. I would never step into a marriage if this is what you have to deal with.

Many became so consumed with monitoring their partner's health and providing care to the Veteran that they either approached or reached a state of emotional burnout, as one spouse/partner expressed, "As a spouse dealing with someone who has PTSD, you're so much in the caretaker role that you forget to take care of you," and another spouse/partner echoed, "Going from one stressful all day job to a very stressful home life all the time, it takes a toll." They often abandoned previously enjoyed activities and social events, largely out of necessity, because they felt they did not have time to participate due to caring for their partner. For example, several spouses/partners explained that, early in the healing process, they always had to accompany the Veteran on outings as he would not leave the house alone: "It's just very recently that he's able to leave the house. And for a very long time, if he did have to leave, I had to go with him." Similarly, some spouses/partners shared that they were afraid to leave the Veteran alone if he was suicidal. This initially made being apart from the Veteran a daunting task for some spouses/partners. Other spouses/partners who were working outside the home at the time explained that they were compelled to frequently check in over the course of the day to ensure their partner's safety: "I would phone home here three times a day while I was at

work to check in. Ok, yes, he's still answering the phone. Ok, he's still alive, everything's good so far. And so it was really stressful."

In some cases, spouses/partners shared that they became less trustful and more wary of other people because it was painful to perceive that friends had judged and dismissed them because of the PTSD diagnosis. This temporarily impeded socializing for the spouse/partner leading to a sense of social isolation early in the healing process. Some spouses/partners felt shame due to the stigma attached to PTSD and chose to withdraw from social settings for fear of judgement.

> You know there's a lot of judgment in the world, I'm sure you're aware of that, and people will think that, 'Oh, you know, like your husband has PTSD, like, you know, something's wrong with him,' right? And that makes it something wrong with you right? That was hard for me for awhile.

Many spouses/partners disclosed that they had lost their sense of self outside of their supportive role early in the process: "I would never say "Boo" before. I knew, ok, it's now noon, I better make his lunch. He had me so conditioned for his every need that I automatically did things without even thinking anymore." This lack of segregation from their supportive role was confusing for many, as one spouse/partner explained: "I had totally lost myself and I sat many days just staring at walls going "What do I do today? I have no idea." In addition, some spouses/partners suggested they had taken on the injury in a way that resulted in experiencing undesirable changes in themselves, which occasionally mirrored the Veteran's symptoms, as depicted in one spouse/partner's experience of hypervigilance:

> I think the problem for, for myself and us in general, the spouses, is that we have now become hypervigilant. And their [Veteran's] hypervigilance has decreased because they've achieved a better place of wellness whereas for us it's still very fresh. So there are times where I would be in a situation where I could see potential for, you know, him being reminded of something and I'm like on the edge immediately. I've got the room scoped out. I know exactly what I'm going to do and I've got the problem solved right until the end for every step that's going to happen because I've prepared for what would've happened in the past. And then it's like, 'Oh, well that didn't happen. Ok woo. Settle yourself down.' And I mean you can feel your body's reaction. I mean you go from this, you know, perhaps a chilly state to a complete like almost sweating state to, 'Ok, well, we're good. We're good, we're good, we're good.'

One spouse/partner exemplified the centrality of the OSI to family life by explaining that she had become so deeply entwined in providing support to her partner that it was initially difficult for her detach from this role as healing progressed: "I don't have any regrets, but when he started to gain wellness, it was hard for me to separate from that and go back into not being the caregiver and the parent." Similarly, some spouses/partners were left with what one described as "residue" from PTSD symptoms, where stress and reactivity persisted for spouses/partners even though the Veteran's had reduced.

> I find even for myself, that I don't do crowds very well anymore either. Because they're stressful for me…you become reactionary to them and

> settling situations down. And, you know, kind of being the mediator to everything in public and at home.

OSI impact on family system. On a relational level, the OSI created family disruption by upsetting previously held hopes, expectations and ideals for their family life, necessitating a re-conceptualization of who they were as a family as one spouse/partner shared: "You're stuck playing nurse maid or mother 24-7 for someone who is supposed to be your partner, not your kid. Like your spouse [Veteran] has evolved into your child."

Early in healing, especially prior to diagnosis and treatment, spouses/partners often described the Veteran as volatile, which made him unpredictable and difficult to handle when interacting with family members: "He was so impatient and frustrated and angry, oh my land. He would just flip off for just little reasons. You know, the dog barked and he was angry." This meant that the Veteran's moods largely dictated couples' interactions as one spouse/partner explained:

> He can throw damn right little tantrums or he pouts. He gets in these really pouty moods. And at that point you can't do anything with him. I mean you just basically have to step away and stay away from him for a few hours

Some spouses/partners shared that their children were confused by the changes in the Veteran and how he interacted with the spouse/partner:

> What it officially took was his daughter going to my husband at a very young age and saying, "Daddy, why are you angry all the time? Why are you not happy? Why don't you smile anymore? Why's Mommy crying all

> the time?" And it was then that he realized, this is affecting my family.
>
> This is affecting my child. This is affecting my wife.

Other spouses/partners disclosed a compulsion to protect their children from the PTSD symptoms early on as exemplified in the following account:

> I would shield the kids from this, "Just go on into the computer room, you have freewheeling on the computer," because they were only permitted one hour per day. See, I just let it open, let them at the computer, at least they can get lost in what they're doing there and not have to deal with his rages.

In addition to volatility, the Veteran frequently had difficulty connecting with his family members, which manifested as family withdrawal and avoidance. For example, reduced sexual intimacy commonly ensued for couples, "He became withdrawn from me. It affected our sexual intimacy big time. I felt very disconnected from him.", and the Veteran often became less involved with his children. In at least one case, the Veteran avoided his children because a child was involved in the injurious event linked to his PTSD and he was afraid that interacting with them would "trigger" an intense emotional reaction. Consequently, the Veteran's relationship with his children often became strained, leading children to became closer to the spouse/partner and more detached from the Veteran, which sometimes persisted even after healing had progressed.

> Both boys are extremely close to me and if they ever phone here, they phone here to talk to me. And they'll always ask how their dad's doing but they don't ask to speak with him, which I know he [Veteran] feels.
>
> It also creates huge conflicts in our relationship where, you know, the kids will come to me versus going to him because it's not safe for them to go to

> him. And they know that instinctively. So it's helping re-build that relationship now as they become adults.

Military cultural factors. Spouses/partners shared ideological factors, embedded within the military culture, which complicated diagnosis and treatment of the OSI. This often meant longer periods of strain on the couples' relationship coinciding with delayed recognition of the problem as PTSD. For example, spouses/partners explained how certain masculinity-driven mindsets dominant in the military context, such as "soldiering on" through challenges, shrouded the experience and sometimes contributed to either missing or dismissing a problem by medical professionals or the Veteran himself.

> And I was never given the opportunity to express, well, that things aren't the same. And, you know, so they say, "Ok, you've been given a clear, there's nothing wrong with you. This deployment has had no impact on your life." And they basically give you, not like a write off on it but, sign off that you're ok and they send you off on your way, right?

The majority of spouses/partners believed that the Veteran underwent at least one additional deployment after acquiring the OSI. In some cases, they felt this was because behavioral changes were not recognized as abnormal. In other cases, they believed stigma compelled the Veteran to conceal their symptoms, which prevented him from disclosing the problem to their commanding officers or a medical professional.

> The stigma's just too strong. You're just going to go back and do your job. And they're really, really well trained to shut that off. I mean, we, as humans, become trained to shut off some emotions, you know, traumatic

> events in our lives, but eventually, you know, it's the pressure effect and you just can't do it anymore.

These barriers seemed especially strong when the OSI was incurred during the 1980s or 1990s and for spouses/partners who, themselves, were raised in a military family. Specifically, having a family military history, added a cultural layer that sometimes impeded the healing process by delaying treatment seeking. For example, one spouse/partner articulated how she equated early signs of PTSD symptoms to "normal" behaviors that accompanied a military lifestyle because of her engrained conception of a military lifestyle:

> Growing up in a military family, the support systems then compared to the support systems today are very different. There was none. What happened at home stayed at home. That was kind of the generation that I grew up in. So, if there was any problems, you dealt with it. You didn't talk to anybody, and God forbid, you didn't mention it to anybody else because if it went to the chain of command, that was, you know, career limiting for them and what not. So, you just accustomed yourself to some of the behaviours that, in hindsight now, would have been inappropriate. Being a young, you know, twenty-something starting a new family, living on your own kind of mentality, it's like, "Well, I guess that's just how it's supposed to be,' and you accept it and you move forward and you live within the confines of those behaviours not knowing that they are inappropriate or unacceptable.

CAF release process. The CAF release process emerged as a unique cultural factor that confounded hindrances associated with the OSI. All spouses/partners described the Veteran's transition from military to civilian life as challenging for both of them. In part, this was because many lost their social circles (largely comprised of other CAF service members and families) and their sense of military identity became ambiguous throughout the release process. As such, spouses/partners associated decreased self-esteem in the Veteran with both the OSI and the release process. As many spouses/partners explained, this was especially the case when the Veteran was medically released because he often was not ready to release and felt a sense of abandonment and loss. This sentiment of loss was often echoed by spouses/partners.

> Well, you know, you're looking at a 50 year old man who's dedicated his career to serving his military. Never saying, 'No,' doing what was asked of him. Well, he's got all these physical injuries. He's in constant pain. Post-traumatic stress. Yet, in the end, what was it for?...the military goes on and you're out of luck.
>
> I was hurting too because the military life was all I've known. All my friends are military. What am I going to do? As much as it was a sense of loss for him, for his job, it was sense of loss of my community for me.

Some spouses/partners remarked that the Veteran's shift from a highly structured environment (military context) to a less structured one (civilian context) during the CAF release required spouses/partners to bridge this gap. This added another layer of to the PTSD healing process necessitating support from the spouse/partner.

> They've come from a culture of being told what to do all the time and, you know, especially somebody who's born into it. So they have a father who's telling them what to do all the time and they join the military and they have a boss or a senior supervisor and it doesn't matter what rank you are but there's always somebody telling you what to do and when to do it and then you enter into a relationship and you're expecting your spouse to tell you what to do and when to do it. And that's not always ideal for a healthy relationship.

Summary of theme 1. Couples lost family stability as the introduction of the OSI disrupted family life, even before it was recognized as such. Veterans' functional capacity was hindered by PTSD symptoms, leading to work conflicts, reduced self-esteem, and family withdrawal. Masculinized military cultural ideologies intersected the OSI experience creating stigma and delayed PTSD diagnosis for couples. Indeed, some attributed a loss of their social network to stigma and all couples lived a prolonged period of time without understanding the problem as PTSD, often because symptoms were dismissed.

Spouses/partners experienced high levels of stress associated with concern for the Veteran's safety, confusion about the underlying issue and self-blame. In addition, spouses/partners redefined their role in the couple relationship from "partner" to "parent", as the Veteran's diminished functional capacity required spouses/partners to assume his family roles and responsibilities. This relational shift took a toll on spouses/partners as they compromised their self-care in order to take care of the Veteran, often resulting in near emotional burnout and a decreased sense of self outside of their supportive role.

Theme 2: Couples regain stability through an interdependent relationship between informal and formal supports

Despite the significant personal and relational challenges imposed by the OSI, the CAF Veteran couples regained family stability through a social support system constituting a bi-directional, interdependent relationship between support resources at the home and community levels. At the home level, the care spouses/partners provided to the Veteran (i.e., spousal support) constituted the primary source of informal support within the couple system. The spousal support system was, in turn, supplemented with informal support from couples' friends (largely spouses/partners' personal social network) and/or extended family. At the community level, couples accessed formal support resources represented by people and organizations in both military and civilian spheres that provide support for Veterans and their families, generally, and PTSD support programs/services, specifically. Notably, spouses/partners regularly engaged with both formal and informal support resources to regain their personal stability. However, according to spouses/partners, the Veteran mainly accessed formal support resources, rather than informal support resources.

Theme 2a: Spouses/partners as linchpins throughout healing. All spouses/partners described themselves as a mainstay throughout the healing process, as captured in the following narratives: "I was like his rock that he used as a tether", "He says I'm his anchor", and "I was always by his side". Moreover, they all recognized how fundamental their provision of support was to the Veteran's course of healing. As one spouse/partner expressed, extended family members sometimes echoed this viewpoint:

"Honestly, I don't know where he would be or he would be alive right now [without her support]. His mother actually said that to me before she passed away."

The type and level of support spouses/partners provided to the Veteran throughout the PTSD healing process can be depicted as three overlapping yet distinct roles: *caregiver*, *manager*, and *cultivator*. All four of the social support types previously outlined in the literature review (emotional, instrumental, informational, appraisal) were employed within these roles, but different types were at the forefront of each role as spouses/partners shifted to match the changing needs of the Veteran (i.e., day-to-day changes and as healing generally progressed). For example, the provision of instrumental support was prominent within the caregiving role, a combination of informational and instrumental support was salient in the managing role, and appraisal support was robust in the cultivating role. I have detailed below how instrumental, informational and appraisal support uniquely transpired within the three supportive roles; however, emotional support warrants a special note because it was provided consistently by spouses/partners across all three roles and represented a constant form of support throughout the course of healing.

Emotional support emerged in spouses/partners narratives of *commitment* and *acceptance* encompassing their reliable presence, reassurance, listening, and empathy for the Veteran. The spouse/partner's commitment, and continued reassurance of it, offered a foundation of security for the Veteran that enabled a positive course of healing: "It feels like the stakes are higher, you know? Like, this person's depending on you and you depend on them so it's not, I guess it's not all about you, it's about just you as a couple." Reinforced commitment was especially important early in healing where the Veteran's

self-esteem/self-worth had decreased. Moreover, as spouses/partners came to understand the Veteran's functional capacities and limitations as a result of the OSI, they more easily empathized and accepted him, which reinforced their commitment: "And that is basically the journey that we're on now. Knowing that this is who he is now. And he has good days and he has bad days."

Overall, the spousal support process for CAF Veteran couples was largely portrayed as a continuous cycling through the caregiving, managing and cultivating roles over the course of healing. The word "overlapping" noted previously is important because these roles appeared to be relatively fluid and interchangeable. Specifically, all three roles were enacted as needed throughout healing in a non-linear fashion, rather than a linear, mutually exclusive trajectory. However, there was a loose progression from caregiver, to manager, to cultivator as each role marked, to a certain extent, a degree of healing where the caregiver and manager roles were more frequently enacted earlier in healing and the cultivator role became more salient later in healing.

Caregiver. The caregiver role is marked by the spouse/partner providing instrumental support to the Veteran, in the form of tangible aid, in order to assist with basic needs. Although this role was largely assumed while the Veteran's functional capacity was lowest, spouses/partners described themselves as caregivers over the course of healing to varying degrees. For example, as the Veteran's healing progressed, functional capacity did not return to all areas of life simultaneously, and some spouses/partners described temporary regressions in progress. The caregiver role was particularly prolonged in cases where the Veteran also had physical injuries, which compounded the OSI: "And when his back and that flares up, I have to wash him and

dress him. I have to make all the meals." Therefore, spouses/partners assumed the caregiving role over the course of healing, accordingly, to meet functional gaps.

Assisting with basic needs. Spouses/partners depicted instrumental support within the caregiving role as instances of assisting the Veteran with basic, everyday needs, including cooking, cleaning, dressing, driving him to and attending medical appointments, and monitoring the Veteran's medications.

> We're talking like very basic needs at some point where, you know, they're not getting out of bed and they haven't showered and they haven't brushed their teeth in a week and they haven't taken their meds and they're not going to appointments.

Many spouses/partners remarked that they assumed a caregiver role out of necessity and less out of desire: "Part of me felt like I kinda had to like always make sure I took care of everything to take care of him."

Relational role. Spouses/partners often paired their caregiving role with a perceived regression in the couple relationship where interactions resembled that of parent-child relationship (i.e., spouse/partner as parent; Veteran as child) rather than a partner relationship: "I was definitely a caregiver…my role as a traditional partner/wife/spouse was no longer. I was providing primary care for him for a long time." As such, in order to regain family stability, spouses/partners assumed much of the Veteran's family roles and responsibilities to compensate for the Veteran's diminished functional capacity. For example, similar to a parent, spouses/partners often felt compelled to shield the Veteran from additional stress early on in the healing process, leading them to address household issues on their own that they had previously handled

together: “I’ve kind of over the last many years tried to protect him and not, maybe not have him as tuned in to, you know, if there are problems in the kids’ lives or about the finances.” Most spouses/partners expressed they became totally consumed by this role, similar to a new parent, leading to social isolation in many cases because of the intensity. In turn, this contributed to an ambiguous sense of self for spouses/partners outside of their supportive role.

> You’re stuck playing nurse maid or mother 24-7 for someone who is supposed to be your partner, not your kid...like your spouse has evolved into your child…because you know when you first have a baby, you’re at home more and you’re more worried about it, you lose sleep. You know, you end up in your own little bubble and that’s kind of what happens is that you end up, because you’re doing the care and you’re so overwhelmed with trying to handle all their problems as well as run a house on your own, that you end up in your own bubble. And you end up losing perspective with anything around you.

Manager. This role characterizes how spouses/partners’ provide informational and instrumental support to the Veteran by organizing, overseeing and offering advice for completing daily tasks (informational support), mediating and advocating (instrumental support) on behalf of the Veteran. The manager role depicts how spouses/partners delegated familial tasks rather than assuming all of them on their own as with the caregiver role.

Organizing and overseeing. Spouses/partners exemplified their provision of informational support as giving the Veteran directions and advice for undertaking a task,

but allowing him to complete it on his own, always with the understanding that they could check in with the spouse/partner if needed.

> What I've done with letting him stay at the cottage by himself, I go up with groceries. I set things up. I show him where I've put things and then phone him and say, 'What are you having for supper this evening?' And sometimes he'll call and say, 'What do I do with ___?' So we'll discuss different ideas he can do with ___.

Spouses/partners delegated small tasks back to the Veteran through their managerial role, such as cooking meals, doing laundry and paying bills. The type of task matched the level of capacity that the spouse/partner perceived the Veteran had on any given day. Some spouses/partners described making lists for the Veteran and overseeing the completion of daily or weekly tasks.

> So lists are very important at home because I find for me to tell my husband, you know, he asks me what needs to be done, I've decided on Sunday night, I make a list of what I'd like to accomplish this week. So then if he's home, he doesn't feel overbearen by I expect him to do this". He knows this is what I would like to achieve this week. So then maybe there's one thing on the list he can do that can lighten the burden on me. So he'll do it. So it's not asking him to definitely do a task, but knowing that there's something there that is a task, if he really does want to help me, he can do so by such things.

One spouse/partner articulated that, similar to a child reaching a certain age, she recognized the Veteran was well enough to re-gain some responsibility, but also recognized he still needed her guidance:

> It's like training a 12-year-old, "Ok, you're big enough now," like I did with the boys, "you're big enough now". Laundry, your whites go here and your dark clothes go here, don't mix the both of them. Do your laundry. This is how much detergent to use.

Advocating. Advocacy comprised a large part of the manager role. Specifically, the spouse/partner advocated on behalf of the Veteran, when he was not well enough to do so on his own, to facilitate access to treatment and/or financial benefits. This largely involved spouses/partners engaging with formal support providers (e.g., VAC case managers, mental health professionals, family physicians) and being involved in VAC appeals tribunals. For example, spouses/partners both attended and prepared for VAC appeals, which meant engaging with formal community supports to gather necessary documentation (e.g., health records). Albeit, spouses/partners explained that they were typically prohibited from directly interacting with formal supports. In one case, the spouse/partner assumed power of attorney for the Veteran because of his deteriorated state of health early in the process, which allowed her direct communication with key formal support providers. In other cases, spouses/partners described laying all the groundwork in preparation for medical appointments and appeal hearings:

> They won't talk to me, so I do all the paperwork. I gather up all the information, I go back through all of our records, and I take notes. I write things out – things that I think they might be asking. Then I tell (Veteran)

> what I found, he reads it over. Then I sit with him, he calls his lawyer because the lawyer will talk to him, which is really frustrating but, I'm on the other phone, so I'm listening. And everything that's going back and forth, I'm taking notes so that when I do go into an appeal, we're armed.

Spouses/partners played an instrumental role in the Veteran's healing by contacting multiple people and institutions on his behalf in order to access formal care. One spouse/partner shared an initial difficulty in accessing a civilian mental health professional while the Veteran was suicidal, so she acted on his behalf to remedy the situation:

> So I got on the phone and I just started calling phone numbers. Literally. I just, military phone numbers. And I got some Major in (location) and I said, "We're in trouble. I'm going to lose him if something doesn't happen and we don't get some help." He said, "Leave it with me. I'll see what I can do."…he got us into the OSI clinic in (location). That man saved my husband's life.

All spouses/partners deemed providing this means of support as challenging but necessary.

> When he came back from Afghanistan, I would say my role would have been as more of an advocate. I'm not sure how soon he would have saw treatment if I hadn't advocated…having someone who advocates when you're not in a place to advocate for yourself can make a huge difference in the type of support that someone reaches out for.

Mediating. In some cases, spouses/partners described mediating interactions between the Veteran and their children as part of the manager role. Whereas in the caregiver role, contact between the Veteran and his children was minimal (as spouses/partners often attempted to shield children from the experience and to reduce stress for the Veteran), contact increased between the Veteran and his children as healing progressed, and spouses/partners mediated their interactions as required: "I felt I was constantly playing referee between my husband and my daughter."

> I've been a mediator between him and the kids for many years…a lot of times I was an interrupter…and I've been the, you know, the in between to say, "Ok, you settle yourself down, you settle yourself down…you've gotta come together and have a civil conversation".

In some cases, spouses/partners mediated between the Veteran and his mental health professional in order to maintain treatment engagement. For example, one spouse/partner accompanied the Veteran to his appointment because he wished to terminate his treatment sessions and he could not voice this desire on his own. Instead, by attending the appointment, the spouse/partner provided key information that led to a PTSD diagnosis by the mental health professional. She believed that if she had not participated in the session, the diagnosis would have been missed and important treatment might not have been implemented:

> He asked me to come to the appointment with him, which I did. And I'm like the mouthpiece for him. He has a lot of trouble with confrontation and speaking up…his intention at that appointment was to tell her, "I don't

> want to see you anymore." That was what I was there for. Because, like I say, I'm the mouthpiece. And he was just sitting in the corner like a little whipped puppy. And I don't know what would have happened if she hadn't realized that his, like that they had missed that diagnosis.

Relational role. Spouses/partners interactions with the Veteran within the manager role were still largely akin to a parent-child relationship. However, couples started to shift from a parent-child relationship back to partnering as the Veteran began to re-assume some familial roles and responsibilities matching his increasing functional capacity. The parent-child interaction was still portrayed as an unequal power dynamic apparent in the directive nature of the manager role and how spouses/partners felt they needed to either lead or hold space for relational communication to occur, despite the Veteran's healing progress. For example, one spouse/partner stated that, even if she had a challenging day, when the Veteran was making an effort to share something with her, she always ensured she was open to receiving it as she perceived this as beneficial to the Veteran's healing:

> Depending on where I'm at, if I've got a whole junkyard kind of stuff that I didn't want to deal with…then the one time when he's going to come and, you know, meet the need, it's like am I going to be open to it or am I going to go back, you know? So it's being open to being mindful to it because if I negate that, then I lose everything again and we're starting from scratch. So again, it's that parenting role that you have.

Cultivator. The cultivator role emerged from spouses/partners' accounts as their provision of appraisal support to the Veteran by way of intentional efforts to re-build the

Veteran's sense of autonomy. Spouses/partners accomplished this by bolstering the Veteran's self-esteem and fostering his (re)independence from relying heavily on the spouse/partner for everything: "I can't be my husband's keeper, this is his journey and this is his life." Perhaps most distinguishing from the other roles, spouses/partners portrayed their provision of support in the cultivator role as active attempts to keep "moving forward" and to take the Veteran's healing to the "next level" As such, spouses/partners largely enacted the cultivator role later in the course of healing once a degree of stability was re-established in the family system. However, the cultivator role was not solely enacted during later stages of healing as spouses/partners voiced their attempts to increase the Veteran's self-esteem throughout the course of healing.

Notably, spouses/partners efforts to foster the Veteran's autonomy did not denote he had regained his pre-injury quality of life: "He's not 100% well, he has his good days and his bad days, but he's still part of the family and he can still contribute to the family." Rather, the cultivator role captured spouses/partners' striving to continually move forward personally and relationally by simultaneously accepting the present and aiming for incremental improvement in the future. By the time the cultivator role became regularly enacted, all spouses/partners believed the Veteran and the couple relationship were, ultimately, in "a good place" and they were capable of reaching an "even better place": "It's like we're moving forward. This is where we are now and we're both committed to working on it."

Boosting self-esteem. As previously noted, most spouses/partners shared that the Veteran's self-esteem had diminished early in the healing process, and all spouses/partners perceived that re-instilling it was a necessary step in healing. This theme

persisted as healing progressed and spouses/partners depicted continuously fostering the Veteran's self-esteem over the course of healing. To this end, spouses/partners intentionally attempted to bolster the Veteran's self-esteem by praising and recognizing any efforts and actions perceived as positive steps toward healing: "If he does something over the top then I make a big deal out of it." Further, some believed that without mirroring and validating the Veteran's efforts toward healing, that progress would plateau restricting further healing.

> And it's still kind of a parenting kind of thing where you're in it. It's like, 'Oh my gosh, thank you so much for doing that, I really appreciate it, I look forward to you doing it again.' So it's building up that inner self-esteem that they've lost.

Fostering independence. As the Veteran's healing progressed, spouses/partners perceived that he was capable of and would benefit from reclaiming his sense of autonomy: "We have to allow them to take responsibility for their own healing and well-being." Spouses/partners urged the Veteran to try accomplishing things on his own prior to seeking advice on how to do so, and they provided less guidance for the Veteran to complete tasks as his functional capacity increased: "Whenever he puts something forth, I try not to be the wet blanket. I try to make it happen so that I'm supporting him in the steps that he's taking to do that."

Encouraging the Veteran to structure, perform and make decisions about his daily activities more independently sometimes involved the spouse/partner reminding him that he was capable of doing certain things on his own: "So I said, 'No, [Veteran's name], that's just lazy.' (chuckles) I'm trying to turn it around as, it's not because you *can't* do

the things, you're just being lazy now." One spouse/partner shared that the Veteran had achieved enough healing to independently spend time at their cottage and take care of his basic needs without the spouse/partner. However, she explained that when he returned home, the Veteran would often revert back to relying on the spouse/partner for support in basic tasks. Rather than obliging the Veteran, as she would have earlier in the healing process because of the Veteran's diminished capacity, the spouse/partner instead reminded the Veteran that he was capable of accomplishing these tasks on his own now:

> I find that when he comes back here he reverts back and I have to remind him now and then. Like he came down the other day and stayed for two days when I was sick and he said, "I'm starved, I could use some lunch." And I go, I bet you're hungry, you haven't eaten all day. There's the fridge. Your whole wheat bread's over there. There's tomatoes and everything in there. Now help yourself.

Relational role. Spouses/partners described actively seeking opportunities to grow as a couple as part of the cultivator role, and spousal support aimed at fostering the Veteran's autonomy matched the couple's relational progress toward re-partnering. That is, family roles and responsibilities became increasingly equally distributed within the couple relationship as the Veteran became more self-sufficient and many spouses/partners depicted returning to a more egalitarian relational power dynamic compared to the caregiving and managerial roles. One spouse/partner described how relinquishing and returning some family responsibilities back to the Veteran as he healed was a positive healing element for their relationship:

> I've kind of over the last many years tried to protect him and not, maybe not have him tuned into, you know, if there are problems in the kids' lives or, like I said, about the finances. I don't want to bring more stress to him than what he already has, but I need to not baby him as much. Maybe giving him something to think about other than himself, that's not always a bad thing.

Reciprocity emerged as a key factor in re-partnering, which paralleled the Veteran's increasing functional capacity. For example, one spouse/partner shared how the Veteran surprised her with special plans to celebrate their anniversary, which made her feel like she was regaining her partner:

> He always used to count on me to make arrangements for everything. I don't know if it's just "a guy thing" or what, but like making plans for dinner, you made the plan kind of thing. And we had our anniversary, was in [month] actually, and we were 19 years married. He had actually made the plan, arranged to get a sitter, and took me out to dinner. That was like a pretty big deal.

The extent of reciprocity varied between spouses/partners' accounts. For some, reciprocity was only beginning to re-emerge in their relationship. For others, spouses/partners recounted that the Veteran was able to provide some support back to them, reflecting more egalitarian dyadic interactions as healing progressed: "Even though I'm supporting him, he's supporting me just as much. The support, it goes both ways." Another spouse/partner shared how she perceived the Veteran was ready to move forward

and she helped cultivate positive change for them as a couple by attempting to re-foster reciprocity in their relationship:

> You know we want quality. We want conversation. We want healthy debating and we don't always want to be right. We just want to know that, you know, there is a difference in opinion and that's ok. Don't tell me what I want to hear. Tell me what you feel and what you want to hear. It's a fine balancing act. It's just helping them switch that kind of focus in the brain.

Coinciding with progress toward re-partnering, several spouses/partners described how the Veteran had reached enough healing to resume a stronger parenting role. Furthermore, many believed that, as healing progressed, mediating between the Veteran and his children had become more of a hindrance than a help to their relationship. As such, the cultivator role involved the spouse/partner mediating less between the Veteran and children, in favor of allowing them to work out their own conflicts. One spouse/partner exemplified this by sharing her story of her first trip away from home since the injury where the Veteran had to take the lead parenting role. She also described her hesitation in doing so, but recognized the importance of this step for relational healing as well as the Veteran's personal healing:

> Instead of me saying, 'Well, no, this is what she's going to wear on Friday, and this is what she's going to wear Saturday, and this is what she's going to wear Sunday. And you have this for supper on Friday and this for supper on ___', I just left everything to him. It was an awesome thing because he made plans.

Theme 2b: Formal supports as channels for healing. Formal support resources reflected care provided to the Veteran, the spouse/partner, and the couple by government and non-government (e.g., not-for-profit support groups and centers) establishments at the community level. Here, the Veterans and the spouses/partners sought PTSD support and treatment through health professionals (e.g., psychologists, social workers, family doctors, OSI clinics, VAC case managers) and peer support groups for Veterans and their families living with PTSD. Often, couples participated conjointly with these supports (e.g., couple's counselling) and some of the programs were tailored specifically for couple engagement.

Couple engagement in PTSD treatment. Most spouses/partners attended at least one treatment session with the Veteran: "I always have to go to the first appointment because he just sits there. He doesn't offer up any information about himself. So, like I say, he's there but I'm the one doing all the talking." Spouses/partners were able to provide intricate details about the experience because of their complex involvement in the situation. Some shared that direct communication with the Veteran's mental health professional was important, at least early in the process, to ensure important details were not missed or glossed over by the Veteran, and for enabling transparency as a couple. Spouses/partners often clarified or added new insight into the Veteran's account or spoke on his behalf when he had difficulty expressing himself.

> …you can sit there and ask him questions and my mind will be turning going, 'Ok, now you can tell them', and he'll go, "No, everything's fine. No, I'm ok. This is good."…and I'm going, "What? You had the

> opportunity to tell them these issues". And, no, he can't see beyond that moment. And so that's when I started stepping in…

In some cases, spouses/partners described joint involvement in treatment sessions as a means of holding the Veteran accountable for his statements: "He was always open to a certain degree to getting support but once they get into a counsellor's office then they tell them what they want them to hear, not what needs to be said." Spouses/partners deemed this important for enhancing the treatment regimen: "The professionals do need verification that what the former members are telling them and the Veterans are telling them are actually what's going on. So sometimes it's, 'Ok, so what's the other side of the story?" In other cases, joint treatment, such as through couples counselling, was helpful for improving relational functioning as spouses/partners become educated on living with PTSD, generally, and learning useful strategies for managing challenges together, specifically.

> It added to my education about what was going on. It added to my skills, rather than just him going and me filling in what was going on with that…the step that I was involved in is probably the stuff that was really effective for our relationship because then everybody's on board. Everybody knows what the situation is and what skills the other person has so, I don't mean to sound harsh, but there are no excuses, right?

One spouse/partner shared how attending treatment sessions conjointly shaped how they viewed emotional reactions associated with PTSD symptoms and, subsequently, improved their collaborative problem solving skills:

> I know a lot of people tend to say, you know, they use the word "trigger" a lot and "being triggered" and I try not to use that word. Because, for me, it seems almost in a negative connotation because it's taking somebody back to reliving their trauma. They're triggered by something that brings them back to that live altering event. Um, actually [anonymous] uses the word "reminders" versus using the word "triggering". And I really like that because if you believe that you can become well, or achieve a better place of wellness throughout a trauma, is it really a trigger or is it a reminder?

Some spouses/partners explained how engaging in couples counselling, as part of PTSD treatment, provided a "safe environment" for them to broach difficult conversations, which was also beneficial for the spouse/partner to have her "voice be heard". Moreover, some spouses/partners believed that engaging in treatment together solidified for the Veteran their commitment to him and their relationship: "We probably spent the greater four weeks of our marriage counselling, when we went to marriage counselling, of him realizing that no matter what happened, I was here for the long haul." However, a few spouses/partners noted that they were cognizant of the Veteran's emotional safety in sharing details in front of them, particularly early on, and they continually gauged his comfort. In at least one case, the spouse/partner removed herself from the session because she felt it was too much for her partner at that time:

> She immediately started asking me very heavy, personal questions with him sitting right there and I just said, I think it's time for me to go, I can't answer those questions". I knew the things I had to say to her, I couldn't

> say it with him sitting right there because i knew it would bother him. So I thought, "No, don't put me on the spot like that".

Couple engagement in community programs. Beyond engaging in formal PTSD treatment or couples counselling together, several spouses/partners noted they had participated in community support programs that were designed for couple engagement while living with an OSI. These types of programs were valuable resources for learning how to manage a range of issues associated with PTSD. As with couple engagement in PTSD treatment, conjointly attending community programs enabled transparency and accountability in the relationship so that they continued to work together toward a common goal: "It keeps you accountable and it's supporting us through the everyday stuff that's coming up and challenging us to use those communication skills that we used to have." As exemplified by one spouse/partner, couples learned dyadic skills through their engagement in formal support programs, which became a routine part of their relationship. In turn, this reinforced their co-commitment to the relationship:

> The worse that he got, the more, I guess, reactionary I became until we got into a pattern where I'd just, you know, react, he'd shut down. But I think through participating in [couple's support program]…we're learning to communicate…we're communicating in a much better way. And I'm not thinking we're going to go back to where we were. It's like we're moving forward.

Support for spouse/partner. Spouses/partners' narratives largely captured the care they provided to the Veteran; however, accessing care for themselves was a key factor in maintaining the spousal support process. In fact, all spouses/partners engaged in some

type of formal support at the community level (e.g., peer support groups, mental health professionals), often through multiple channels (e.g., psychologists/psychiatrists and social workers both in private practice, at OSI clinics, or on military bases), which they described as a fundamental part of their self-care regime. For example, several spouses/partners expressed value in working with their own mental health professional, separate from the Veteran, as part of their self-care routine. This engagement not only taught them personal stress management strategies, but also underscored the importance of taking care of themselves for positive family functioning.

> It's only just in the last year that [mental health professional]'s been working with me and encouraging me to do things myself that don't revolve around [Veteran]. Because I worry like a huge amount about what's happening to him when I'm not watching him….I think that a lot of the changes that I've been trying to make with myself I certainly attribute those to [mental health professional]. Without her help, I would never have thought of a lot of the things that have changed [in the family] in the last year, year and a half.

Learning to ask for help was part of the self-care process for several spouses/partners. It was particularly challenging for those who viewed themselves as "the helper" not the one needing to be helped. Spouses/partners echoed that formal supports, particularly peer support groups, emphasized that even "the helper" deserves and requires support from time to time and, without it, the spousal support process would be less likely to be successful.

> It helped, I find that it's helping you to look at it from a different perspective and also look at yourself as a number one person to take care of. And I know I had never been doing that because it was always about him and what he needed and what I had to do day-to-day.

Regular engagement with formal support groups also served as a constant reminder for spouses/partners to continue practicing self-care.

> …even when I'm not there it makes me mindful of it, is they always end every meeting with going around the room, um, with, 'What are you going to do this week for self-care for yourself?' And it reminds me that, even if there's a week if I'm not there, and I look back and say, 'Ok, what did I do this week for [spouse/partner]?'

Spouses/partners commonly believed that others who were not living the same experience (i.e., living with an OSI), especially outside of a military context, could not adequately relate to their experience. This made peer support groups tailored specifically to military families living with PTSD and other OSIs particularly rich sources of emotional support for spouses/partners. They described feeling a sense of empathy, acceptance, and belonging by attending, and listening to other military spouses/partners' stories made them feel like they were not going through the experience alone. For example, one spouse/partner stated,

> What I gained most of the, of my peace of mind I guess, was knowing there was somebody that understood and there was someone else who was or had gone through the same thing as me…I mean it doesn't matter that

> the situation wasn't exactly the same. It's like sitting in the same room with someone who speaks your language, right?

Similarly, another spouses/partner explained,

> As you got to know the ladies and heard people's stories, all of a sudden there was not the shame attached. And there were people who understood. There were people with the same lived experiences. All of a sudden you had a little community of people and I belonged. And I didn't have to hide. I didn't have to make excuses. And without having to go into a lot of detail, people got it. And that's the word I use, you know, they get it, they get it. When you walk that walk, you get it…being able to sit in that group and speak your truth and not be judged. Be a part of people who understood was huge.

Further, friendships were formed by attending military family oriented peer support groups, and other attendees often became sources of informal support for the spouses/partners outside of the formal group. This was particularly beneficial for those who had lost military-connected friends when the Veteran released or in the early phases of healing as it helped relieve their sense of social loss and/or social isolation.

> When you're in the military, your military community becomes kind of like, you know, that's your, they become your friends and that becomes your family life. And I had went through a sense of loss when he was getting, it wasn't just him getting discharged, I was hurting too because the military life was all I've known. All my friends are military. What am I going to do? As much as it was a sense of loss for him, for his job, it was

> a sense of loss of my community for me. And then so when I got involved with [peer support group], what I loved so much about the program is I found another family.

Two spouses/partners were also service providers within the CAF Veteran Community and they noted that co-workers were a trusted source of support for them because they had an understanding of the military lifestyle and OSIs.

In a few cases, spouses/partners received informal support from other family members. For example, one spouse/partner's adult son supported her as she managed her own health issues concurrently with the Veteran's OSI. However, extended family was relatively de-emphasized in spouses/partners' narratives. In fact, a few spouses/partners had either lost or perceived reduced connections with extended family due to PTSD stigma. Other times, spouses/partners expressed that they were not close with extended family prior to the injury, so this was not an option for support.

Formal support access/availability issues. Although the importance of formal support was highlighted by all spouses/partners, many of them voiced concerns related to access and availability. Quality of care emerged as one access/availability issue as some spouses/partners described inconsistencies in the amount of support they received across different formal support professionals. One spouse/partner exemplified this in describing how the quality of formal support services shifted when they moved to a different geographical location:

> The girl that was supposed to be his rep from VAC never ever contacted him when we were in [city]. We used to call and call and call and call but we never got any answers back and when we moved from [city] into

> [city], we got a phone call one day at Veterans Affairs and she said, "I am now your case worker." And I said, "Wow, what a nice option here. A case worker." And she came right out and visited us and took it from there.

Another common issue voiced was a gap in care continuity post-release where a lengthy period of time passed before formal support programs/services were available. For example, some had difficulty accessing formal support in the civilian context due to long wait lists for family physicians who could refer them to mental health professionals. In contrast, one spouse/partner, whose Veteran served in the reserves, expressed the benefit of already having a civilian family doctor prior to her husband's CAF release. This enabled them to be referred to a mental health professional quickly, which facilitated treatment access. In other cases, health care professionals in the civilian context dismissed the Veterans' symptoms. Spouses/partners articulated this as one of the most stressful aspects of the healing process – they suspected there was a health issue with their husband, but could not access specialized treatment without a health care professional recognizing the urgency of the symptoms. Some voiced that, even if a health care professional recognized the symptoms suggested PTSD, not all health professionals "believed" in this diagnosis as one spouse/partner shared: "…and their [health care professional] attitudes as well, right? Whether they believe that this is actually an illness. They may be educated in it but do they believe it?"

The burden of care was reduced for spouses/partners following the Veteran's formal PTSD diagnosis as more treatment and support options became available: "He got a case manager through Veterans Affairs. Who, I mean, all of a sudden there was

someone there to facilitate all the ins and outs." However, several spouses/partners expressed that it was a lengthy, complex process involving many appeals to VAC decisions before the PTSD diagnosis was officially documented. Sometimes, it was a matter of qualifying for a certain release category or an certain disability percentage in order to secure financial benefits and this often created another layer of stress for the couples: "He needs to be at 100, he wants to be at 100% because [Veteran] is terrified that if something happens to him, I will be [financially] left without."

Spouses/partners echoed that it would be beneficial to have more resources available directly for family members living this experience, rather than most of them being indirectly available through the Veteran. Some voiced how currently available resources do not adequately match the level of intensity that spouses/partners experience on a daily basis while living with PTSD. Consequently, they expressed that a more tangible recognition, by way of advancing programs/services specifically for family members living with OSIs, would better meet the task.

> For families as a whole, I don't think that they're still recognized at all. And for most of these Veterans, I'd say they could, you know, thank their families. And it would thank their families for sticking by them and getting them to the point where they are, that without their families they may not even be here. Some are alive because they have a family, so it's a pretty important role.

Spouses/partners believed accessing formal supports made such a difference in the spousal support process, that several voiced concern for other spouses/partners living

with PTSD who either were not aware of available programs or who had difficulty accessing them.

Theme 2c: Adaptive processes arise from the informal-formal support network. As couples engaged with formal supports, they learned and applied adaptive coping strategies applicable to living with PTSD within the spousal support system. There were some accounts of adaptive processes at both individual and dyadic levels having been in place before the OSI, but they became increasingly developed, intentional and routine as spouses/partners participated in formal support programs/services both by themselves and with the Veteran. The informal-formal interdependence was discernable as spouses/partners recounted that adaptive processes became part of their caregiving, managing and cultivating roles, which, in turn, helped sustain the spousal support process and encouraged overall healing. Adaptive processes at individual and dyadic levels appeared to work in tandem, reinforcing each other and continually moving the spousal support process forward.

Individual processes. Three adaptive processes within spouses/partners emerged from their narratives: *determination*, *positive outlook,* and *self-care*. Determination presented as perseverance to move forward and stay committed to the relationship despite challenges and setbacks: "I wouldn't give up on him. I wouldn't give up on us. And I wasn't going to give up on myself." Positive outlook encompassed perspectives of hope and strength, which propelled the spousal support process forward.

> I'm strong and I'm a fighter. But the only reason I am is because I always look at the only thing I can control in all situations is my attitude. And if

> you can control your attitude towards anything, the outcome of what that's going to be is basically positive or negative depending on yourself.

All spouses/partners engaged in self-care practices, which many identified as their most beneficial personal resource. This made self-care a priority for most spouses/partners leading to firm boundaries around their practices that were rarely compromised. In fact, one spouse/partner described her self-care time as so valuable that she marked it on her calendar so that she would never miss it:

> It goes on the calendar so I know it happens. So pencil yourself in. Make time for you ahead of time. Like, don't wait till, "Oh I think this week I'd like to go for a facial," call on Monday and expect to get in. Make it priority and stick to it like it's something on the schedule. Because most of us who have schedules will stick to our schedule. So pencil yourself in. Pencil yourself in the opportunity to take time out for you.

Spouses/partners engaged in a variety of activities for self-care unique to their particular interests and lifestyle such as engaging in hobbies, spirituality/religiosity and volunteering. Although modes of self-care varied between spouses/partners, they all emphasized that this was time separate and apart from the Veteran, even if it was just spending time alone. They recounted that self-care time provided an outlet and temporary distance from stress related to the OSI, which enabled them to develop a piece of self-identity separate and apart from their supportive role. One spouse/partner described how her self-care time enabled her to re-group and re-charge, which, in turn, strengthened her determination and positive outlook:

> When you get that outside socialization and stimulation and have some fun and, you know, you're a better person when you come back as opposed to staying in the situation at the time. And you take on those negative traits and, you know, nothing seems rosy anymore. Get out and see the sunshine once in awhile and bring it back.

One spouse/partner exemplified how she learned the value of self-care through engaging with formal supports, which enhanced her informal provision of support and benefited the couple relationship:

> I have learned myself through [formal support program], like again, I can't give the program enough credit, that I need to take care of me. Because if don't take care of me, I'm no good to my daughter, and I'm definitely no good to him [Veteran]. And I think having a better understanding and knowing that I don't stand alone and that there's other women who are going through the same thing and who are feeling the same thing, it has affected finding our way back.

Dyadic processes. Spouses/partners discussed how they communicated, problem solved, and spent time together as a couple to help manage day-to-day challenges and maintain their relationship. Three adaptive dyadic processes emerged from spouses/partners accounts, which underpinned these relational acts: *mutuality*, *flexibility* and *openness*. Mutuality characterized the "dyadic" piece of adaptive processes by fostering a sense of connectedness and joint effort, even if levels of effort were not always equal. For example, one spouse/partner exemplified mutuality by stating, "We are a team and we're in this together." Spouses/partners demonstrated flexibility in their

relational interactions through a willingness to change expectations, boundaries and roles as circumstances changed day-to-day over time. Spouses/partners articulated flexibility as "ebb and flow" and "give and take", rather than adhering to a rigid set of patterns, which they believed would hinder rather than help healing. Openness emerged in spouses/partners accounts as awareness, preparation, and willingness to address challenges as they arose: "I've had to let stuff go. Not that I wasn't understanding before, but I have to be understanding on a different level." Collectively, these dyadic processes became interwoven into couples' communication, problem solving and time spent together to provide concrete relational strategies used to navigate the PTSD healing process together.

Communication. Incorporating mutuality, openness, and flexibility into couples' communication with each other enabled instances of *open emotional expression, trust,* and *courage*. One spouse/partner portrayed this in her description of how her and the Veteran discussed a topic that was previously difficult to broach:

> And instead of being worried about it and not talking about it, we talked about it before he came home. And we wouldn't have done that before. I would have just worried about it and been defensive and been anxious about it and then we would have fought, right?

Mutuality appeared in couples' communication as a shared willingness to converse for a common purpose: the maintenance of the relationship. For example, one spouse/partner noted they were "on the same page" and "speaking the same language about the whole thing". *Open* communication was fostered by replacing judgement with acceptance, despite being described as a challenging task. This created an atmosphere that felt safe to

express and receive without judgement, as one spouse/partner depicted: “We’re left and right. We really are. And so for him to come just a little bit to the left to listen is a big deal. And he wouldn’t have been able to do that before.”

Many spouses/partners shared how their communication patterns had changed throughout the healing process in ways that demonstrated joint effort (mutuality), open expression and flexibility. As one spouse/partner articulated, flexible communication involved continually shifting to meet the current capacities of the Veteran and the relationship itself: “…and communication changes from diagnosis through treatment through after, so the way you communicate has to ebb and flow and change because you’re growing.” Another spouse/partner exemplified how spouses/partners learned to apply flexible boundaries to their communication by knowing when to give the Veteran space and knowing when was a good time to have a discussion:

> And there are times that I’ve learned also when he’s in a moment and I can tell that he’s having something triggering his mind, that I just don’t push it. I let him be. And then later, when he’s back to where I need him to be, or where he should be, I’ll go, ‘Is there anything you want to talk about?’…and I find by not forcing, but knowing that I see it, and by telling him that it’s, ‘If you want to share, it’s ok. If you don’t want to share, you don’t have to,” I find he’s become more open with me.

Overall, it was the *way* that couples’ changed how they conversed that characterized their evolving trust and courage to speak openly with one another, which highlighted an adaptive aspect of their communication.

> And he's learned how to read himself a little better and he'll turn to me and go, 'I'm sorry, I didn't mean to blow up at you like that.' It used to go on and on like half the day but now he catches himself more, tries to think it out with what little he can do of that and then he'll apologize and say, 'No, I was wrong.' And he's never one to admit he's wrong.

Problem solving. Superimposing the qualities of mutuality, openness and flexibility to problem solving, couples engaged in *collaborative problem solving* that moved away from a reactionary stance to a more solution-focused stance: "I've kind of learned, myself, not to react. Have less reaction to it and more about listening to it." Couples collaboratively problem solved by proactively working together toward a common goal with courage, honesty and trust: "We just put it out there. Like there's no hesitation. No, 'Ok, this is yours.' Out there. It gets dealt with and we problem solve." Communication was inherently part of couples' problem solving and, similar to how couples communicated, part of collaborative problem solving involved spouses/partners being aware of good times to engage rather than needing to resolve an issue immediately when emotions were intense, as the following example shows:

> I mean I'm still wary, not wary, but I'm still conscious of when a good time is to approach and have a conversation or ask him, "Is such and such a, is it a good time to have a conversation?" Or, "Let's set a time. I think this is something that we need to talk about," we do that. Whereas before I would have been so nerved up to even bring up the topic for fear of the reaction and most likely the explosion. And things just didn't seem to get dealt with before.

Couples' collaborative problem solving comprised reciprocal exchanges of patience and compromise: "And it's good because I find we're meeting halfway. And it's hard to get there. And some days are harder than other days, you know?" Several spouses/partners articulated that instances of mutuality/reciprocity in problem solving "made the difference" for them as a couple, which helped them move forward in a positive direction. However, one spouse/partner explained that regaining reciprocity in the relationship took patience and encouragement over time to re-develop it as the Veteran healed:

> You have to be your own cheerleader while you're being everybody else's cheerleader is kind of how it works within the relationship until they reach a point where they're able to reciprocate that. And it comes in small doses. But you have to be mindful to recognize it when it happens and celebrate it for that.

Mutuality in problem solving fostered a sense of connectedness and joint effort that helped couples persevere through challenges together, which, in turn, reinforced their commitment to the relationship: "We're both committed to working on it and we're both still showing up for the sessions with [support group] so I mean, to me that shows we're both still committed to working on it." Moreover, spouses/partners often voiced that commitment was a conscious choice, and this commitment was not perceived as one sided.

> I know that he lives with regret and for what he's put me through, what he feels that he's put me through. And I respect that coming from him but I'm

> also mindful to say to him, "you know I made a choice. And you know I could have left anytime, and so could have you"

Many spouses/partners discussed how they had developed a system for managing emotional triggers, associated with PTSD symptoms, as part of collaborative problem solving. This often consisted of the spouse/partner offering cues or distraction when they anticipated or noticed a potentially stressful situation for the Veteran. This enabled the Veteran to stay present, and reduced instances of becoming overwhelmed by a stress reaction. For example, one spouse/partner expressed, "You have to steer his mind," while explaining how she distracted the Veteran through conversation as they drove across bridges because he was afraid and the Veteran had previously experienced strong emotional reactions in doing so since the OSI. Collaboration in problem solving sometimes emerged as a simple act of taking responsibility for relational interactions that led to an emotional reaction as one spouse/partner shared: "He's learned now to read himself a little better and he'll turn to me and go, 'I'm sorry, I didn't mean to blow up at you like that.'" Emotional reactions were diffused most effectively when the spouse/partner offered flexible boundaries (i.e., giving space or being present, as needed), understanding and patience. Several spouse/partners described how they approached community engagement as a couple differently post-OSI for special outings (e.g., seeing a movie) and daily tasks (e.g., grocery shopping).

> We still don't go to a movie theatre on opening night. You know, why would we do that? You know? I mean I don't need to see a movie that bad to subject myself to all of the stressors that go with that for us. Whereas, you know, we'll go two or three weeks once it's already been played. And then go on a night that nobody

> really goes. And, you know, get there a half an hour early so we can get the back row and find our seats and sit comfortably. You know those kind of things.

As couples learned how to safely negotiate public settings, through implementing strategies that worked for them in different environments, this marked a shift away from complete social avoidance toward a degree of social engagement outside of the home. Successful stressor management involved advance preparation (e.g., planning for how to handle potentially triggering situations) that included a respect for functional boundaries. As one spouse/partner shared, sometimes this meant finding quieter days in the week to be in public together: "You know, Costco on Saturday, you just don't do it. Most people don't do it anyway but why would you do it with somebody who's living with, you know, post-traumatic stress? That's just not, it's not fair."

Parenting together, as a form of collaborative problem solving, marked an important part of re-partnering for couples. Spouses/partners that had children living in the home described shifts in how couples parented over the course of healing corresponding to increasing wellness in the Veteran. Namely, as mutuality and reciprocity developed between partners, they learned how to collaborate in this family domain. As previously noted, re-partnering roughly coincided with spouses/partners' cultivator role through a re-allocation of family roles and responsibilities, such as parenting, to the Veteran. One spouse/partner exemplified how collaborative problem solving changed in relation to parenting as her and the Veteran re-established a unified parenting front:

> And me letting them work, him and my daughter especially, letting them work their battles out…and if Daddy said, 'No,' then it's kind of like

> bringing back to being on the same page again. Because she would come to me and say, 'Well, Daddy said I had to ask you,' because I was making all the decisions and 95% of the time she was coming to me because he would just say, 'Ask your mother.'…I told him, 'If you make a decision about, you know, like she's not doing something, then I need to know that she's not doing something,' instead of her trying to come to me and manipulate saying, 'Well Mommy can I do this?' not knowing that she already asked Daddy and that he said, 'No.'…getting on that same wavelength. Now, like, when she comes to me and I'll say to her, 'Did you ask Daddy?'…'And what did Daddy say?' 'Well Daddy said no,' 'Then you've got your answer, you don't need to ask me.

Spending time together. Couples often blended adaptive strategies to manage stressors. For example, effective communication skills were incorporated into couples' problem solving strategies. In turn, it appeared that having these two in place subsequently facilitated couples' ability to spend time together, both in private and public settings. Spouses/partners expressed the importance of taking time with the Veteran as a couple.

Couples spent time together in a variety of ways, unique to their lifestyle, such as going to the movies, taking trips, attending church and partaking in recreational activities. A shift was apparent for many couples where they adjusted and tailored which types of activities they engaged in to match the Veteran's current functional capacities. For example, one spouse/partner shared how the Veteran had difficulty leaving the house in a city environment while he was still learning to manage his PTSD symptoms. This

prompted them to purchase a camp in a country setting where it was less stressful for them to spend time together: “He was too claustrophobic. It was too many, it was too close to other people. So we got him a little camp and I’d go out there and we’d four-wheel together. Because I love being outside.”

Spouses/partners explained how finding ways to spend time with each other as a couple was an important part of reconnecting following the impact that PTSD symptoms had on their relationship (e.g., withdrawal, avoidance, reduced intimacy).

> I mean, sure, I miss the sex, but it’s not always about the sex. Sometimes it’s just about sitting together and like holding his hand and putting my hand on his lap. And that’s been a big reconnection for us.

One spouse/partner described how spending time together was also important for family cohesion:

> Yeah so it’s just going through and it’s finding out what gets you through. Like for our relationship it’s been very important that I make time out for just the two of us. But I equally make time out for us as a family unit because even though it’s my husband’s diagnosis, we’re going through this as a family.

Initially, activities aimed at “couple time” were often implemented by the spouses/partners as a deliberate coping strategy, such as for distraction from day-to-day stressors; however, over time they became an integral part of dyadic adaptation relied upon and enjoyed by both partners. For example, one spouse/partner explained how taking day trips served as a break in their normal routine, so she and the Veteran could

refresh and re-balance. They enjoyed these trips so much that they adopted them as a key way for them to spend time together as a couple:

> We like to just sometimes hop in the car, pack a lunch, hop in the car and just go somewhere. Pick a direction and go for the day and just go with the flow. And that's kind of like a really nice outlet for us.

Although spending time together presented as an adaptive dyadic strategy, some spouses/partners expressed that learning how to do so was still evolving, sometimes through continual trial and error (i.e., flexibility), yet they shared a goal of relational improvement (i.e., mutuality). As one spouse/partner explained, openness was key to facilitating this evolution: "Together activities can still be challenging, but it's a work in progress. And he's [Veteran] taking initiatives to do certain things and that's nice. It's, it's being open to receiving it again is the thing."

Summary of theme 2. The time, effort and value of spousal support portrayed in spouses/partners narratives highlighted them as the foundation of couples' healing at personal and relational levels. All spouses/partners viewed formal support as a significant channel for healing, and engaging with these resources reinforced spousal support. Spouses/partners played a key role in establishing and maintaining the informal-formal relationship by facilitating initial access to the Veteran's PTSD treatment at the community level and reinforcing its continuity at the home level. Despite placing great value on engaging with formal supports, spouses/partners voiced concern about access and availability, such as issues related to inconsistent quality of care, continuity of care, and limited programming for family members.

Spouses/partners became educated on living with PTSD in general, as well as specific options for treatment and financial compensation, by engaging with formal support networks either with the Veteran or on their own. At the dyadic level, couples learned how to partner in new ways as they developed adaptive dyadic processes, a more specific aspect of the spousal support system, alongside their engagement with formal supports. At the personal level, spouses/partners adopted regular self-care routines, now understood as essential for sustaining the spousal support process and for their own psychological well-being. As couples regained stability through the informal-formal support system, they worked toward establishing a "new normal" for family life.

Theme 3: Couples move beyond stability as PTG develops at personal and relational levels through the social support system

As couples' "new normal" was shaped through their informal-formal support network, it became their new baseline (i.e., a new place of family stability different than before the OSI). Notably, couples grew as they moved out of crisis to regain stability; however, growth beyond stability represents how couples developed new personal and relational qualities after they reached the new baseline and positive changes emerged beyond this point.

Spouses/partners generally depicted growth as a sense of moving forward personally and relationally with the Veteran, and their narratives indicated that their experiences of distress and growth were not mutually exclusive. For example, all spouses/partners recounted being in a "good place" at the time of the interview, but recognized there was still room for improvement. Consequently, most stated they were persistently working toward reaching a "better place", even if they did not have a clear

picture of what that resembled: “I think for myself I’ve, I don’t know, I don’t’ want to say that I’m there yet, because I don’t know what ‘there’ looks like.” In addition, all spouses/partners believed that the positive changes they perceived in themselves and their relationship with the Veteran derived from progressing through the negative changes resulting from the OSI: “I think we needed to have kind of the blow outs in order to get to the next level.”

Personal growth. At an intrapersonal level, growth emerged as narratives of positive psychological and social change within spouses/partners’ throughout healing in areas related to their global viewpoint (*transcendence and greater appreciation for life*), relationships with others (*more understanding and compassion for others; greater emphasis on quality of relationships rather than quantity*), and self-concept (*greater sense of personal strength and boundaries).* It is noteworthy that some spouses/partners alluded to personal growth within the Veteran as well; however, without speaking directly to him, I could not draw conclusions about PTG in the Veteran on a personal level. As such, personal growth is portrayed solely as it pertained to the spouse/partner.

Transcendence and greater appreciation for life. This avenue of growth represented positive changes in spouses/partners’ global viewpoint and it denoted how they came to perceive the overall experience of living with PTSD. Often, spouses/partners’ viewpoints reflected transcendence as they came to ascertain the experience as “bigger than them” and living with PTSD was one component of their broader life path. This was exemplified by one spouse/partner stating, “This [living with PTSD] is a journey,” and another explaining, “I think when you’re living your life, you’re

meant to learn and grow. This just happens to be our experience of how we're going through it."

Some spouses/partners who discussed positive changes to their global viewpoint, also made more specific reference to shifts in how they identified with spirituality/religiosity. For example, some described a deepening of their religious beliefs and practices, related to a more traditional religious sector (e.g., attending church regularly, participating in Bible study groups):

> Now we're more like, 'God's in control. God's got this,' you know? And even through the whole process of him going from being dishonorably discharged to getting his medical release, I prayed about it through the whole thing…that was the ground of my foundation.

Whereas others described developing a viewpoint that represented spirituality more broadly:

> I do believe that we all have a path and a learning here on this earth, and post-traumatic stress just happens to be one of the lessons in how we're learning our lesson. I could be with another spouse doing something totally different and learning the exact same lessons but in a totally different way. I look at it that OSIs are just the method with which we're learning the lesson.

Although spirituality and religiosity are not necessarily independent concepts, many spouses/partners made a distinction, remarking how they had become less involved in traditional religious institutions, such as attending church, in favor of what they perceived as a less structured practice, without attachment to a specific religion. For example, one

spouse/partner expressed, “For me, I find that I have probably moved more towards the spiritual belief and value system than religion,” and another spouse/partner echoed, “I mean, I’m not like suddenly going to church and, you know, singing hymns because I’ve actually been moving more away from that. But I’ve become more spiritual…less traditionally religious but more spiritual.”

Spouses/partners’ transcendent viewpoints of living with PTSD also fostered a greater appreciation and gratitude for life and many made a connection between the negative aspects of the healing process, and how positive changes developed from working through these challenging points. As one spouse/partner articulated, this new perspective helped her persevere through the challenges:

> I’m actually grateful for the experience. A horrible thing to have to go through. It absolutely, it caused us hell, but I would not be who I am without it. I think without that perspective, you can drown in it. It would eat you up.

Spouses/partners also voiced a greater appreciation for the Veteran and their relationship with him, as they came to view him in a more positive light.

> We have found such great ways to cope and learn to appreciate each other so much more and are happier together that I wouldn’t want to go back to the way that it was before. So accepting that really isn’t, not that I want him to have PTSD, but that forced us to make the changes and then the good stuff came out of that.

More understanding and compassion for others. As spouses/partners learned how to contend with an OSI, they echoed developing a better recognition of complexities

that others might be facing in their own lives: "Without his illness, his suffering, I wouldn't be who I am today. I'm a more compassionate, empathetic, caring person because of what my husband went through." They often expressed having more patience and openness with people in their day-to-day interactions:

> It's broadened my view of mental illness and what it means in someone's life, what it means for family…it just made me, I guess, more willing to talk to other people and just be open about things that other people, that talking to them may be uncomfortable about…it's just things that happen in life. People are injured in many different ways and they become ill in many different ways and I think it's, that solidified for me.

In addition, they perceived they held less judgement over people's life choices as part of their compassion for other people's life circumstances:

> As humans we're judgmental, so it's difficult to find yourself in that place of, you know, questioning or judging or ridiculing or, you know, that kind of negative place. And I really, I'm more so on the other side where it's about acceptance. And when I say to somebody, 'That's your choice. I don't judge you for making your choice,' because I don't want to be judged for making my choice. And what that looks like for you and your experience and when you're making the best decision you can based on your life experience.

Growth transpired for many spouses/partners in their relations with others. For example, spouses/partners often described how they had become more mindful in their

interactions with family members and friends as they developed a greater understanding of how their actions contributed to the well-being of others.

> Like stopping in the moment. I know there are times when in my previous job to this one where I was working 60 hours plus a week and I would come home and it was just like, you know, I had no time for anything or anyone including myself. And now I recognize that it's like, if I come home after a busy or a taxing day or a heavy day or a day that was less favorable, I will go in and I will acknowledge whoever's there and say, 'You know what? Just give me five minutes. I'm just going to decompress. I'm going to go and change or brush my teeth or wash or do whatever, then I'm all yours.' Or, acknowledge too when I'm not present.

Some spouses/partners voiced an emerging or stronger desire to help others as a result of the PTSD healing process: "It's just about sharing what works and what you can provide somebody in support. And that gentle touch for someone else and helping them recognize that there is a soft place to land and you're not alone." In a few cases, spouses/partners changed careers and assumed roles in helping professions as a result of this desire.

> I remember even in the beginning working he [Veteran] was like, "I think it's really good you're working with these families and these Veterans who are, you know, living with post-traumatic stress and OSIs and that's really great. That's commendable." And I'm like, "Are you kidding me? You're the reason why I'm doing this."

In other cases, spouses/partners volunteered with formal support groups that they, themselves, had previously accessed, in order to give back the support they had received. Further, many spouses/partners shared that their motivation to participate in this study arose from a motivation to help other families living with PTSD.

Greater emphasis on quality of relationships rather than quantity. As spouses/partners learned how to take care of themselves throughout the healing process, many shifted away from "quantity", in favor of "quality", in their relationships with others. This emerged as maintaining relationships with people (e.g., friends) in their lives whom they perceived had a positive influence on their healing and growth and releasing relationships they perceived impeded this goal. For example, some spouses/partners relinquished relationships because they were perceived as unsupportive to living with PTSD or to the couple relationship: "It was just so strange because I stopped going to her [friend] because I realized she'd became toxic in my relationship." They described their subsequent pool of relationships as a group of positive, trustworthy people who helped rather than hindered the healing process.

> There has been some people who have just kind of shied away when you say, "Oh, he's got PTSD." Because a lot of people assume that when you have PTSD, you're violent…There are friends that you thought would be there that aren't, and different ones who kind of step up.

Greater sense of personal strength and boundaries. Most spouses/partners expressed a changed self-perception as a result of the PTSD healing and support process that translated as developing better boundaries and a greater sense of personal strength,

> Like I would never say, "Boo," before. I knew, "Ok, it's now noon, I better make his lunch." He had me so conditioned for his every need that I automatically did things without even thinking anymore. And being with the [formal support group], [name of group leader] has gotten all of us to step back and have a look at how we were, and now have a look at how we want to be.

Further, these two qualities seemed interconnected, whereby an increase in personal strength helped spouses/partners assert better boundaries, as one spouse/partner exemplified:

> I've gained a little more independence than I had before and I'm not afraid to say, "Oh no, I'm not going to be home this evening. I put such and such there in the fridge. You know where the other stuff is, so enjoy." And I go.

Spouses/partners described themselves as strong and resilient when they reflected on the committed, determined role they played throughout the healing process.

> When I look back, I amaze myself at the lengths and the determination that I, I went to the point that I could've probably been down, been right down there with him. That I was burning out and I had to say, "Ok, like this can't happen because there's going to be two of us."

One spouse/partner explained how she had grown stronger in her social orientation throughout the spousal support process. She explained that prior to the OSI, the Veteran was outgoing and social, but this quality receded with his PTSD symptoms. In contrast, she described herself as a shy person pre-injury. As a result of the OSI, the spouse/partner adopted a more socially-oriented role in order to support her partner. She remarked that

this was originally out of necessity to increase the Veteran's well-being, but over time she noticed that it had become more routine for her to be more outgoing and social:

> He was always "Let's go to the party, let's go dance, let's go this" and now it's "No, I don't want to do that, I don't want to go there, I don't…" You know, he doesn't want to talk to people that he doesn't know and now it's completely reversed. I'm the one who has to push him out the door and it's been quite a change. You know, it's a complete 180 for both of us. But because he retreated in, I've, you know, I have to push him out… I used to be the real private, quite person until I really got to know somebody and now it's kind of the other way around.

Relational growth. At an interpersonal level, spouses/partners described relational growth in their relationship with the Veteran as positive changes in how they viewed themselves as a couple (*couple identity*), how they felt in relation to their partner (*couple bond*), and what events or viewpoints took precedence in their life (*family priorities*).

Couple identity. This relational growth theme captured how couples viewed their relationship as it changed over the course of healing. This commonly emerged as spouses/partners stating their relationship with the Veteran had become stronger: "I think going through these challenges it's a case of it either "makes ya or breaks ya." One spouse/partner shared how, early in the healing process, she would rarely disclose to others that they were living with PTSD because she felt ashamed and she had difficulty integrating it into how she viewed their relationship. However, as healing progressed she came to believe that it was not a shameful experience, which enabled her to not only

accept PTSD as part of their relationship, but as something that made them stronger: "Although I'm not happy that we've gone through the challenges it definitely has made us a stronger couple. And I feel that, and I know that he feels the same way."

Viewing themselves as a stronger couple depicted an aspect of "re-partnering" as they redefined their relationship differently than prior to the OSI, yet, ultimately, something positive. For example, spouses/partners portrayed how they shifted to viewing their relationship as an ever-changing, fluid process, rather than a rigid, static entity: "It's moving forward and growing. Growing as a couple. Growing individually. And yeah, so that's kind of huge." In fact, as one spouse/partner depicted, some spouses/partners voiced that their relationship had evolved to a more positive place than before the OSI as a result of the spousal support process: "I would say we were probably a dysfunctional couple before and now we're a healthier one if that makes sense."

Couple bond. This relational growth theme captured positive changes in how spouses/partners felt within the relationship generally and in relation to their partner specifically. They expressed an increase in connectedness/closeness, "We didn't pull away from each other, we moved toward each other," and a deepening of trust toward each other, "I think in an ordinary relationship, couples have their ups and downs. I think when you go through this experience and you're still together after a certain point they really know you have their back," as a result of the spousal support process. In addition, spouses/partners commonly described being more attentive to each other's moods ("He doesn't have to say anything. You know, he wakes up in the morning and I know if he's in a good mood or a bad mood. I don't have to tell him if I'm not feeling well"), needs ("I think I'm more in tuned with him now. Like I know what sets him off. I know what can

make a good day turn bad"), and desires ("I probably try to do more and [Veteran's name] is more encouraging of that than he probably would have been if we hadn't have gone through this stuff [PTSD]").

Many spouses/partners disclosed reduced physical intimacy early on in the healing process. However, several of them spoke of how intimacy evolved to take on different meaning and form as healing progressed, "There's no physical attention, but he's there, and he'll look at you and you can tell when he says something it's coming from his heart," and spouses/partners came to regard small gestures from the Veteran as holding more relational significance, as portrayed in the following two accounts:

> For a spouse now to get a hug is a big thing. For their spouse [Veteran] to kiss them good night is a big thing. To hold their hand. To take their hand when they're walking. That's a big thing. So it's the little things that you just kind of take for granted that become the big things and those are the connections.

> I mean sure I miss the sex, but it's not always about the sex. Sometimes it's just about sitting together and like holding his hand and putting my hand on his lap. And that's been a big reconnection for us.

Although spouses/partners perceived the closer couple bond was a positive change, it was not necessarily described as a smooth path to reach this new level of connection, showing again that distress and growth were not mutually exclusive for spouses/partner. For example, some spouses/partners linked this change to the initial periods of social isolation they experienced (e.g., loss of friends due to stigma), which required them to rely heavily on each other during this time in the absence of other sources of support: "We're tighter

now because we had to lean on each other for support. Others haven't been there, so we're tighter."

> It's been positive because we've learned more about each other, we can depend on each other, you know, we've become more in tune to each other, which has been kind of good. But then it's bad because we haven't, by becoming so close together, there's been more alienation from everywhere else. We've become more isolated by being more of a couple.

Similarly, sometimes this closer couple bond appeared to have, at least initially, developed at the cost of spouses/partners own individuality: "We used to be a lot more independent. Like more of our own individual person. And I think we've morphed into more one blended person."

Family priorities. Most spouses/partners expressed changing their family priorities as they redefined their relationship, and their expectations for it, after acquiring an understanding of what it meant to live with PTSD. For example, many spouses/partners expressed that family priorities became clearer and more focused on the present (e.g., day-to-day), rather than the future (e.g., long term goals).

> And I have a different outlook now. I was always planning for the future. The future, we have to do this, we have to do that for 20 years down the road. We have to, well yeah we do, but we need to enjoy the journey along the way now…So we need to be able to think about and do things now because we don't know what he's going to be link in 10 years, 15 years. I mean, we had this kind of idyllic like idea in our head. We know that's not going to happen. We have to make the best of what we have right now.

Mental and physical health concerns now superseded other areas of life, such as career progression and financial gain, for many couples: "Just with the stress load, we had to think of health. We didn't really have a choice. That had to become a priority and so we had to lean on each other a lot." A greater emphasis on making the relationship itself a priority resulted from the healing process, which often included dismissing minor irritations in favor of addressing more major issues: "I guess we have really, really learned that the little things aren't worth fighting about. Stand back. Take a breath. Look at the bigger picture and why are you even worrying about such trivial things?"

Some spouses/partners remarked how focusing on family values had become a more active priority in their relationship with the Veteran and couples more intentionally implemented their values into day-to-day living compared to before the OSI.

> I don't know if the core values of what is important have changed, but we're more focused on those. It's not like we didn't think it was important before, but we're more likely to, you know, put our money where our mouth is, if you want to say that.

Link between spousal support and PTG. Spouses/partners' depicted a positive feedback loop between social support and PTG as many described growth and social support as an interconnected cycle. Expressly, the more spouses/partners committed to informal support at the home level and engaged with formal supports at the community level, the more they perceived that they grew. Likewise, the more they grew, the more willing and able they were to provide support and continue engaging with formal support programs and services.

> It's all kind of circular, right? Like the more we commit to this, then the better the outcome. And then the more you are, you feel gratitude for life and people and your relationships…and then you're more likely to do more of that [support].

Spouses/partners' accounts additionally indicated a positive relationship between adaptive processes and PTG. It appeared that, for many spouses/partners, adaptive processes, as a specific aspect of spousal support, represented an interface between social support, more broadly speaking, and the development of PTG. Although linkages between specific adaptive processes and areas of PTG were not well-saturated in the data, some key trends are outlined below.

Positive outlook. Positive outlooks held by spouses/partners on a smaller scale (e.g., perceiving hope for healing) fed their transcendent viewpoints on a larger scale (e.g., their experience was part of a bigger picture). For example, one spouse/partner stated, "You can turn a really, you know, less fortunate thing into something that is more positive and resilient…and it's about the coming full circle." Similarly, another spouse/partner expressed, "It's a life experience that you can take with you wherever you go…just little pieces of it throughout your life," in describing how she learned to draw strength from her experience. In turn, these developing transcendent viewpoints reinforced spouses/partners positive outlook: "All families have challenges, I know this now; it's what you do with those."

Spouses/partners' positive outlook for the Veteran's healing seemed to permeate beyond the home front to foster greater compassion and appreciation for others. For example, many spouses/partners believed that the Veteran was still the same person at his

core, despite the behavioral, physical and emotional changes the OSI had imposed on him, as one spouse/partner expressed: “I want people to know that just because someone has an OSI, doesn’t mean they’re broken. There’s healing that happens.” This outlook helped spouses/partners appreciate the complexities of other people’s challenges. In addition, spouses/partners’ positive outlooks impacted their development of more understanding and compassion for others as some described how they attempted to intentionally mobilize and express their personal values when interacting with others.

> There’s still compassion in the world and we need to practice it and the simplest gestures can be given and received with a magnitude unlike anything that we would even know… it’s the simplest things whether you, you know, provide somebody with a compliment or open a door or stop the traffic to let someone in front of you. It’s those. You don’t know where that other person is in that moment in time and that might be the one thing that made their day. And you don’t know the impact that that may have had on them.

Determination. Some spouses/partners made specific mention of their determination and the role it played in persistently moving the healing process forward: “I’m just that type of person. I’m committed to something and I don’t shy away…I try not to stigmatize those things [emotional issues] any different than if someone had another problem, like a physical problem or something like that.” In addition, it appeared that spouses/partners’ positive outlooks fed their determination to enhance their commitment to the Veteran, and fostered growth.

> I'm a very optimistic person as well and that's why I'm still here. Like, you know what I mean? It's, in every situation, like, it's always easier to walk away from the problem and close the door on it behind, but there's no growth in that.

A closer couple bond developed as spouses/partners' perceived that the amount of time and effort they invested in the relationship was shared by the Veteran. This sense of co-commitment helped sustain the spousal support system while simultaneously bringing couples closer together.

> I stayed and I sucked it up, so he does that too as well now, because it's important to both of us, right? And we've worked too hard to give it up for, you know, "Ok well, that's too hard or I just don't feel like it," like that's not an option at this point, right? We've got too much invested in this relationship and we are in a really good place right now.

Although some spouses/partners could not articulate why they chose to stay in the relationship during the most challenging periods of healing, others voiced that they reached this decision by reflecting on underlying values they held about long-term, romantic relationships. For example, one spouse/partner shared, "If you love someone, you've got to stick it through. We married for better or for worse," and another added, "People are not to throw away. People are not disposable… like you don't commit to something and then just go, 'I don't, someone will clean up my mess,' right?" Actively reflecting upon these values, combined with spouses/partners' determination to implement and uphold them, supported their commitment to the couple relationship and enabled them to prioritize improving family life in their day-to-day living. In these cases,

growth seemed to transpire as spouses/partners deliberately enacted their underlying relational values as part of their changing family priorities.

Self-care. Spouses/partners' self-care routines, and the value they placed on them, laid the foundation for multiple areas of growth, highlighting it as a key adaptive process in facilitating PTG. For example, spouses/partners largely linked their development of better personal boundaries to their adoption of self-care practices as they grasped the vital impact it had on successfully living with this experience. For some this involved learning that they deserved self-care, and learning how to assert boundaries around doing so:

> I guess because of this journey in general, I'm more diligent about trying to take care of myself. And I'm a bit more demanding of that, if that is the right word for it. I'm a bit more expecting, well, I deserve time as well.

For others, self-care routines helped spouses/partners better recognize their personal limits of care for the Veteran:

> Just looking at what's my own and what's not. And also looking at what role I can play versus, like I can only do so much and then it's up to that other person to take it from there. And I think I would have had [pre-injury] much clearer boundaries in my work than I would have, say, in my home.

Similarly, some spouses/partners voiced a greater sense of personal strength that typically arose from developing a more robust self-identity as they learned the importance of taking time for themselves, separate and apart from their supportive role in the Veteran's healing: "Who are you? What do you like to do? Let's dig deeper because finding out

who you are and fulfilling your own needs brings you into this relationship with a better perspective -- a bigger, better person."

Many spouses/partners made a link between engaging in spiritual practices, as part of their self-care routine, which helped them develop a transcendent viewpoint of living with PTSD. Specifically, it appeared that by engaging in spiritual practices, many spouses/partners drew on core spiritual/religious values to shape how they broadly perceived the world post-OSI and how to conduct themselves within it:

> I very much believe that everything happens for a reason. And I don't know when I really started thinking that but I very much think these things aren't random. These challenges are put in front of us for a reason. And I don't know if it's, you know, God or Buddah or whatever you want to call that higher power.

This sometimes guided how they interacted with others: "I do agree with, you know, the Biblical version and how, you know, we need to treat each other in our life is applicable to a good world." Other spouses/partners described how they became motivated to explore different spiritual avenues as part of their self-care practices: "I think the whole part of it where I learned to take care of myself better allows me to be a bit more experimental with that [spirituality]."

Spouses/partners described developing a greater appreciation for life by taking care of themselves, "I've looked at things differently that everyday's a blessing and taking care of myself physically as well as mentally, and so I've changed," which often included greater compassion for others as they came to better recognize complexities that others might be facing in their own lives. For many, this transpired into a stronger desire

to help others, particularly as they drew strength from participating in formal support groups as part of their self-care regime.

> I'm sitting there one night [at a formal support group], and I'm sitting next to a 30, a young 30-something mom of two kids and she's just crying her eyes out. And I'm looking at her and I'm thinking, "I know what that feels like."…And it just hit me. I'm to a point of wellness where I can help somebody else.

Collaborative problem solving. Many spouses/partners noted how they felt stronger as a couple by coming to believe that, if they were not currently at an ideal place in their relationship, they could get there by working together. Couples' learned that living with PTSD necessitated shifts in how they interacted as partners and that any future challenges, big or small, might require additional modifications: "I think it's become a work in progress. I think that we've had to start a new canvas versus working with the canvas we had." In addition, spouses/partners widely shared that they identified as a stronger couple through learning how to work together to solve problems in a proactive manner: "If we've survived what we've gone through, then we can handle pretty much anything."

The collaborative, mutual aspect of couples' problem solving fostered a closer relational bond, which helped them better appreciate each other: "We're more of a team…it's a sense of that we're a value to each other, like valued by each other and we know each other and, although we're very different, we are a team and we're in this together." In turn, this closer bond enabled spouses/partners better recognize and avert potential problems:

> The connection is that you're more aware of your own behaviors and of theirs. And when you spot their behaviors, what might be a trigger, without them having to say so, you can, you know, quietly say, "You know, look, why don't you just have some quiet time. I'm going to go do this. I'll leave you to do this."

The sense of mutuality in solving problems together also appeared to foster a better understanding of each other's needs and desires, which forged a closer couple bond. One spouse/partner exemplified this by contrasting her current marriage (i.e., to the Veteran) against her previous marriage wherein she dealt with another mental health issue:

> I used to always try to problem solve. Find solutions, you know, whatever, like to help him [previous marital partner] and help him feel better and come up with things. And he would agree to them but he never engaged in them. Like he would promise and then not do anything. And I know that that's [mental health issue], right? It's hard to do things. But the difference between that and what the process I've gone through with [current marital partner's name], is that [current marital partner's name] will stand up, even if it almost kills him, he will make an effort to change if he knows that's important to me and it's important to our relationship. And that's what saved us.

Communication. Many spouses/partners described how the dyadic communication skills they acquired through the healing process had resulted in a more functional relational foundation. In particular, spouses/partners voiced how underlying relational values, such as acceptance, respect and trust, more intentionally formed the

basis of their communication within the relationship. For example, one spouse/partner stated, “There are times where they will not be able to communicate with you, they’ll come back, but there’s where you’ll just have to accept it,” to explain how she emotionally supported the Veteran through acceptance, which impacted their dyadic communication to enhance their relationship. Another spouse/partner shared how she and the Veteran had learned to trust each other enough to broach difficult topics as they refined their open communication skills:

> Because part of his symptoms would be that he would have been more, the same as I would have been, he would have been anxious about something that was coming up and he wouldn’t have wanted to talk to me. He probably may have lied to me about it, not told me and found something else, you know, found some other reason why he was going to be doing such and such. You know, so it makes it easier, the skills we’ve got, it makes it easier for us to take advantage of those opportunities and that kind of thing.

Still another spouse/partner voiced how the Veteran increasingly showed her respect when she expressed her goals and desires to him:

> I’ve discussed with him things that I’d like to get back into doing and I find [Veteran’s name] is encouraging me a little more to, ‘If that’s what you want to do then you’ve got to do it,’ which he never would do before.

In a few cases, open emotional expression took the form of couples knowing when to apologize for something, which spouses/partners perceived as an increased appreciation for each other, developed through the healing process.

> He said, "Didn't mean to blow up at you like that, and you're right, take that road."…it used to go on and on and on like half the day but now he catches himself more, tries to think it out with what little he can do of that and then he'll apologize and say, "No, I was wrong." And he's never one to admit he's wrong…I think talking is about the best that we've done. Trying to communicate how we feel back and forth because that's been difficult.

In turn, they believed this greater appreciation, vis-à-vis open communication, strengthened their couple bond.

> He'll [Veteran] encourage me on [day of week], "Don't forget your group. You be there for that group."…and he has mentioned that he believes that it's because of him that I've dropped all the stuff I used to do…so it's a big step for him.

Spending time together. Many spouses/partners voiced that learning new, unique ways to spend time together fostered trust and helped them reconnect as a couple, leading to a closer bond between them.

> We eventually learned how we could go to a movie together. And you know ah to sit in the last row in the seats at the very corner where, closest to the escape was what he could manage, so that's what we do. To go to the [venue]. We managed to do that together. I knew the exact seats where he was comfortable. There was nobody behind him. There was an aisle beside him. And we could go to a concert. You, you figure out, I mean, they don't really want to come out and say, "I can't." They go, they try,

> they get triggered, they get angry, then, you know, everybody gets kind of hyped up. I'm very, I'm pretty calm and I think that that has helped a lot. That I don't fly off the handle.

Some spouses/partners shared that spending time together as a couple had moved to the forefront of their relationship to represent a change in their priorities: "We're making time for each other, which, you know, we could be both really busy to avoid, but now we're taking that time to really connect because it's important." One spouse/partner described how she and the Veteran had become more simplified in how they spent time together, which removed pressure and expectations, allowing them to gradually reconnect and deepen their couple bond.

> We used to like um go to the movies a lot whereby now I find we're more content to either buy or borrow or rent from the library a movie and watch it at night at home in our own time frame.

Summary of theme 3. As couples increasingly settled into their "new normal", they gradually underwent personal and relational transformation, moving beyond stability, which resulted in personal and relational post-traumatic growth. Personal growth emerged for spouses/partners as they remained determined to take care of themselves as well as the Veteran, and maintained a positive outlook while doing so. These adaptive processes uniquely fostered spouses/partners' transcendent viewpoints, deeper compassion for others and stronger self-concepts. Relational growth developed as an aspect of re-partnering as couples became more adept at communicating, problem solving and spending time together in novel ways, specific to living with PTSD, which, in turn, fostered a closer couple bond, stronger couple identity and clearer family priorities.

Theme 4: Couples traverse healing phases as spouses/partners redefine what it means to live with PTSD

Spouses/partners reached turning points vis-à-vis the informal-formal support relationship, depicted as transformative junctures, which propelled couples away from a state of crisis toward regaining stability and beyond. This involved a gradual process of defining and redefining what it meant to live with PTSD in the family system. Points of "defining" and "redefining" represented meanings that spouses/partners attached to their disrupted family system following the introduction of the OSI (defining) and how they shifted this meaning to more positively interpret their circumstances (redefining) following key events or information. Couples' pathways to growth unfolded as spouses/partners assimilated these significant events/information into their view of their circumstances, allowing them to reappraise the overall situation, and more positively re-frame their perspective as a result. As such, the key events/information acted as precursors and represented catalysts for spouses/partners to redefine their experience living with PTSD; this enabled them to attach new meaning to it and re-frame their circumstances in a more constructive way. Moreover, this new meaning encompassed mechanisms of hope, letting go/acceptance and empowerment that placed spouses/partners on a growth trajectory.

Spouses/partners' narratives demarcated three turning points for them: 1) "It's about me" vs. "It's about the injury", 2) "Fixing it" vs. "Living with it", and 3) "Losing myself" vs. "Saving myself". Although they are distinct, all three turning points involved spouses/partners assimilating what it means to live with PTSD in the family context and how to do so in a constructive manner. Spouses/partners often recounted "reaching

points", or used language of "then" and "now", which suggested shifts from one meaning to another. The first half of each turning point title (i.e., phrase before the "vs.") represents the old meaning spouses/partners attached to changes in their family life (i.e., how they initially defined their experience) and the second half (i.e., phrase after the "vs.") embodies the new meaning spouses/partners attached following assimilation of a key event or information (i.e., how they redefined their experience).

It's about me vs. it's about the injury. This turning point entailed identifying the underlying problem as PTSD and, subsequently, re-appraising the situation based on this new information. All spouses/partners spoke of how they initially lacked an understanding of changes they were facing in the Veteran and their relationship. As a result, many spouses/partners internalized relational challenges as something detrimental they were personally doing or not doing, i.e., "about them", leading to self-blame as an early reaction. For example, prior to having the underlying problem identified as PTSD, many spouses/partners experienced confusion, frustration, a lost sense of control and even despair, which contributed to decreased self-esteem for many of them: "Well, the 'I'm not good enough,' or 'I'm doing something wrong.' You know, 'I'm the bad person. I have to be because he's angry at me.' You really personalize this too I mean you don't know where it's coming from." Receiving a PTSD diagnosis enabled spouses/partners to re-appraise the challenges they were experiencing in the family system, prompting a shift in their understanding that the familial tensions were "about the injury", not their personal actions/inactions, the relationship itself, or a new undesirable quality in the Veteran. As one spouse/partner voiced, this realization helped re-build lost self-esteem: "I think that once individuals recognize that it's not personal, that it's not about them, it's

a big thing. Self-worth, self-confidence, certainly self-esteem suffers. You know, it's not personal on that, and bring yourself back up."

This new understanding additionally offered direction for a course of treatment, "…knowing that he got that diagnosis, it was almost like, for me, a sense of relief…so now it's like I'm looking at, "Ok, what's our next step now? Like where do we go from here?", and validated spouses/partners' observations that the Veteran had changed, "I think it [PTSD diagnosis] just kind of validated the experience and then at least then you can make a plan for treatment." This re-fostered a sense of control and hope in place of confusion, frustration and despair. Indeed, *hope* for improving their family circumstances became a mechanism for positive change embodied within this turning point as it fed a more positive outlook for living with PTSD that represented a potential for change: "If you don't have hope then there's no potential for change. When you lose hope that's when it stops." This sense of hope enabled the spouses/partners to release self-blame and to redirect efforts toward improving circumstances surrounding the OSI rather than qualities within themselves.

> There was finally something to say, 'This is what this is, so now we can treat it.' Because before it was like pulling, just pulling hair. Like, what is this? What's going on? Why is he like this? So, to have a label, a name, was good. Because ok, we've got a name, there's got to be treatment. Now we know what angle and what avenue we have to go to pursue help. And on a personal level, for me, it was, "Oh. It's this. It's not me."

Fixing it vs. living with it. This turning point seemed to follow the PTSD diagnosis, after spouses/partners had integrated knowledge about what it meant to "live

with" this particular type of OSI. Their education about PTSD often derived from engaging with formal supports. For example, one spouse/partner shared how she came to read books about living with PTSD as part of her support group involvement:

> I got a better understanding of what it's all about. And one book that we're almost finished in the [support group] is [book title]. It's from [book publisher] and in there she describes trauma and PTSD and PTSR. And I look upon it as I'm impacted in a way as looking at PTSR, my reaction to what has been happening here. And we'll discuss the book. Like each week we read two chapters and we're just about finished it now. And we'll sit in the group on a [day of week] and we'll discuss what we got out of the book and how it impacts us. And I find it an excellent book.

This turning point partially manifested as spouses/partners came to understand PTSD healing as a long term, chronic health issue that they would have to "live with" rather than a short term problem that could be "fixed".

> I guess my natural instinct is to try to fix things, right? That's who I am. "Let's talk about it. We can fix it if we talk about it," you know, right? And I had to accept that I did not have all the choices in that, and he had to be ready to be that willing partner in that at the time. So I had to learn to kind of step back and change my expectations.

Learning what was possible and realistic for negotiating PTSD in the family context was important for spouses/partners to re-appraise and re-frame the situation, as reflected in one spouse/partner's account:

> Right now we're in a place where I would say it's positive but I mean there would have been a period of a few years where I would say we were stuck and maybe that hope wasn't there, if that makes sense. Whereas right now where we are, like I feel like we're moving forward, which is huge and hopeful and but also my perspective has changed too. Because I spent a long time wondering, "When will it get back to the way it was?" But there is no "the way it was".

Spouses/partners' process of redefining, by way of attaching new meaning to their experience, was supported through complementary acts of *letting go* and *acceptance* as mechanisms for positive change. It is noteworthy that neither of these acts denoted giving up on the relationship or the Veteran. Rather, letting go was akin to relinquishing control over things the spouse/partner perceived she could not personally change, such as letting go of pre-injury goals, ideals and states of being to better match the scope of the present situation.

> I've learned to let go. That the person who left to go on a deployment in 2003. And the person I loved and the person who was happy-go-lucky all the time and just always making jokes and just loved to smile and make others smile, he's not coming home…it's really sad to say but for 13 years, I held on to "when's he coming home".

Acceptance represented accommodating, rather than resisting, the personal and relational boundaries imposed by the OSI.

> I think I'm working on acceptance in a different way. Knowing that I can't change or receive what I thought I wanted in the past. So my vision of

> having my needs be met within the relationship has shifted. Where I am ok with less but when there is, when I am receiving it, I'm accepting of it versus, you know, pushing it away.

Together, letting go of past ideals, re-aligning them within the boundaries of the present situation, and accepting those boundaries, enabled a positive shift in spouses/ partners' perspective.

> I was fighting a losing battle. I couldn't put it back to the way it was. You know, you're spinning your wheels if you're trying to fight life…it's much easier to accept and move on and deal with what you have control over and make the best of the rest.

Some spouses/partners' described grieving in order to both let go of previously held expectations and to accept the present state of affairs. They grieved the loss of who the Veteran was prior to the OSI and the loss of their envisioned family life. Many of them noted that, without undergoing this "grieving process", they felt stuck and resisted moving forward. Upon completion, they could accept and redefine their relationship in a new way that fostered a more hopeful, positive outlook. Again, many spouses/partners remarked that they learned the value of grieving in this context through their engagement with formal supports.

> …the funny thing was, she [mental health professional] asked me, "[spouse/partner's name], have you ever grieved?" And I thought, "No, I don't think I have. I haven't grieved the loss of that man I married, who he was. And he's there, but it's very infrequent that I really see him anymore. I haven't grieved the loss of the life that I thought and we thought we were

> going to have, and what our future looked like, and what the reality was." So, no, I hadn't looked at it that way. And I wasn't angry that he was not going to be the same, but I was sad.

Some spouses/partners explained the importance of coming to understand the Veteran's functional capacities in light of the OSI. Specifically, this permitted them to let go of unrealistic expectations for the Veteran and "meet him where he's at", as one spouse/partner put it, rather than expecting family participation beyond his current capacities. For example, spouses/partners commonly recounted empathizing that the Veteran *could* not, rather than *would* not accomplish certain tasks, as one spouse/partner articulated: "The desire's there, the action or ability to put it into place doesn't come to fruition. It's not an easy process for them and I'm very mindful to that." Consequently, this understanding reduced the spouse/partner's disappointment in the Veteran when he could not accomplish his typical family roles and responsibilities, which allowed her to re-focus her energy on providing support that was conducive to a forward-moving healing trajectory: "I've realized that I can't change him. He is who he is and he can't help having this and being the way he is." This also helped spouses/partners to recognize that new, unfavorable personal qualities in the Veteran (e.g., "personality" changes) were a function of the OSI, not because he became a "bad" or "mean" person: "I could put that [challenging behaviors] into perspective into what he, where it was coming from, and so we worked through those things."

One spouse/partner explained that letting go and accepting the present enabled her and the Veteran to re-partner by redefining their relationship as it had become rather than what it used to be. However, she noted that this was not an easy task:

> You know it's that whole kind of "recapturing the new relationship" and, you know, "Oh". It's like everybody's in the honeymoon phase in the first whatever period of time and it's the butterflies and it's like the, "Oh, I'm so excited," that kind of stuff. But it's recapturing that in a long term relationship but in a different way…there's grief and loss that goes with that. And allowing yourself to grieve the loss of what was but the loss of what will never be either. And how do you accept or come to a place where it's ok and celebrate that.

Another spouse/partner echoed that redefining the relationship was challenging:

> And I wasn't angry that he was not going to be the same, but I was sad. I was sad for him because he knows he's not the same. And he's sad because he wanted to give us and be a certain partner to me. And that's difficult for them.

Losing myself vs. saving myself. This turning point was entrenched in the OSI's cumulative effect on spouses/partners and peaked as they reached or approached a state of emotional burnout. Specifically, spouses/partners explained how they had temporarily "lost" themselves as stress accumulated from the intense level of support they provided to the Veteran.

> I had to hit my spot where something has to change. If I keep doing what I'm doing, I'm going to keep getting what I'm getting. Something has to change. And going from one stressful all day job to a very stressful home life all the time, it takes a toll. So to get to a point where I can support but I don't have to lose myself.

Given the centrality of the OSI to family life, spouses/partners invested significant time providing care to the Veteran in order to support his healing. As such, they, themselves, often put things on hold that had provided them with a sense of balance: "Awhile back when he was going through a real bad time with everything, we stopped going to church. We used to, well, we would never miss it." In addition, spouses/partners "took on" the injury in multiple ways, including how they integrated it into how they viewed themselves, representing another way spouses/partners had "lost themselves":

> The hardest thing I find like is that you know people will say, "Oh…" You know, there's a lot of judgment in the world, I'm sure you're aware of that, and people will think that, "Oh, you know, like your husband has PTSD, like, you know, something's wrong with him," right? And that makes it something wrong with you, right? That was hard for me for a while. I had to let go of that.

Spouses/partners echoed coming to view PTSD healing as a bi-directional process wherein their own well-being impacted the Veteran's healing as much as his course of healing impacted the spouse/partner. Expressly, they learned, mainly through engaging with formal supports, that in order to "save" themselves, they needed to buffer the brunt of their supportive role by implementing structured, regular self-care practices into their day-to-day living. As such, practicing self-care became a precursor for positive change within this turning point. This entailed spouses/partners' recognizing that by taking care of themselves, they were also taking care of the Veteran because their support was of higher quality when they, themselves, felt well: "If I don't take care of me, I'm no good

to my daughter, and I'm definitely no good to him." One spouse/partner explained how she noticed a difference in her emotional state when she did not make time for self-care:

> One thing I've learned is that the weeks that I haven't done anything like for self-care for myself, going into the following week, I'm more razzled, I'm more frazzled. My patience is less...Like, I just have little tolerance for everything and everything in my life.

Recognizing how their own wellness helped rather than hindered the Veteran's healing was an important realization as many spouses/partners expressed that they initially felt guilt over taking alone time apart from the Veteran, as one spouse/partner shared: "I think it's realizing too that what I want is not hurting him for me to say, 'No, I want this, or I want to do that, or I'm going here by myself.'"

As spouses/partners came to better understand how they were impacted by living with PTSD, many realized they had lost an identity outside of their supportive role to the Veteran. Education received through attending formal support programs/services encouraged spouses/partners to re-claim their individuality through self-care practices. In turn, as spouses/partners increasingly re-claimed their individuality they felt a sense of empowerment, which represented the mechanism for positive change within this turning point. For example, spouses/partners came to recognize self-care as an aspect of the healing process that was within their own control (e.g., "In order for me to help you, I need to help me too.") and they also came to believe they were deserving of time outside of their supportive role to the Veteran; together, these viewpoints empowered spouses/partner to re-claim their sense of individuality: "I don't have to lose myself. I'm worthy. This is my life too. I only get one chance at this."

Although many spouses/partners remarked that it was their responsibility to ensure self-care continually happened, many also felt responsible for monitoring their personal limits of care provision and they learned to set clear boundaries around their support.

> It's also part of establishing better boundaries as well…just looking at what's my own and what's not. And also looking at what role I can play versus, like I can only do so much and then it's up to that other person to take it from there.

This involved spouses/partners recognizing what was actually their responsibility (rather than assuming all family roles/tasks), and releasing what would overburden and surpass their support capacity.

> …and just feeling totally burnt out with no time for me. And then actually telling him, you know, like actually expressing myself. And it's kind of something I've learned through [formal support group] as well that they're [Veterans] not always in tune to what's going on around them. So it was basically telling him, "You know what honey? I am burnt out."

Most spouses/partners disclosed they had contemplated leaving the relationship due to emotional exhaustion in an attempt to re-group: "I spent a couple years trying to decide whether or not to stay in this relationship and I chose to stay. But I was at the point where when I wanted to get out, it was to save myself." However, all chose to stay, and integrating self-care into the support process became a primary "saving" factor for spouses/partners. In part, by "saving" themselves spouses/partners believed they were also "saving" their relationship, as one spouse/partner stated:

> And when spouses learn that their identity's almost become their spouse's [Veteran's]. And that their whole world and their whole being, their whole reason and purpose becomes entwined in their spouses and they forget that they are an individual human being with their own needs and their own, to do their own self-care. When they forget themselves, they're not coming whole into the relationship either. That aspect is really important.

Summary of theme 4. Couples transitioned between phases of losing stability, regaining stability and beyond stability as they redefined their circumstances vis-à-vis re-appraising and constructively re-framing what it meant to live with PTSD. Experiencing key events and information over the course of healing marked turning points for spouses/partners, such as moving from ambiguity to clarity, learning how to live with PTSD in the long-term rather than fixing it in the short-term, and coming to understand healing as a bi-directional process between the spouse/partner and the Veteran.

Spouses/partners' turning points embodied mechanisms of hope, letting go/acceptance and empowerment, which enabled them to move away from crisis toward stability and growth. Specifically, hope set the stage for the possibility of positive change, letting go and accepting enabled spouses/partners to move forward in a positive direction, and empowerment provided the motivation to progress beyond stability. Collectively, spouses/partners' turning points enabled them to transform themselves and the couple relationship by attaching new, strength-based meaning to living with PTSD that promoted new courses of action aligned with a growth trajectory.

Chapter 6: Discussion

"The family is often the trauma antidote."

(Figley & Figley, 2009, p. 179)

The findings from this study bring into view an intricate healing process for CAF Veteran couples living with PTSD. They gradually transformed themselves and their relationship in positive ways over time through their social support system and the meaning-making process it fostered. That is, interplay between social support systems at home and community levels shaped couples' healing process in such a way that positive outcomes ensued. Spousal support underpinned this process and laid the groundwork for a post-traumatic growth trajectory as couples moved across points of crisis, stability and beyond.

The current study sought to answer two research questions: 1) How has PTG been experienced within the couple relationship for CAF Veterans living with PTSD and their spouse/partner? 2) How have social processes within the spousal support system fostered PTG? Overall, the answer to these two questions can be summarized as follows: PTSD is a systemic injury for CAF Veteran couples, affecting not only the directly injured individual, but also family members and family functioning. A social support network, comprised of informal and formal resources, enables couples to redefine what it means to live with PTSD, moving them forward in healing, away from family crisis. A potential for personal and relational growth develops as couples establish a "new normal" for family life, which is fostered as couples redefine through meaning-making. Indeed, a growth mindset ensued as spouses/partners embraced a "survivor mentality", moving forward from a place of hope, acceptance and strength.

Contributions to Models of PTG

The following discussion integrates the current study's findings with existing literature on the subjects of post-traumatic growth and couple functioning while living with traumatic stress. Specifically, it presents how the results of this study complement and add to leading models of post-traumatic growth at individual (Calhoun & Tedeschi, 2004; 2006; Calhoun, Cann, & Tedeschi, 2010; Tedeschi & Calhoun, 1996; 2004) and family (Berger & Weiss, 2009) levels. The findings of this study show how family functioning fluctuated as couples lost stability, regained stability and moved beyond stability as healing progressed. This evolving functionality will be discussed in reference to Nelson Goff and Smith's (2005) CATS model portraying the systemic nature of traumatic stress for couples.

Losing stability. Despite originating as a direct injury to the Veteran, the OSI infiltrated the couple system and disrupted family equilibrium. This aligns with research showing potential for a systemic spread of traumatic stress from a primarily injured individual to close, supportive others, such as family members (Dekel & Monson, 2010). It is also consistent with PTG modelling of how a seismic event evokes subsequent challenges for individuals and families vis-à-vis a "shattered assumptive world" (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004). Specifically, the centrality of the OSI in day-to-day family living highlights it as an event that was sufficiently intense to upset couples' family schema comprised of previously held family ideals, expectations and goals (Berger & Weiss, 2009).

Tedeschi and Calhoun (2004) suggest that sizable stressors impact individual's well-being as they struggle to reconcile them with their existing worldview. Specifically,

they purport that as one's basic beliefs about their world become vulnerable, such as how much control they have over day-to-day living, challenges ensue, impacting how they view themselves and their expectations for the future. The unpredictable nature of the Veteran's PTSD symptoms often resulted in emotional distress for spouses/partners through instances of fear, hypervigilance and social withdrawal. Although not explicitly framed as such, this emotional distress mirrors descriptions of secondary traumatic stress (STS) among close others supporting primarily traumatized individuals (e.g., Dekel & Monson, 2010; Frančišković et al., 2007; Herzog et al., 2011). Notably, the OSI became central to family life even before the problem was identified as PTSD, leading spouses/partners to attach negative meaning to their circumstances, such as self-blame ("it's about me"), as they sought to unearth the problem.

Role disruption is a prime avenue leading to relational instability, particularly through its potential for impeding relational power dynamics (Nelson Goff & Smith, 2005). The disruptive impact of the OSI on family life was evident as couples rearranged family roles and responsibilities to compensate for the Veteran's reduced functional capacity associated with PTSD symptoms. Couples lost their stability as their normative relational power dynamics (i.e., relatively egalitarian) were redefined, taking a toll on couple's day-to-day living and hindering their relational connection. Specifically, an unequal power dynamic emerged as spouses/partners replaced their partnering role with a caregiving role, resembling that of a parent-child relationship, to compensate for lost relational stability. This blurred relational boundary between the spouse/partner and the Veteran sometimes resulted in an unclear identity for spouses/partners as it became difficult to individuate from their supportive role. Consequently, many spouses/partners

perceived they had "lost" themselves early in the healing process as they questioned whether they were now a caregiver, a partner, or something in between. A consideration of these enmeshed relational boundaries, leading to an ambiguous self-identity, helps explain how the OSI became the epicenter of family life, around which everything else revolved (Minuchin, 1974). Furthermore, it mirrors Tedeschi and Calhoun's view that disruption to mental schemas leads to a "shattering" of worldview assumptions. Specifically, these findings imply that spouses/partners' pre-trauma schema of what it was to be a spouse/partner/wife was challenged as they were required to shift from partner to parent.

Relational attachment patterns risk interference as couples negotiate traumatic stress within their relationship (Nelson Goff & Smith, 2005). This resonates with the relational distance and confusion spouses/partners experienced early in the healing process. Namely, the Veteran's PTSD symptoms of avoidance and withdrawal contributed to reduced intimacy and communication in the couple system, suggesting unmet attachment needs in the couple system (Nelson Goff & Smith, 2005). Spouses/partners internalized this relational disconnection as self-blame, which decreased their self-esteem and furthered a decline in couple functioning.

Regaining stability. The informal-formal support relationship represented a key socio-cultural influence that enabled couples to regain their family stability and to continue moving forward. In relation to models of PTG, these resources represent proximate factors, constituting individuals' and families' social environment (Berger & Weiss, 2009). The military cultural backdrop offers another layer intersecting couples' experience of living with PTSD and represents a distal factor in the development of PTG.

Namely, these distal factors highlight ideological themes reflected in society that drive social values and influence the management of traumatic stress (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006). Socio-cultural context is an integral component of PTG as it becomes part of the rumination process, shaping individuals' and families' cognitive processing of trauma in ways that foster growth (Calhoun & Tedeschi, 2006).

Informal-formal support as proximate factors. Spouses/partners have been acknowledged as linchpins in this study to underscore their vital role in Veterans' PTSD healing process and in positive couple adaptation. Indeed, it fell entirely to the spouses/partners to build a foundation for healing, and many of them disclosed that they perceived, or the Veteran had shared, that they would not be in a positive personal or relational place without the spouses/partners' continued support. However, formal supports were acknowledged as channels to healing, and this applied to the spouse/partner as much as to the Veteran.

The exchange of trauma narratives between supportive others, including their responses to disclosed experience, are important in the development of PTG through their impact on ruminative processes (Calhoun & Tedeshi, 2006; Tedeshi & Calhoun, 2004). Tedeschi and Calhoun's model of PTG states that talking with supportive others can help shape an individual's trauma narrative; that is, how individuals and families come to view their experience as it relates to their past, present and future (Tedeschi & Calhoun, 2004). Primary reference groups may provide affirmation and acceptance for trauma experiences that increase the likelihood of PTG (Calhoun & Tedeschi, 2006). Hearing similar, yet distinct accounts from others helps advance schema changes that match new, post-trauma circumstances (Tedeschi & Calhoun, 1996; 2004). Moreover, there is suggestion that

hearing others' accounts of growth potentially fosters PTG (Calhoun & Tedeshi, 2006). On an individual level, spouses/partners' military-specific informal network (i.e., other military spouses/partners in peer-support groups) represented spouses/partners' primary reference groups, particularly in their capacity to "share certain attitudes and assumptions" (Calhoun & Tedeschi, 2006, p. 12). As spouses/partners shared their experience of living with PTSD with other military spouses/partners during peer support participation, they felt a sense of relief as converging accounts validated their experience. This emotional support from other spouses/partners' unique, yet similar stories gave them meaningful perspective, particularly as everyone was at different points in healing. As a result, they felt hopeful for the future and became empowered to persevere through the challenges knowing this source of strength was readily available to them.

On a relational level, spouses/partners represented a primary reference group for the Veteran as they co-engaged in his healing process through their provision of support. Spouses/partners demonstrated they were active participants, rather than passive observers, by continually adjusting the type and level of support they provided to match the Veteran's functional capacity over time. In fact, spouses/partners' narratives suggested they were not only supporting the Veteran's healing, but they were *leading it* to a great extent. They were more than a "reference group" for the Veteran and they went beyond their previously envisioned role as "spouse/partner" to become caregivers, managers and cultivators as the situation required.

Spouses/partners' three supportive roles (caregiver, manager, cultivator) helped delineate the utility of different types of support toward different ends. Indeed, different types of support in this context matched different goals attached to a particular phase of

healing. For example, the provision of instrumental and informational support aimed to re-stabilize the family system, appraisal support was more directly growth-focused and emotional support served as a constant foundation, enhancing and reinforcing other types of support throughout healing.

Spouses/partners did not place higher value on any one of their three supportive roles toward healing and growth. Rather, their accounts presented a mutually beneficial relationship between them that transpired through a continuous, iterative process. However, as spouses/partners cycled through these supportive roles, they placed increasing emphasis on cultivating as time passed. This captured a shift from a highly dependent social environment (i.e., the family context) to an autonomy-supportive one as healing progressed (Joseph & Linley, 2004). Indeed, the type of spousal support provided in the cultivator role is consistent with an autonomy-supportive environment where the basic psychological needs of competence, autonomy and relatedness are met (Joseph & Linley, 2004; 2005). For example, the main purpose of the cultivator role, through the provision of appraisal support, was to re-build the Veteran's self-esteem after losing stability, re-foster his competence as he regained stability and encourage his autonomy as he strived to reach new levels of healing beyond stability. As the Veteran's self-esteem improved, spouses/partners stated he increasingly recognized he belonged and was still a value to the family despite the OSI (relatedness). Similarly, as he gradually re-assumed family roles and responsibilities, the spouses/partners perceived that the Veteran recognized his increasing capacity to do so (competence) and they reminded him of these strides in order to keep moving him forward. In turn, the Veteran was able to function more independently from the spouse/partner as healing progressed (autonomy). Couples'

re-partnering paralleled this shift to an autonomy-supportive environment as relational power dynamics returned to a more egalitarian state. Consequently, the spousal support system began to include "support with" the Veteran as well as "support for" the Veteran, which marked a shift from a unidirectional to a bidirectional provision of support (Nelson Goff & Smith, 2005; Walsh, 2003). This mirrors characterizations of social support identifying reciprocity as an effective component of a support system leading to positive adaptation (Nelson Goff & Smith, 2005).

Spouses/partners are often described as caregivers in existing literature on Veterans living with PTSD (e.g., Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Patel, 2015). Although managing and cultivating perhaps comprise aspects of this role, the current study details each role's unique contribution to healing by distinguishing them from each other. In this way, different dimensions of social support were captured as spouses/partners varied the types and levels of support over the course of healing. Accordingly, this study's findings offered a context-specific portrayal of social support, which may vary from other contexts (e.g., other mental health issues, disabilities, injuries, etc.). Furthermore, a focus on how these supportive roles nurture positive outcomes is a relatively novel contribution to existing literature on military families living with PTSD, considering most, to date, focuses on negative outcomes. The cultivator role, in particular, emerges as a new way to conceptualize aspects of spousal support that marks an especially useful resource for understanding the development of PTG.

A flexible yet cohesive family structure, which contains social and economic resources, primes families for positive adaptation (Walsh, 2003). As the Veteran's primary social resource, spouses/partners enabled positive adaptation to the OSI by

flexibly interchanging their supportive roles to match his changing needs. In addition, spouses/partners secured economic resources for the family by advocating on the Veteran's behalf for financial remuneration such as pension and medical/disability benefits. On a dyadic level, family cohesion was facilitated by jointly attending treatment and support programs in the community. Spouses/partners identified this as a key element of the informal-formal relationship that enhanced couple functioning, especially for learning adaptive dyadic processes. In cases where adaptive dyadic processes may have already been in place prior to the OSI, they may have diminished early in the healing process, and accessing formal supports served as a reminder to consciously re-implement these strategies in their day-to-day living.

Military culture as a distal factor. Distal factors in this context largely represent ideologies associated with military culture, such as duty, loyalty, sacrifice, comradery, unit cohesion, strength, pride and honor (Britt, Adler, & Castro, 2006; Hall, 2011). Findings of the current study suggest that these principles trickle into a military family context to both negatively and positively influence the social support and growth process. As a negative influence, distal factors presented tensions between needing help and seeking help through formal resources. This was illuminated through narratives of stigma showing the Veteran's dismissal of signs associated with PTSD or denying there was a problem in order to uphold the military ethos of strength (Britt et al., 2006). This sheds light on why a prolonged period of time passed before an inquiry was made, and was often prompted by the spouse/partner reaching a point of crisis herself. However, some spouses/partners voiced how they also needed to learn how to seek help because they were accustomed to being able to multi-task and handle everything on their own. Some

were ashamed to come forward due to stigma surrounding mental health issues and others initially believed it was something they should handle on their own. Therefore, out of necessity, spouses/partners pushed past certain military cultural ideologies (even when the Veteran could not) that were preventing identification of the underlying problem and subsequent treatment and/or formal support. As such, from a social support lens, a beneficial ideological shift in the military community might emphasize viewing strength as "it takes strength to ask for help" rather than a belief that suffering in silence makes someone strong (as spouses/partners voiced Veterans held this belief tightly). It follows from this that a strong person does what is necessary to protect themselves and their family by pushing through pride or shame. In doing so, military families might access formal supports sooner.

As a positive influence, distal factors seemed to encourage joint effort and teamwork. For example, military service members are indoctrinated to work together to support their unit, and this is of prime concern for enabling operational effectiveness and readiness (Britt et al., 2006). Further, many spouses/partners explained that the Veteran's military identify persisted post-release. Similarly, spouses/partners explained it was normative to rely on the support of other military spouses/partners while the Veteran was still serving. Principles of comradery and unit cohesion (Britt et al., 2006; Hall, 2011), might make peer support groups an appealing option given that spouses/partners explained how they were accustomed to relying on a close knit group for support (e.g., military operations for the Veteran, other families in military community for spouses/partners). At the home level, comradery and unit cohesion appeared to be reinforced through couples' acts of mutuality and teamwork. In this light, it is not

surprising that spouses/partners voiced how a sense of mutuality and reciprocity, characteristics of teamwork, "made the difference" for couple functioning, placing them on a growth trajectory. In addition, co-engaging in adaptive coping helped couples address any immediate, day-to-day challenges (similar to operational effectiveness) and prepared them to address any future challenges (similar to operational readiness). Perhaps incorporating these aspects into their social support system may have provided a sense of cultural familiarity that resonated with these CAF Veteran couples.

There is suggestion that PTG is more pronounced in collectivist cultures than in individualistic cultures (Arnedo & Casellas-Grau, 2016). This is an interesting consideration for contextualizing PTG among military families given that military culture relies on collectivist principles such as teamwork, loyalty, and a willingness to sacrifice for the group (Britt et al., 2006). In turn, these cultural ideologies infiltrate family life, impacting how military families navigate the unique aspects of a military lifestyle (Hall, 2011). For example, sacrifice is a familiar concept for military and Veteran spouses/partners as they learn how to manage fluctuating family roles and responsibilities associated with frequent moves due to military postings and lengthy separations from the Veteran due to deployment (Ombudsman, 2013). They maintain loyalty to the service member, despite having to self-sacrifice, such as relinquishing steady employment (i.e., due to moving), in order to support the career of the CAF service member (Battams, 2016). As such, with these mindsets and routines already in place, it is not a far reach to imagine these cultural ideologies also permeate the spousal support system for CAF Veteran couples. Moreover, Berger and Weiss (2009) note that having a history of managing normative stressors acts as a precursor to family PTG.

An interaction between proximate and distal factors in this context can be gleaned by reflecting on how spouses/partners' provision of support initially filled an organizational gap following the Veteran's CAF release as he left the highly structured military environment. Specifically, during active service, spouses/partners described how the military organized all aspects of accessing health care services. Negotiating the civilian health care system became a daunting task for Veterans on their own, regardless of contending with functional barriers associated with PTSD symptoms. As such, many spouses/partners felt compelled to fill this gap by providing instrumental support in the form of tangible aid, advocacy and mediation to offset this missing structure the military had previously provided. This underscores the importance of the informal-formal support relationship as spousal support at the home level was vital for enabling the Veteran's access to programs and services at the community level.

Beyond stability. Couples were able to move beyond stability, attaining personal and relational growth, as part of their new normal for family life. Their continuous growth was apparent throughout the healing process, as seemingly minor steps demarcated major points of growth in many cases. However, it is worthwhile to distinguish between "general personal growth" and models of "post-traumatic growth" pioneered by Tedeschi and Calhoun (1996) and Berger and Weiss (2009). For example, moving out of a crisis period into a stable period undeniably represents growth. However, couples' progression beyond the stable point better aligns with models of individual and family PTG (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006; Calhoun, Cann, & Tedeschi, 2010; Tedeschi & Calhoun, 1996; 1998; 2004) informing this study.

As in models of PTG, the development of growth did not necessarily mark an end to distress and struggle for couples. In fact, it was their ongoing effort that seemed most indicative of PTG, as gleaned through a link to its development and adaptive processes. The linear portrayal of couples' PTSD healing phases (Figure 3) is only meant to capture the overall process of social support and growth, and likely oversimplifies what is probably better described as an iterative process. However, it appears that once growth had developed, couples' could more easily draw on their established adaptive coping strategies to get back on a forward-moving track from any regressions to couples' new stability.

Although Tedeschi and Calhoun's (2004) model of PTG intends to describe transformation among individuals who have directly experienced traumatic stress, the findings of this study suggest that supportive others may experience PTG in similar ways. Spouses/partners' experiences of PTG match the individual model of PTG in the following ways: 1) spouses/partners' transcendent viewpoints and greater appreciation for life demonstrate positive change in their general philosophy of life, 2) their greater compassion for others and greater emphasis on quality friendships indicates positive changes in their relationships, and 3) spouses/partners' greater sense of personal strength and boundaries represent positive change in their self-perception. These avenues of growth are consistent with another qualitative study (McCormack et al., 2010) portraying specific avenues of PTG among military spouses/partners. For example, spouses/partners' PTG in the current study align with McCormack et al.'s (2010) findings of greater empathy and acceptance (relationships), gratitude and transcendence (life philosophy), and personal strength (self-perception) among spouses/partners of military Veterans in

Australia. Interestingly, the international context of McCormack et al.'s study (in relation to the current study) suggests that PTG may be experienced in similar ways cross-nationally for military spouses/partners.

Likewise, spouses/partners accounts of relational PTG correspond to the family model of PTG as follows: 1) couples stronger identity represents positive change in couples' family identity and legacy, 2) their stronger couple bond denotes positive change in family member's relationships with each other, and 3) couples' shifting views on what is most important to them represent positive changes to their family belief system and priorities in life. As noted earlier, existing research on PTG in the dyadic context has largely been conducted among cancer patients and their spouse/partner using quantitative methodologies (e.g., Manne et al., 2004; Weiss, 2004; Zwahlen et al., 2010). These studies have placed little emphasis on the specific avenues of growth experienced by these couples, as a unit; however, one study did suggest that high marital quality was a consequence, rather than a predictor, of PTG (Manne et al., 2004). This premise corresponds with the present findings showing the development of a closer couple bond and stronger couple identify as a result of the PTSD healing process. The current study contributes to the growing body of literature on family PTG by outlining not only how *both* members of a dyad may experience PTG (i.e., not only the directly injured partner), but also how couples grew together, as a family. Further, its qualitative design allowed for in-depth information to be gleaned about the specific ways in which these couples have grown over the course of healing.

Lahav et al. (2017) provide a fresh take on PTG in the dyadic context by demonstrating that PTG originated with the spouse/partner of war Veterans, rather than

the Veteran, as is typically documented. Although the current study's design could not yield concrete data on it, this growth sequence is not unreasonable for the current sample given the strong leadership role spouses/partners played throughout the process.

Although the broader social support system underpinned the culmination of growth, spouses/partners often connected it more specifically to elements of personal and dyadic coping (i.e., individual and dyadic adaptive processes, respectively). Notably, the team mentality consistently identified by spouses/partners seemed to enable a level of dyadic functioning that surpassed an "adequate" point of stability, sometimes even beyond pre-injury family equilibrium.

Spouses/partners' descriptions of evolving relational goals as healing progressed helped distinguish between earlier and later points of healing. Earlier in the healing process, spouses/partners strived to reach a point where they could reduce constant concern for the Veteran's safety (e.g., mitigate suicide ideation), learn how to interact with him (e.g., improve communication), and have the Veteran leave the home without them (e.g., regain independence). Later in the healing process, many spouses/partners expressed their relational goal was to "keep moving forward". The notion of *continuing* to move forward implies that spouses/partners had attained some success in navigating the challenges of living with PTSD, through "regaining stability", and growth emerged as they moved beyond this stable point, taking their relationship in new directions. Specifically, as couples' transactions (i.e., family roles, responsibilities and power) become increasingly egalitarian and routine (Nelson Goff & Smith, 2005), they settled into a "new normal" for family life including new hopes, expectations and ideals for the future that differ from those held before the OSI.

Although traumatic stress in the couple system may hinder attachment, there is also potential for strengthening attachment through dyadic coping, which can provide a relational resource for healing (Nelson Goff & Smith, 2005). My findings reflect this premise as an avenue of relational growth emerging as a stronger couple bond and stronger couple identity. Namely, relational attachment increased as couples increasingly spent quality time together, openly expressed themselves and addressed problems as a family unit. Consequently, couples became closer, more secure and more confident in their relationship as they learned to partner in new ways. As spouses/partners settled into their new way of partnering with the Veteran, they accepted the "new normal" and came to view their relationship as something fluid, rather than static (similar to CATS model; Nelson Goff, 2005), meaning it was something they avowed to continuously work to improve and they could redefine it together, as needed, to meet future challenges. Notably, many spouses/partners voiced that this transformation was not an easy path and some relational challenges still remained, aligning with the notion that distress and growth are not mutually exclusive (Tedeschi & Calhoun, 2004).

Turning points in the healing process. Past studies portraying the development of PTG in a couple context (e.g., Dekel, 2007; Manne et al., 2004; Weiss, 2004; Zwahlen, et al., 2010) have highlighted a potential for growth in spouses/partners through their supportive role. However, the mechanisms for this development have been unclear thus far, and the findings of this study related to spouses/partners' turning points and couples' adaptive dyadic processes help fill this gap. For example, spouses/partners' redefinition of meaning over the course of healing suggests a form of meaning-making coping. Similarly, it also aligns with how Calhoun and Tedeschi (2004) model deliberate

rumination as a meaning-making process that individuals undergo to re-frame adversity in a more positive light (i.e., model of PTG at the individual level). In addition, couples' adaptive dyadic processes accord with literature showing the adaptive value of jointly engaging in meaning-making coping and problem-focused coping in the wake of traumatic stress (e.g., Badr et al., 2011; Blalock Henry et al., 2011; Creech et al., 2013; Nelson Goff et al., 2006; Wick & Nelson Goff, 2014).

Denzin's (1989) notion of "epiphanies", a central feature of interpretive interactionism, provided a valuable lens for interpreting spouses/partners meaning-making process as they reached various turning points that fostered positive change. For example, the introduction of the OSI to family life represented an "experience that shatters a person's life, and makes it never the same again" (Denzin, 1989, p. 17), aligning with Denzin's "major epiphany". It was most exemplified through accounts of the Veteran coming home from deployment as "a different person". This marked a drastic change for the family (i.e., crisis point) that necessitated a new way of life in order to re-gain and move beyond stability. This initially led spouses/partners to attach discouraging meaning to the changes in the family system as "I'm doing something wrong", "I can fix this" and "I don't know who I am anymore".

The PTSD diagnosis impacted couples as a "minor or illuminative epiphany", described as the point where "underlying tensions and problems in a situation or relationship are revealed" (Denzin, 1989, p. 17). As the problem was identified as an OSI, spouses/partners were able to re-frame their circumstances and attribute family disruption to the injury rather than to themselves. The two turning points of "losing myself vs. saving myself" and "fixing it vs. living with it" align with Denzin's cumulative epiphany,

which "occurs as the result of a series of events that have built up in the person's life." (p. 17). In these cases, the defining moment followed either a gradual accumulation of stressors or prolonged attempts at (unsuccessfully) resolving the issue, respectively. In both instances, spouses/partners realized they needed to change their actions or viewpoints to remedy the situation.

Meaning-making as spouses/partners' personal rumination process. Key events, namely, receiving the PTSD diagnosis and learning how this OSI impacted family life, provided the impetus for spouses/partners' turning points, or "epiphanies", as per Denzin (1989). These turning points echo literature highlighting the positive effects of meaning-making coping during hardship, whereby negative viewpoints can be transformed in more constructive ways (Figley & Kiser, 2013; Larner & Blow, 2011).

Meaning-making represents the fulcrum for transformation in models of PTG (Berger & Weiss, 2009; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004), and the current study adds to these models by highlighting specific mechanisms that mobilized this process for spouses/partners. Specifically, as spouses/partners repositioned from a place of confusion, self-blame and despair to a place of hope, acceptance and empowerment, couples' positive adaptation to traumatic stress ensued. These shifts reflect Calhoun and Tedeschi's (2006) notion of moving from brooding rumination to reflective rumination. Replacing old, discouraging meaning with new, strength-based meaning enabled spouses/partners to positively reframe their circumstances, which, in turn, enabled new courses of action aligned with a growth trajectory.

Findings of this study resonate with literature discussing positive psychological effects of moving from a fatalistic frame of reference to a mastery frame of reference

while living with trauma (Dekel, 2007; Figley & Figley, 2009). Moreover, shifting between "then" and "now" echoes a research describing spouses/partners' positive post-trauma changes as "self-in-time" (McCormack et al, 2010, p. 10) to demarcate moving from vicarious trauma to vicarious growth (McCormack et al., 2010). Dekel (2007) suggested that wives of former combat Veterans and prisoners of war felt increasingly competent in their provision of support over time, contributing to a sense of mastery that enabled them to grow while living with PTSD. This matches the shift that spouses/partners in the current study underwent from "losing" themselves to "saving" themselves. Expressly, spouses/partners moved from a place of helplessness (fatalistic) to strength (mastery) as they came to recognize how they could personally influence the healing process. Spouses/partners' increasing success in navigating PTSD-associated challenges allowed them to evolve and uphold their positive outlooks. Consequently, as they grew, their motivation to provide support to the Veteran was enhanced.

Spouses/partners' initial response to how the OSI intersected family life mirrors automatic, brooding rumination where they experienced negative affect, leading to self-blame, while the underlying problem remained ambiguous (i.e., "it's about me" vs. "it's about the injury" turning point). In addition, this sense of self-blame has been echoed in other international studies (McCormack et al., 2010). Contextualizing adversity helps normalize associated family challenges making them seem more manageable as they become understood and meaningful (Walsh, 2012). This clarifies how receiving a PTSD diagnosis helped spouses/partners attach new, hopeful meaning to their circumstances. As spouses/partners contextualized the problem as an injury, and something external to them, they were able to reflectively ruminate vis-à-vis cognitive re-appraisal and re-framing of

their circumstances. In turn, modifying restrictive worldviews in a hopeful way mobilized the development of post-traumatic growth (Joseph & Linley, 2005).

Hope is a vital mechanism for shifting away from despair, blame, and shame, enabling families to recognize potential for change, access supportive resources and strive for betterment. Hope is also a key factor in holding positive outlooks (Walsh, 2012). This point illustrates how the spousal support-PTG cycle was sustained over the course of healing. For example, official recognition of the OSI, through PTSD diagnosis, provided hope for treatment. This inspired spouses/partners to seek formal support in alleviating the symptoms associated with PTSD. In turn, spouses/partners incorporated knowledge acquired through this engagement into their spousal support and they learned how to "live with it" in a more hopeful way.

Disengagement from previous goals signifies a key mechanism for shifting between brooding and reflective rumination (Tedeschi & Calhoun, 2004). As spouses/partners' came to understand the nature of PTSD, and what living with it entailed, they ceased trying to "fix" the problem in the short-term (initial goal) in favor of learning how to "live with" the problem in the long-term (later goal). This shift was possible through spouses/partners' deliberate, reflective rumination in the form of letting go of previously held expectations for family life and accepting that living with PTSD was a long term process requiring patience and empathy. Spouses/partners' reflective rumination in this regard permitted them to attach new meaning to living with PTSD, which enabled them to develop a new family schema that better matched the new state of affairs.

Through their supportive role, spouses/partners often became so enmeshed in the experience that it was difficult to recognize the impact that living with the OSI was having on them (Minuchin, 1974). Coming to understand self-care as a bi-directional process was an important milestone for spouses/partners as it instilled a sense of agency, empowering them to persevere through challenges. Rather than going through life as passive observers, agentic individuals proactively participate in their circumstances with intentionality, forethought, regulation and reflection (Bandura, 2006). It stands to reason that as spouses/partners became more agentic through reflective rumination, they were better able to assert clear boundaries around their self-care time. Consequently, self-care allowed them to individuate from their supportive role and recharge, enhancing their provision of support, which contributed to regaining couple stability and moving beyond toward positive adaptation. Conversely, without these boundaries around their self-care practices, spouses/partners' were not able to periodically compartmentalize their supportive role and their personal well-being suffered.

As members of a dyad individuate, enabling healthy emotional separation from each other, they are better equipped to empathize in the wake of traumatic stress (Nelson Goff & Smith, 2005). Following this rationale, as spouses/partners developed an identity outside of their supportive role to the Veteran, their empathy grew, contributing to greater levels of acceptance and commitment. In turn, this may account for spouses/partners' constant provision of emotional support across the three supportive roles, despite changes in other forms of support. Consequently, this moved couples beyond stability toward positive change.

Re-partnering as couples' relational rumination process. Couples regained their functional stability by learning, through engagement with formal supports, how to reconnect with each through adaptive dyadic processes. Specifically, couples learned how to strategically interweave flexibility, openness, and mutuality into relational acts of communication, problem solving and spending time together. Collectively, these acts represented adaptive dyadic processes that helped couples re-partner and grow as they redefined their relational roles in new, more positive ways.

Berger and Weiss (2009) delineate family rumination as relational processes including communication to make shared meaning and shared problem solving; adaptive dyadic processes in the current study reflect this premise. Couples' joint effort in communicating, problem solving and spending time together demonstrated how they interacted with one another to create shared meaning through a systemic co-construction (Berger & Weiss, 2009). For example, open communication fosters a climate of trust, empathy and tolerance for families (Walsh, 2003). This resonates with spouses/partners' accounts of collaboratively communicating and problem solving with courage, honesty and trust. Spouses/partners depicted a deliberate, co-engagement in rumination with the Veteran through narratives of mutually participating in these strategies for the common purpose of improving their relationship. Moreover, the connection between adaptive dyadic processes and the development of relational growth aligns with studies of military families showing an association between meaning-making and problem-focused coping styles lowering PTSD symptoms and fostering positive family outcomes in the wake of adversity (Badr et al., 2011; Creech et al., 2013; Nelson Goff et al., 2006; Wick & Nelson, 2014).

Underlying belief systems influence how families perceive crises, and these beliefs can be modified based on how families co-manage stressful circumstances (Walsh, 2003). The value of a "team" mentality was a key belief highlighted by spouses/partners that gave the sense that healing was shared, encouraging positive dyadic adaptation (Nelson Goff & Smith, 2005). This represented a form of dyadic meaning-making coping that was especially important for couples' re-partnering and relational growth. Family belief systems are also influenced by and reflect spiritual affiliations (Walsh, 2003). Although several spouses/partners stated their adoption of spiritual practices as a self-care strategy, one spouse/partner specifically noted that she and the Veteran shared religious faith as part of their family healing, helping them to reconnect and make shared meaning of their new family life.

Rumination is associated with negative outcomes to the extent that troubling thoughts become intrusive and cannot be cognitively/psychologically reconciled (Tedeschi & Calhoun, 2004). However, Tedeschi and Calhoun (2004) point out how rumination can also result in positive outcomes as distressful thoughts are cognitively processed and re-framed in an intentional, meaningful way. This study highlights how spouses/partners engaged in this deliberate rumination through the spousal support process, facilitating a growth trajectory. Although spouses/partners' turning points represented rumination on an individual level, this process also impacted the couple system. This came into view by recognizing that spouses/partners not only underpinned the PTSD healing and growth process, but they directed it to a great extent through their provision of support.

Contextualizing adversity helps families gain a "sense of coherence" in navigating stressful circumstances together as they come to view the problem as something they can handle and learn what resources are available to address it (Walsh, 2003). This accords with couples coming to view family disruption as a concrete problem they could address through treatment and they gained a better sense of where they might seek support to do so. Contextualizing adversity also considers couples' shared identity as a "military family", which ascribes a set of beliefs attached to broader military culture that might shape their understanding of PTSD (Berger & Weiss, 2009). That is, military families recognize a risk for injury associated with a CAF career, especially when deployed to precarious locations (National Defence and Canadian Forces Ombudsman, 2013) as all of the Veterans in the current study had. Despite PTSD changing their expectations for family life, perhaps understanding PTSD as an OSI resonated with couples' perceiving a potential for injury as part of a military lifestyle. For example, couples' awareness of the risk for injury associated with deployment and even regular training exercises, may have formed part of their pre-injury schema of being a "military family". As couples came to attribute their relational issues to the OSI, they may have been better able to reconcile PTSD into their military family schema.

Berger and Weiss (2009) suggest that dispositional factors and family resources predispose families to experience PTG. Moreover, having managed previous stressors increases the likelihood of PTG (Calhoun & Tedeschi, 2004). This is especially applicable to military families due to mobility, separation and risk comprising relatively normative aspects of their lifestyle compared to civilian families ((National Defence and Canadian Forces Ombudsman, 2013). Indeed, all couples had experienced at least one

separation due to deployment, most multiple times, prior to the OSI. As such, it is likely that couples had previously established a certain degree of adaptability (dispositional factor) from this history of successfully managing post-deployment family reintegration (family resource). However, these routine, pre-injury relational strategies are distinguished from strategic, post-injury strategies to the extent that the latter were specifically tailored to regain lost stability in the relationship from the OSI (i.e., problem-focused coping). Whereas couples' routine, pre-OSI strategies may have helped them navigate normative stressors, it was necessary for couples to deliberately adjust their relational strategies to living with an OSI, as a form of family rumination, to drive them away from crisis toward growth.

Limitations and Future Research

At the outset of this research, it was contemplated whether the unique contributions of spousal support and formal support toward PTG would be discernable. That is, would it be possible to distinguish between how much PTG developed through spousal support and how much developed as a natural progression of couple engagement in PTSD treatment. This study could not conclusively differentiate, highlighting an avenue for future research.

The current findings did, however, demonstrate that informal and formal resources can be viewed as complementary factors, rather than separate ones, in the development of PTG. Specifically, their interdependent relationship comprised couples broader social support system in this context and marked the difference between "surviving" (stability) and something that resembled "thriving" (beyond stability) despite hardship. Spouses/partners' narratives suggested they presently had a support system in

place that could be described as "effective" in the dictionary sense of being "successful in producing a desired or intended result" (Oxford University Press, 2017a), i.e., successful in supporting PTSD healing. However, reaching this point was an arduous process for many couples as they encountered awareness, access, and availability issues regarding formal support options. As such, I suggest that it would be beneficial for future research to examine more definitively what an *effective* informal-formal support relationship entails in this context, or alternatively, how its effectiveness could be improved. Whereas this study emphasized the positive role of spousal support, as informal support, future research should aim to conduct an in-depth inquiry into the specifics of formal support that make it effective for military couples to complement the present findings. Clearly demarcating what helps/hinders the informal-formal relationship from a formal support standpoint would advance our understanding of social support across home and community levels in this context.

The current study highlights the importance of positive relational functioning, as a component of spousal support, toward healing from PTSD, generally, and the development of PTG, specifically. However, the dataset did not allow for an in-depth understanding of any one relational process, such as attachment patterns or relational boundaries, which may be useful considerations for program development. Magnifying specific relational processes would enable a more comprehensive understanding of adaptive couple functioning that leads to PTG. For example, examining specific relational attachment patterns might provide further insight into couples' motivations, such as decisions to stay or leave the relationship. However, an in-depth examination of such was outside the scope of this study because it is an intricate theory that warrants structuring

within a research design from its inception. Similarly, disrupted role boundaries emerged in this study as an element leading to family instability. However, a more in-depth examination, elucidating how couples navigate enmeshed, disengaged and accommodated relational boundaries (Minuchin, 1974) across points of healing, could inform not only research, but clinical practice as well.

It is important to clarify that spouses/partners in the current study described accounts of living with chronic, rather than acute, levels of stress. Therefore, it is not to say that findings of this study might not apply to families experiencing acute stress, but to caution that they might better generalize to families who have endured and managed traumatic stress over a lengthy period of time. Indeed, most spouses/partners described living with this OSI for over a decade, and time itself was noted as a healing factor. However, *how much* time was necessary for couples to move between the phases of losing stability, regaining stability and moving beyond stability could not be gleaned from this study's dataset. This is a worthy avenue for future research to explore as it will better operationalize social support in this context to inform ideal timing for implementing formal support services/programs to optimize military families' course of PTSD healing.

Findings of this study showed a trend toward links between certain adaptive processes and certain areas of growth. Although not conclusive, this research provides groundwork for future research aiming to more definitively understand specific pathways between social support and PTG via adaptive processes. For example, a qualitative approach was warranted as a first step in identifying key mechanisms underlying the relationship between social support and PTG, particularly as it is a fairly novel inquiry.

This enabled a rich account of PTSD healing among CAF Veteran couples, another relatively novel inquiry. A reasonable avenue to build on the current research might include a quantitative research design that that aims to further particularize specific adaptive processes that predict specific areas of growth and the strength between these relationships. This would not only be interesting but informative for formal support program development, particularly given that the adaptive strategies outlined here are teachable.

The cross-sectional design of my study, and its partial reliance on retrospective accounts (i.e., remembering their experience during the most challenging points), limits pinpointing when certain processes occurred and the sequence of the support process. Although some directionality and sequencing can be gleaned from data in the current study, it remains to be further developed through longitudinal examinations. In addition, the directionality of PTG in a couple context is incomplete from the current findings given the first-hand experience of the Veteran, as the primarily injured partner, could not be gleaned. That is, did the Veteran need to first experience PTG before it developed in the spouse/partner, or is was the spouse/partner's PTG experience independent of the Veteran's? There is at least one study that suggests it is possible for PTG to originate in a spouse/partner before the Veteran (e.g., Lahav et al., 2017), but this claim warrants further substantiation. A future study that included accounts of both partners would help clarify.

Although it appears that spouses/partners helped cultivate an autonomy-supportive environment, the larger self-determination theory from which this concept derives is more complex. Furthermore, it relies on understanding how the experience

internally unfolds for the support recipient (e.g., the Veteran) based on how others (e.g., spouse/partner) have externally fostered a supportive environment (Deci & Ryan, 2008). As such, speculations cannot be made beyond the social environmental aspect of the theory given first-hand accounts were not obtained from the Veteran. However, this represents an interesting avenue for future exploration among CAF Veteran couples that might help frame the Veteran's experience of growth and provide a more complete understanding of PTG in this context.

Across the board, spouses/partners voiced a theme of assuming a caregiving role out of necessity rather than desire. Notably, all participants in this study were female spouses/partners who provided support to male Veterans (i.e., traditional military family structure). However, military families have become increasingly diverse over time (Ombudsman, 2013), leaving room to contemplate the impact of gender on this dynamic. For example, about 12% of CAF members are female today and over 1 in 10 spouses/partners are male (Snyder, 2013). However, societal norms expecting that women should be nurturing and the resulting traditional roles of women as caregivers and men as providers seem fairly persistent (Denholm, 2012). This raises question about whether the patterns depicted in this study would hold for non-traditional couples. Further, would a male spouse/partner feel the same drive to provide long term support and commitment to a female service member/Veteran? Or does part of this imperative derive from dutiful expectations associated with what it means to be a female spouse/partner of a male service member/Veteran? The current study leaves room for applying a gender lens to this inquiry in future research.

This research has demonstrated a potential for systemic growth in the family context. Expressly, this study adds to existing literature showing that spouses/partners can grow from living with traumatic stress through their provision of support, even without being the primarily injured party (Arnedo & Casellas-Grau, 2016). However, the unit of analysis for family was limited here to the couple system and we have yet to grasp how far reaching PTG may be in a family context. Namely, there is room to explore intergenerational growth in future studies, such as growth in children or parents of Veterans living with PTSD. This is an important avenue of research for advancing our understanding of PTG, albeit, outside the scope of this study.

This inquiry did not assess for different levels of PTSD severity. It could be that couples' experiences of PTG vary as a function of low, moderate or severe levels of PTSD, but this type of analysis was not possible with the current dataset. Similarly, this study did not directly assess for STS symptoms in the spouses/partners, although some narratives alluded to distress consistent with descriptions of this type of reaction to traumatic stress in existing literature. At least one spouse/partner did identify with descriptions of "secondary stress reactions"; however, without concrete information, a full understanding of secondary PTG (i.e., among supportive others) is incomplete. For example, models of PTG propose that a stressor is sufficient to incite a growth process to the extent that it "shatters" an individual's or family's worldview (Berger & Weiss, 2009; Tedeschi & Calhoun, 2004), yet it is not entirely clear what constitutes "shattering" for secondarily impacted individuals. For example, do spouses/partners need to, themselves, experience traumatic stress symptoms that mirror the Veteran (i.e., STS) in order to put the process in motion? Or does the turmoil of a disrupted family life, leading to distress

that does not necessarily mirror PTSD symptoms, suffice? In other words, where does the secondary PTG process begin? Does the shattering of worldview assumptions need to first be psychological in nature or can it perhaps begin with a "social shattering" that leads to an internal dilemma? Future research on family PTG can apprise this gap by incorporating specific measures into their research design to assess for these contrasting standpoints.

The findings of this study highlight a potential for social change within the military/Veteran community that comes into view through the interdependence of the informal-formal support relationship. Spouses/partners' formal support engagement offered new channels of informal support for the spouses/partners as they formed friendships with other spouses/partners living under similar circumstances. This scenario is the epitome of community capacity that fosters social change, and military communities have been applied as a platform for conceptualizing community capacity in past research (Bowen, Martin, Mancini, & Nelson, 2000; Huebner, Mancini, Bowen, & Orthner, 2009). Viewing a social support-PTG inquiry through a community capacity lens, particularly as it represents a systemic process, could delineate concrete avenues for social change that could optimize community support for military/Veteran families living with an OSI. Specifically, living with military service-related PTSD is not solely an individual or family issue. Rather, it is a systemic issue at the community level as much as at the home level. This means that building community capacity through the informal-formal support relationship could result in community level change in how the problem is viewed and handled systemically.

Conclusions

Although the conceptualization of PTG has been validated across varying contexts, (including among military Veterans) to my knowledge, this is among the first Canadian research to demonstrate growth among spouses/partners of military Veterans living with PTSD. Overall, this study has established a context-specific account of social support that builds a potential for PTG. Examining PTG through a social support lens depicted how CAF Veteran couples' experiences living with PTSD intersect family and community levels. Findings from this study align with existing research on military families and PTSD by showing how this type of OSI permeates family life, creating systemic disruption and a potential for deleterious effects for supportive family members. However, the spouses/partners who participated in this study additionally portrayed how they "made it work" as a couple despite struggling, and how they took their relationship to a new, positive level vis-à-vis the spousal support system. As such, the current study provides an important counterbalance to the dominant view of negative outcomes for military families following traumatic injury by demonstrating a potential for positive outcomes.

Most PTG research to date has examined family as a viable context for growth to the extent that members provide social support to an individual living with traumatic stress. The current study expands on this body of literature showing that the family system can also be the unit of growth, as proposed by Berger and Weiss (2009). Further, it provides a context-specific portrayal of spousal support and family PTG, offering valuable insights for enhancing support systems for military couples living with service-related PTSD.

Findings provided by this research demonstrate how spouses/partners underpinned and led the PTSD healing process through their provision of support to the Veteran. By assuming a highly directive role for the Veteran post-release, positive changes in these spouses/partners fostered positive changes in the couple relationship. Spouses/partners were life lines for Veterans as they learned how to negotiate PTSD symptoms within family life; their commitment and leadership helped keep couples' marriages intact, despite living with significant hardship, and led to positive family outcomes. In turn, formal support resources represented a life line for spouses/partners, enabling them to sustain their supportive role over time. This amplifies the need for advancing formal support resources for military spouses/partners as well as for Veterans.

The age cohort of this study's sample (i.e., largely middle-aged women) brings to light the multiple, competing roles negotiated by the spouses/partners. For example, middle-aged caregivers have been referred to as the "sandwich generation", describing how they may be simultaneously raising children and caring for aging parents, and this also extends to spouses/partners who are caring for injured Veterans (Smith-Osborne & Felderhoff, 2014). Indeed, all except one couple in the current study had children and over half of the spouses/partners held employment outside the home while supporting the Veteran. These competing roles and responsibilities underscore the importance of developing formal resources that directly target military family members, especially spouses/partners, rather than indirectly through the Veteran. Perhaps in doing so we can prevent spouses/partners from "losing themselves".

Existing models of PTG have been comprehensive to the extent that they demarcate key components of the PTG process, yet specific mechanisms that bridge

shifts between automatic and deliberate rumination have been overlooked. By casting a social support lens on the PTG process, this study was able to apprise this gap and illuminate how spouses/partners became part of the rumination process. The unique insight provided by this study into the specific mechanisms of growth via social support for CAF Veteran couples living with service-related PTSD denotes a strong contribution to existing PTG frameworks. This work offers a novel angle by showing *how* supportive spouses/partners experience growth as a function of their intense level of involvement in the Veteran's healing process. Moreover, the present findings demonstrate that secondarily injured individuals (e.g., spouse/partner) undergo a similar process of growth through their provision of support and shows how *their* growth impacts positive couple adaptation to traumatic stress.

The leadership role spouses/partners demonstrated in couples' healing and growth process stands in contrast to existing models of PTG, which portray them as a component. This implies the military community might benefit from the development of a family PTG model that reflects their unique cultural background. Namely, the extent to which spouses/partners strongly guided the PTSD healing and growth process implied that the authoritarian military environment informed couples' mental schemas (comprising their worldview), representing a familiar support hierarchy that transferred post-release into the spousal support system. Spouses/partners in a civilian context might also lead a social support/growth process; however, it is especially salient in a military context where Veterans are accustomed to following directives through the chain of command for purposes of safety and operational effectiveness (Britt et al., 2006) and spouses/partners seem to adopt this directive role upon the Veterans release from service.

If a case can be made for a distinction between military families and civilian families in general, it stands to reason that their experience of PTG may be unique as well. The development of a model of PTG that shows how spouses/partners guide the healing process would support their agency in the process, depicting them as "strength *beside* the uniform" rather than "strength *behind* the uniform" (DMFS, 2004). In turn, by bringing spouses/partners to the forefront, such a model could inform policy and program development for military families living with an OSI. For example, developing a culturally-informed model of PTG for CAF Veterans and their families would increase cultural competence among service providers delivering formal support to this population. This is especially valuable for service providers in the civilian context who may not be well-versed in the nuances of this similar, yet distinct military community.

At the outset of this research, the goal was to examine social processes at the home level. However, it quickly became apparent that social processes between home and community levels are interconnected, such that one could not be considered without the other to understand couples' experiences of PTSD healing and growth. CAF Veteran couples can both survive and potentially thrive following traumatic stress through a social support network involving informal resources at the home level and formal resources at the community level. In particular, the adaptive dyadic coping depicted in this study represents teachable skills for military families living traumatic stress injuries. Once established, these skills reinforce the broader social support system, enabling couples to grow as they heal together, as a family. However, engaging with formal resources was hindered by access and availability issues. For example, availability of programming and quality of services seemed to vary by geographic location, and some spouses experienced

a lack of consistency as they re-located. Another issue, more closely connected to the post-release transition from military to civilian life, was difficulty connecting with medical care in the civilian setting, such as contending with lengthy waitlists to see a family doctor. In several cases, this created a barrier to identifying the problem as PTSD and securing treatment. Together, these points highlight a need for better streamlining of supports both across different geographic locations and during the transitional period between military service and release. Moreover, there is a demand for greater community outreach efforts for families who have difficulty seeking help. In addition, this study highlights a need for earlier inclusion of spouses/partners, such as at the level of post-deployment screening, in identifying negative changes in the Veteran and family system as PTSD, especially since they are often aware of a problem, or willing to address it, before the Veteran.

This study contributes to the burgeoning viewpoint that healing from traumatic stress constitutes a bi-directional process between the primarily injured individual and supportive others. Indeed, this study depicted bi-directionality across home and community levels. For example, the spouse/partner's well-being was shown to influence the Veteran's well-being and vice versa, contributing to the PTSD healing process in both negative and positive ways. Namely, symptoms of PTSD initially bore a negative impact on spouses/partners as they provided support to the Veteran. However, as they learned the importance of self-care throughout the process, spouses/partners' increasing strength and forward-looking perspectives positively impacted the couple relationship. The informal-formal support relationship was also identified as a bi-directional process linking the home and community levels. Spouses/partners, representing informal support, relied on

formal resources within the community to advance healing as a couple. In turn, formal supports largely relied on the spouse/partner to facilitate access to these resources, particularly if the Veteran was reluctant to engage with them. The more formal support these couples received, the more spousal support was sustainable. Consequently, this informal-formal relationship progressed couples' cycle of growth.

Current models of PTG show that distress and struggle are necessary components of a growth process. Moreover, growth and distress are not mutually exclusive and the presence of one does not necessitate the absence of the other. Finding meaning in the distress bridged negative and positive outcomes for couples in the current study. Even though all spouses/partners recognized there was still "work" to be done, they all perceived they were in a "good place", but not necessarily free from struggle. However, there was consensus among participants that they were through the "worst part", which many articulated as a necessary part of the healing process in order to regain stability in their relationship and continue moving forward/beyond. Ultimately, the findings of this study demonstrate that it is *how* couples organize themselves to live with distress that dictates their family outcome.

This discussion closes with a quote that captures the essence of family adaptation from a family systems perspective. Furthermore, it nicely embodies the findings of this study:

> In well functioning families adaptation triumphs over homeostasis. These families can mobilize coping skills that have remained hidden underneath established complementary patterns…A well functioning family is not defined by the absence of stress or conflict, but by how effectively it

> handles them as it responds to the developing needs of its members and the changing conditions in its environment. (Colapinto, 2015, p. 124)

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Appendix A
Interview Guide

A. Demographic and Service-related Questions

"I'd like to start off with some basic information about you and general questions relating to your partner's service in the military."

1. How long have you lived together?
2. Do you have any children? If so, how many and how old?
3. What is your marital status?
4. What year were each of you born in?
5. Did one or both of you serve in the Canadian Armed Forces (CAF)?
    a. How many years?
    b. Which CAF environment(s)? (Probe: Army? Navy? Air Force?)
    c. Military rank(s)?
    d. Nature of work? (Probe: Trade? What did the work involve?)
    e. Deployed to any "hot spots"? (Probe: combat zones?) If so, how many times?
    f. If deployed, how did you, as a couple, view the experience of deployment? (Probe: what kind of meaning did you attach, as a couple, to the experience? e.g., "necessary part of the job", "an honour", "a major inconvenience")
    g. How long has it been since your partner released from the military?
    h. How would you describe your partner's transition from military to civilian life?

B. OSI-related Questions

"Now, I would like to talk about your experience, as a couple, living with PTSD."

1. Did you first become aware that your partner had an OSI through a diagnosis of PTSD?
2. Please describe your experiences, as a couple, leading up to the diagnosis of PTSD.
3. Did receiving a diagnosis of PTSD have an effect on you, as a couple? If so, how? (Probe: did anything change in your relationship? What kind of meaning did you attach, as a couple, to this diagnosis?)
4. Has your partner received any treatment for PTSD?
    a. How long was your partner engaged in treatment?
    b. Did you engage in any treatment together as a couple?
    c. Has treatment been helpful for you, as a couple? If so, how?
5. How do you view the experience of living with this OSI (PTSD)? Has there been a shift in your perspective over time throughout the healing process? If so, what has facilitated this shift?
6. How would you describe the type and level of support you provided to your partner throughout the process of healing?
7. What aspects of your relationship as a couple, such as coping strategies you engaged in together, were most supportive to healing? Why were these aspects helpful? (Probe: Can you tell me about your communication with each other? Have there been any changes?)
8. What kind of support have you had for yourself, if any, throughout the healing process? (Probe: any formal support programs/services offered through VAC?

Other organizations?) If any, did these forms of support help or improve your ability to provide support to your partner? If so, how?

C. PTG-related Questions

"Next, I am going to ask you a series of questions that are more specific to changes you may have experienced as a couple throughout and following the healing process. As a result of your healing process…"

[*Note: if participants report changes in any of the below questions, probe (for each change) if there was anything specific in the spousal support system that fostered these changes*]

1. Has your bond as a couple changed over the course of healing? (Probe: closeness? Emotional expression?). If so, do you believe there is a connection between this change and the type and level of support you provided within your relationship? If so, please explain. (Probe: was there anything specific about support given and received to one another as a couple that you believe encouraged this change?)
2. Have you experienced any changes in how you or your partner relate to others, including each other? (Probe: do you view people differently? Any changes in willingness to accept help from others? Any changes in level of trust for others?)
3. Have your interests or activities changed, either individually or as a couple?
4. Have any new opportunities arisen, which might not have presented before your experience with PTSD? If so, please explain.
5. Have you experienced any changes in how you handle problems or difficulties as a couple? (Probe: has your level of acceptance and/or strength for challenges changed?)

6. Have you experienced any changes in spirituality or religiosity?
7. Have you experienced any changes in priorities as a couple? (Probe: changes in what is most important to focus on in life?)
8. Have you experienced any changes in your level of appreciation for people or life in general? (Probe: value for yourself and/or as a couple? Value for life itself?)
9. Have you experienced any changes in how you identify as a couple?
10. Have you experienced any changes in yourself that you attribute to your provision of support throughout the healing process?
11. Some of the changes we have just discussed might be described as "positive changes that have developed as a result of the PTSD healing process". Do you view any changes you have experienced as positive? If so, why would you describe them as such? If not, is there another description you believe fits better?
12. Do you believe there were/are aspects of your provision of spousal support that enhanced any aspects of your partner's formal PTSD treatment? If so, please explain.
13. If positive changes have been experienced, are there aspects of the spousal support process that you believe uniquely contributed to these changes? (meaning outside of any changes attributed to formal PTSD treatment or otherwise) If so, please explain.
14. Do you have any tips for other couples that are living with an OSI in the form of PTSD?
15. Would you like to share anything else that we did not discuss about the managing PTSD as a couple?

[*Note: the PTG-related questions were formulated based on the five areas of PTG (Tedeschi & Calhoun, 1996)/ family PTG (Berger & Weiss, 2009) and adapted from some PTGI-SF questions (Cann et al., 2010)*]

Appendix B
Letter to Service Providers ("key contacts")

Department of Family Studies and Gerontology

Title of Study: *The role of spousal support processes in the development of post-traumatic growth among CAF veterans and their intimate partners*

I am looking for participants to take part in a Master-level research project (thesis) being conducted by me through the Department of Family Studies and Gerontology at Mount Saint Vincent University, Halifax, Nova Scotia. This project is in partial fulfillment of my graduation requirements for the Master of Arts in Family Studies and Gerontology program. The purpose of this study is to explore experiences of post-traumatic growth (PTG) among Canadian Armed Forces (CAF) Veteran couples who are living with an operational stress injury (OSI) in the form of post-traumatic stress disorder (PTSD). In particular, I am interested in examining the role that spousal support processes have played in the development of PTG within the couple relationship.

This research project will involve individual interviews with spouses/intimate partners of CAF Veterans who are living with an OSI in the form of PTSD. Participating spouses/intimate partners must be over 19 years of age, they must communicate in English, and the injured partner must have received at least one year of treatment for PTSD symptoms prior to participation in the study. In addition, the spouse/intimate partner should perceive that positive changes have developed either within the injured partner or within the couple relationship as a result of the PTSD healing process. It is not required that the spouse/intimate partner was in attendance for any or all of the treatment sessions to participate; however, the spouse/intimate partner should perceive that he or she provided support to the injured partner during the healing process.

The interview will last about one hour to one hour and thirty minutes in length. During the interview I will be asking questions about living with PTSD that largely focus on the experience of PTG within the couple relationship and the role that spousal support has played in its development. Spouses/intimate partners will be asked questions such as "How do you, as a couple, cope with or manage your experience with PTSD?", "What aspects of your relationship as a couple, such as coping strategies you engaged in together, were most supportive to healing?", "Has your bond as a couple changed? If so, do you believe there is a connection between this change and the type and level of support you provided to your partner?" The spouses/intimate partners may choose not to answer any question, if they so wish, without penalty. They will also be given the opportunity to offer opinions and information on issues or subjects not raised by me that they think are related to my research. With their permission, the interview will be audio recorded and later it will be transcribed verbatim. After it has been transcribed, I will contact participating spouses/intimate partners again to arrange another visit so we can review the responses they provided during their interview. During this time they will also have a chance to go over my initial understanding of the information I have collected for this study.

Any information the spouses/intimate partners share in the interview may be used in future publications or presented at conferences. Their names will not appear in any publications, papers, or presentations that emerge from this research. Only I will know the personal information about each spouse/intimate partner. Their names and other identifying information (e.g. the names of their children, schools, neighborhoods, workplaces) will be changed as required. Identifying information will also be removed from the transcript of each interview. All written material, such as the informed consent letters, transcripts, and notes, will be kept in a locked filing cabinet. Access to the original data will be limited to my thesis supervisor, Dr. Deborah Norris, and me. All electronic records of transcripts will be stored on a computer that is password protected. As noted, interviews will be audio recorded, with the spouses/intimate partners' consent. The recording device may be switched off at any time, if the spouses/intimate partners so choose. Voice files will also be stored on a password-protected computer. Following the completion of my study I will destroy the audio recordings. Other materials (transcripts, notes, informed consent letters) will be retained for five years in the event that an audit of the research project is conducted or that the information is required for further analysis.

Although every effort will be made to keep participants' identity and responses confidential, given they belong to a relatively small, cohesive military community, total anonymity might be difficult to guarantee. Participants will be made aware of this prior to their involvement, and they will have the opportunity to review a transcription of their interview and results of the study prior to my report being finalized. As mentioned, participants' names and other identifying information will be modified in these documents. However, if in reviewing the interview transcription and/or results they encounter contextual information that they believe could inadvertently lead to their identification, they may request this information be excluded from my presentation of results in the final report. Furthermore, participants may choose to change any part of or even exclude the entire interview from the study without penalty.

There is no expectation that any distress will be experienced as a result of these interviews. It should be noted, however, that the personal nature of the questions may lead to unanticipated emotional recollections. Spouses/intimate partners will be advised that they may stop the interview at any time if the process creates any discomfort. If they experience significant emotional or psychological discomfort, I will provide contact information for confidential services within the community that will be able to support them. Their participation or non-participation in this study will not influence any services or programs they are accessing or wish to access in the future.

Thank you for taking the time to review this information about my research. Should you know of CAF Veteran spouses/intimate partners that might be eligible to participate, I would greatly appreciate you forwarding the attached information letter to them; however, you are under no obligation to do so. This letter to potential participants outlines the purpose and nature of my study, and it instructs spouses/intimate partners of CAF Veterans who are both eligible and interested in participating to contact me directly for more details about their involvement. If you have further questions about this research process, please contact me (see my contact information below) or my thesis supervisor, Dr. Deborah Norris (902-457-6376 or deborah.norris@msvu.ca).

In the event that you have any problems with, or wish to voice concern about any part of this study, you may contact the Chair of the Mount Saint Vincent University Research Ethics Board at (902) 457-6350 or by email at research@msvu.ca

Sincerely,

Kimberley Smith-Evans, M.A. Candidate
Department of Family Studies and Gerontology
Mount Saint Vincent University
kimberley.smith.evans@msvu.ca / 902-457-6572

Appendix C
Letter to Potential Participants

Department of Family Studies and Gerontology

Title of Study: *The role of spousal support processes in the development of post-traumatic growth among CAF veterans and their intimate partners*

I am a graduate student at Mount Saint Vincent University (MSVU), Halifax, Nova Scotia. You are invited to take part in a research project that I am conducting in partial fulfillment of my graduation requirements (thesis) for the Master of Arts in Family Studies and Gerontology program. The purpose of this study is to explore experiences of post-traumatic growth (PTG) among Canadian Armed Forces (CAF) Veteran couples who are living with an operational stress injury (OSI) in the form of post-traumatic stress disorder (PTSD). In particular, I am interested in examining the role that spousal support processes have played in the development of PTG within the couple relationship. Examples of PTG that you or your partner may have experienced include a greater sense of personal strength, a greater appreciation for life, closer relationships with others, realization of new possibilities for your life, and spiritual development. The results of this research may be published in academic journals and shared with interested professionals working within the military community (e.g., Military Family Resource Centres, Veterans Affairs Canada, etc.). Recommendations for policy and program advancement will be developed.

You have been invited to participate in this study because you identify as a spouse/intimate partner of a CAF Veteran who is living with an OSI in the form of PTSD. This research project will involve you discussing your experience with me in response to a series of interview questions. These interview questions will focus on your experience of living with PTSD and the role that your provision of support played in fostering growth throughout this experience. To this end, you should perceive that positive changes have developed within the injured partner or within the couple relationship as a result of the PTSD healing process. In addition, you should meet the following eligibility criteria:

- You speak fluent English
- You are at least 19 years old;
- You self-define as being in a committed, long-term relationship with the CAF Veteran partner and have cohabitated with him or her for at least two years prior to the OSI;
- You have remained in a committed relationship with the injured CAF Veteran partner throughout the PTSD healing process;

- The CAF Veteran partner has received (and may still be receiving) at least one year of professional treatment (e.g., medical, psychological) to manage his or her PTSD symptoms prior to participation in this study (it is not required that you were in attendance for any or all of the treatment sessions);
- You provided support to your CAF Veteran partner throughout the PTSD healing process and you perceive that it was beneficial to his or her recovery.

If you are eligible and you choose to participate in this study, the interview will last about one hour to one hour and thirty minutes in length. During the interview I will be asking questions about living with PTSD that largely focus on the experience of PTG within your relationship as a couple and the role that spousal support has played in its development. You will be asked questions such as "How do you, as a couple, cope with or manage your experience with PTSD?", "What aspects of your relationship as a couple, such as coping strategies you engaged in together, were most supportive to healing?", "Has your bond as a couple changed? If so, do you believe there is a connection between this change and the type and level of support you provided within your relationship?" You may choose not to answer any question if you so wish without penalty. You will also be given the opportunity to offer opinions and information on issues or subjects not raised by me that you think are related to my research. With your permission, the interview will be audio recorded (the recording device may be switched off at any time, if you so choose) and later it will be transcribed verbatim. After it is transcribed, and I have had time to read it, I will contact you again to arrange another meeting so we can review the responses you provided during your interview. During this time you will also have a chance to go over my initial understanding of the information I have collected for this study.

Should you choose to participate in this study, any information you tell me in the interview may be used in future publications or presented at conferences. Your personal information will only be known to the researcher, and your name and other identifying information (e.g. the names of your children, schools, neighbourhoods, workplaces) will be changed in any publications, papers, or presentations that emerge from this research. Identifying information will also be removed from the transcript of your interview, if you consent to audio recording. All written material, such as the informed consent letters, transcripts, and notes, will be kept in a locked filing cabinet. Access to the original data will be limited to me and my thesis supervisor, Dr. Deborah Norris, Associate Professor at MSVU. All electronic records of transcripts will be stored on a computer that is password protected. If you consent to audio recording, voice files will also be stored on a password-protected computer. Following the completion of my study I will destroy the audio recordings. Other materials (transcripts, notes, informed consent letters) will be retained for five years in the event that an audit of the research project is conducted or that the information is required for further analysis.

Although every effort will be made to keep your identity and responses confidential throughout the research process, given you belong to a relatively small, cohesive military community, you should be aware that total anonymity might be difficult to guarantee. You will have the opportunity to review a transcript of your interview as well as the results of the study prior to the report being finalized. As noted above, your name and other identifying information will be modified in these documents. However, if in reviewing the interview

transcript and/or results you encounter contextual information that you believe could inadvertently lead to your identification, you may request this information be excluded from my presentation of results in the final report. Furthermore, you may choose to change any part of or even exclude the entire interview from the study without penalty.

There is no expectation that any distress will be experienced as a result of these interviews. It should be noted, however, that the personal nature of the questions may lead to unanticipated emotional recollections. You may stop the interview at any time if the process creates any discomfort. If you experience significant emotional or psychological discomfort, I will provide contact information for confidential services within the community that will be able to support you. Your participation or non-participation in this study will not influence any services or programs you are accessing or wish to access in the future.

If you meet the above eligibility criteria, and you are interested in taking part in this research, please contact me directly by email or telephone (information noted below my signature). At this time, I will provide you with further details about my study by way of informed consent letter. You should make sure that you know the details about this project prior to giving your consent to participate. You will have an opportunity to ask questions and/or seek clarification about my study prior to making a decision about your involvement. You may contact me, or my thesis supervisor, Dr. Deborah Norris (902-457-6376 or deborah.norris@msvu.ca) with any questions about the study. Whether or not you take part in this project is completely up to you and you may withdraw at any time.

In the event that you have any problems with, or wish to voice concern about any part of your participation in this study, you may contact the Chair of the Mount Saint Vincent University Research Ethics Board at (902) 457-6350 or by email at research@msvu.ca

Sincerely,

Kimberley Smith-Evans, M.A. Candidate
Department of Family Studies and Gerontology
Mount Saint Vincent University
kimberley.smith.evans@msvu.ca / 902-457-6572

Appendix D
Recruitment Poster

INTERESTED IN RESEARCH ON POST-TRAUMATIC GROWTH? PARTICIPANTS NEEDED!

We are looking for spouses/intimate partners of Canadian Armed Forces (CAF) Veterans to volunteer in a study to help us better understand the development of post-traumatic growth (PTG) as a result of healing from post-traumatic stress disorder (PTSD). We are particularly interested in learning about the role that spousal support has played in fostering PTG.

Spouses/Intimate partners will be asked to take part in an interview lasting approximately one hour and thirty minutes in length. This interview is open to eligible participants across Canada and interviews can be conducted in person, by telephone or by Skype. In appreciation for your time, you will be entered into a draw for a gift certificate at a local restaurant.

If you are interested in participating in this study or would like to receive more information, please contact:

Kimberley Smith-Evans, M.A. Candidate
Department of Family Studies and Gerontology
Mount Saint Vincent University
Email: kimberley.smith.evans@msvu.ca
Tel.: 902-457-6572

Appendix E
Informed Consent Form

Department of Family Studies and Gerontology

Title of Study: *The role of spousal support processes in the development of post-traumatic growth among CAF veterans and their intimate partners*

You are invited to take part in a research project being conducted by Kimberley Smith-Evans, M.A. Candidate in the Department of Family Studies and Gerontology at Mount Saint Vincent University (MSVU)(Halifax, Nova Scotia). Ms. Smith-Evans is conducting this research in partial fulfillment of her graduation requirements. Your participation in this project is completely voluntary and you may withdraw at any time.

The purpose of this study is to explore experiences of post-traumatic growth (PTG) among Canadian Armed Forces (CAF) Veteran couples that are living with an operational stress injury (OSI) in the form of post-traumatic stress disorder (PTSD). Emphasis will be placed on examining how support received from a spouse/intimate partner during the healing process has fostered the development of PTG within the couple relationship. Examples of PTG that you or your partner may have experienced include a greater sense of personal strength, a greater appreciation for life, closer relationships with others, realization of new possibilities for your life, and spiritual development. The results of this research will be presented at Ms. Smith-Evans' thesis defence conference at MSVU. In addition, results may be submitted for publication in academic journals and shared with interested professionals working within the military community (e.g., Military Family Resource Centres, occupational stress injury clinics, Veterans Affairs Canada). Recommendations for policy and program advancement will be developed.

You have been invited to participate in this study because you identify as a spouse/intimate partner of a CAF Veteran who is living with an OSI in the form of PTSD. In addition, you perceive that positive changes have developed either within the injured partner or within the couple relationship as a result of the PTSD healing process. You are eligible to participate in this study if you meet the following additional criteria:

- You speak fluent English
- You are at least 19 years old;
- You self-define as being in a committed, long-term relationship with the CAF Veteran partner and have cohabitated with him or her for at least two years prior to the OSI;

- You have remained in a committed relationship with the injured CAF Veteran partner throughout the PTSD healing process;

- The CAF Veteran partner has received (and may still be receiving) at least one year of professional treatment (e.g., medical, psychological) to manage his or her PTSD symptoms prior to participation in this study (it is not required you were in attendance for any or all of the treatment sessions);
- You provided support to your CAF Veteran partner throughout the PTSD healing process and you perceive that it was beneficial to his or her recovery.

For this project, Ms. Smith-Evans is asking you to take part in an interview that will last about one to one hour and thirty minutes in length. The interview may take place face-to-face, via telephone, or via Skype. During the interview Ms. Smith-Evans will be asking questions about living with PTSD that largely focus on your experience of PTG within your relationship as a couple and the role that spousal support has played in its development. You will be asked questions such as "How do you, as a couple, cope with or manage your experience with PTSD?", "What aspects of your relationship as a couple, such as coping strategies you engaged in together, were most supportive to healing?", "Has your bond as a couple changed? If so, do you believe there is a connection between this change and the type and level of support you provided within your relationship?" You may choose not to answer any question if you so wish without penalty. You will also be given the opportunity to offer opinions and information on issues or subjects not raised in the interview that you think are related to Ms. Smith-Evans' research. With your permission, the interview will be audio recorded and later it will be transcribed verbatim. The recording device may be switched off at any time, if you so choose.

Any information you tell Ms. Smith-Evans in the interview may be used in future publications or presented at conferences. Should you consent to participate in this study, your personal information will only be known to the researcher, Kimberley Smith-Evans. To safeguard confidentiality and privacy to the fullest extent possible, you will not be identified by name in any publications, papers, or presentations that emerge from this research, nor will your name be released to any other group or agency. A pseudonym will be used in all reports and papers generated from the research. Other identifying information (e.g., the names of your children, schools, neighborhoods, workplaces) will be modified to protect your identity. Identifying information will also be removed from the transcript of your interview, if you consent to audio recording.

Anonymized verbatim segments of the interview will be included as exemplars in future presentations, written reports and publications. After the interview has been transcribed, Ms. Smith-Evans will contact you again to arrange another meeting so you can review the responses you provided during your interview. If, upon reviewing your interview transcript, you are uncomfortable with any or all segments being used as exemplars, you may request they be excluded from Ms. Smith-Evans' presentation of results. Furthermore, you may choose to change any part of or even exclude the entire interview from the study without penalty. You will also have an opportunity to review Ms. Smith-Evans' results prior to finalizing the final report. If you encounter contextual information that you believe could inadvertently lead to your identification, you may request this information be excluded in the final report.

All written material, such as the informed consent letters, transcripts, and notes, will be kept in a locked filing cabinet. Access to the original data will be limited to Ms. Smith-Evans and her thesis supervisor, Dr. Deborah Norris, Associate Professor at MSVU. All electronic records of transcripts will be stored on a computer that is password protected. If you consent to audio recording, voice files will also be stored on a password-protected computer. Following the completion of this study, Ms. Smith-Evans will destroy the audio recordings. Other materials (transcripts, notes, informed consent letters) will be retained for five years in the event that an audit of the research project is conducted or that the information is required for further analysis.

Although every effort will be made by Ms. Smith-Evans to keep your identity and responses confidential, given you are part of a relatively small, cohesive military community, you should be aware that total anonymity might be difficult to guarantee, particularly within close geographical proximity. It is up to you whether or not you personally discuss details of your involvement in this research with others, but you should be aware that in doing so, it could compromise your anonymity. As outlined above, Ms. Smith-Evans will take specific measures to protect confidentiality and privacy, and she will not divulge any details about your identity to others unless, under exceptional circumstances, law obligates her to. Specifically, in her role as researcher, Ms. Smith-Evans is obligated to report information to authorities that might protect the health, life, or safety of a participant or third party. Although it is not expected that any issues will arise given the nature and focus of Ms. Smith-Evans' study, it is important that you are aware of the limitations to confidentiality in this research context prior to giving your consent to participate.

There is no expectation that any distress will be experienced as a result of these interviews. It should be noted, however, that the personal nature of the questions may lead to unanticipated emotional recollections. You may stop the interview at any time if the process creates any discomfort. If you experience significant emotional or psychological discomfort, Ms. Smith-Evans will provide contact information for confidential services within the community that will be able to support you. These services can be accessed through the Veterans Affairs Canada Assistance Service (1-800-268-7708 or via http://www.veterans.gc.ca/eng/contact/vac-assistance-service) or through a family peer support coordinator working through an Occupational Stress Injuries and Social Support (OSISS) clinic located in your community (http://www.osiss.ca/en/family.html). Your participation or non-participation in this study will not influence any services or programs you are accessing or wish to access in the future.

If at any time following the interview you would like to talk about or ask questions about this research, please contact Kimberley Smith-Evans at 902-457-6572 or kimberley.smith.evans@msvu.ca, or her supervisor, Dr. Deborah Norris, at (902) 457-6376 or deborah.norris@msvu.ca

In the event that you have any problems with, or wish to voice concern about any part of your participation in this study, you may contact the Chair of the Mount Saint Vincent University Research Ethics Board at (902) 457-6350 or by email at research@msvu.ca

Consent to Participate in Research Study

Title of Study: *The role of spousal support processes in the development of post-traumatic growth among CAF veterans and their intimate partners*

I have read the information provided with this consent form and understand the purpose of this research. I have been provided the opportunity to discuss this research and my questions have been answered to my satisfaction.

I understand that this study in which I have agreed to participate, will involve the audio recording of confidential interviews involving my and my spouse/intimate partner's experiences of post-traumatic growth (PTG) as a result of living with an operational stress injury (OSI) in the form of post-traumatic stress disorder (PTSD). I understand that my participation in this study is voluntary and that I may withdraw at any time and for any reason without penalty. I understand that there is no obligation to answer any question or participate in any aspect of this project that I find invasive. I understand that all personal data will be kept strictly confidential and that information will be stored securely so that only the researcher and her thesis supervisor will have access to the data.

Participant's Name (please print)_____

Participant's Signature_____

Date_____

Address_____

Phone Number_____

Email_____

Consent – Audio-recording

I hereby provide consent for this interview to be audio-recorded.

Participant's Signature_____

I have fully explained the procedures and purpose of this study to the above participant.

Researcher's Signature_____ Date_____

Cc: participant

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