



Experiences of Parental PTSD for Children Aged 9–17 in Military and Emergency First Responder Families

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Abstract

This study is the first to examine the experiences of children aged 9–17 who have a military or emergency first responder (EFR) parent with post-traumatic stress disorder (PTSD). These experiences of children are important to understand through a lens of intergenerational trauma theory, given the high rates of PTSD in these service populations. Additionally, we need to know if they differ from the experiences of children of civilian parents with PTSD. To examine this, we conducted a total of 17 in-depth interviews in Australia with 5 service parents, 5 co-parents and 7 children aged 9–17 who have a parent who had formerly served in the military or an emergency service. Interviewees were not always from the same family. The families included single-parent, dual-parent, separated, and same-sex families. Gender and service type (military or EFR) were evenly distributed among interviewees. We used a critical humanist approach and undertook a reflexive thematic analysis of the interview data. The major themes were (1) parental emotional extremes, volatility, and unpredictability, (2) changes in home and family relations, (3) impacts on child wellbeing, and (4) PTSD awareness and help-seeking. We found evidence of specific impacts for children related to a combination of parental PTSD symptoms and service conditioning and culture. This study highlights the role of reduced parental capacity in the transmission of trauma from parent to child. It provides an evidence base to direct policy and research into targeted and culturally specific therapeutic interventions and support services for children and parents in service families living with PTSD.

Keywords Military · Emergency first responders · PTSD · Children · Intergenerational trauma

Highlights

- Policy, research and practice need to incorporate service culture and access for all family members.
- Service families with PTSD need emotional regulation programmes addressing anger.
- Clinical assessment needs to improve for secondary, vicarious and moral trauma types.
- Insecure attachment styles related to parental PTSD need to be addressed in interventions.
- PTSD psychoeducation must be accessible for family members from diagnosis to post treatment.

There is an established and growing knowledge base around the impacts of a parent’s mental health on the wellbeing of

their children. In vocations such as military and emergency first responders (EFR) who have a much higher risk than civilians of conditions such as Post-traumatic Stress Disorder (PTSD) (Koenen et al., 2017; Lawrence et al., 2018; Van Hooff et al., 2018a), it is important to understand any impacts on the wellbeing of their children.

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Post-Traumatic Stress Disorder (PTSD) in Military and Emergency First Responder Populations

Post-traumatic stress disorder (PTSD) is a mental disorder that can occur in response to a traumatic event and is a collection of persistent symptoms, including re-experiencing/intrusive thoughts, avoidance of internal and external trauma-related stimuli, negative alterations in cognitions and mood, and hyperarousal following exposure to a traumatic event (APA, 2013; WHO, 2018). The ICD-11 definition includes additional criteria relating to the psychosocial impacts to functioning, such as difficulties with interpersonal relationships. Both definitions highlight high levels of comorbidity between PTSD and other diagnoses, such as alcohol and substance abuse, depression, and anxiety (Pietrzak et al., 2011). Although PTSD can arise from a single exposure to a traumatic event, recent research has identified the role of repeated and cumulative trauma for cohorts such as military and EFR cohorts indicating much higher rates of PTSD for these service vocations (Liu et al., 2017).

In Australia, rates of PTSD are significantly higher in current serving EFRs (10%), former serving EFRs (25%), current serving military personnel (8.3%), and former serving military (17.7%) than they are in the general community (7.3%) (Koenen et al., 2018; Lawrence et al., 2018; Van Hooff et al., 2018a, b). Despite the prevalence of PTSD in military and EFR cohorts, there has been limited research on exactly how the service member's PTSD impacts children and family members, especially in EFR families (May et al., 2023; McGaw et al., 2019a, b; Sharp et al., 2022), however mental health impacts in service families has been raised as an area of concern in numerous studies often linked to PTSD (Daraganova et al., 2018; Kishon et al., 2020; McGaw et al., 2019a, b; McGaw & Reupert, 2021; McKeon et al., 2021; Muir, 2018; Sharp et al., 2022).

Intergenerational Transmission of Trauma

When children are affected by a parent's PTSD, this is understood as the intergenerational transmission of trauma, a phenomenon first recognised in Holocaust survivors' children (Rakoff et al., 1966). There is limited discourse around the mechanisms of intergenerational transmission of trauma from the service parent with PTSD to their child and how this differs from a civilian parent with PTSD. The discourse on intergenerational trauma generally, encompasses different areas of focus including biological or hereditary transmission through epigenetics (Yehuda & Lehrner, 2018), to factors such as family stability and or parental capacity (Banneyer et al., 2017).

Vicarious trauma and secondary trauma are two of the most common pathologies recognised to result from intergenerational trauma. *Vicarious traumatization* refers to when a child may experience a distress reaction or intrusive memory as a consequence of seeing a picture of or hearing about a parent's experience of a traumatic event (McCann & Pearlman, 1990; McCormack & Devine, 2016).

Secondary traumatization is a broader concept that refers to the experience, impact and transfer of trauma symptoms from parent to child, where this transfer may or may not involve the child being exposed to the parent's traumatic experiences (Diehle et al., 2017; Figley, 1978). This phenomenon and the mechanisms of transmission were supported in the findings with indirect transmissions due to emotional dysregulation, emotional extremes and volatility, family functioning, child emulation or re-enactment of behaviour and identification with parental identity and mindset (Ancharoff et al., 1998; Dekel & Goldblatt, 2008).

Intergenerational transmission can also involve *moral trauma* or moral injury, which refers to a form of trauma experienced by military or EFR personnel when a service member perpetrates, witnesses, fails to prevent or learns about acts which transgress deeply-held moral beliefs and expectations (Litz et al., 2009). Common symptoms and outlooks or worldviews of moral trauma in parents can impact interpersonal relationships and be adopted by children, as part of identification, such as the feelings of guilt, shame, betrayal, and hopelessness (Ancharoff et al., 1998; Jamieson et al., 2020; Jones, 2018).

There remains a lack of diagnostic clarity, psychometric testing in research or assessment in clinical practice and consequently, misdiagnosis of child trauma such as: complex, developmental, and intergenerational trauma (including secondary, vicarious and moral trauma), including within service families (D'Andrea et al., 2012; Jamieson et al., 2020; Jones, 2018; Van der Kolk, 2017). There is a growing body of research that children who have a parent with a mental illness, including PTSD, have higher rates of mental health issues (such as PTSD and depression) than children without a history of parental mental illness (Hartzell et al., 2020; Leijdesdorff et al., 2017; Weissman et al., 2016). We know that a dysregulated emotional environment can affect a child's development and their own emotional regulation, particularly from the womb to age 3–5 years, as children's brains and nervous systems are first developing (Ford et al., 2013).

Attachment

Attachment style is an important factor influencing how children developmentally learn to manage distress (Bowlby, 1979). Children are forming attachment styles with parents,

learning and mirroring emotional responses to distress from parents, forming attachment styles of secure, avoidant, ambivalent or disorganised attachment, across their relationships (Bowlby, 1979). Research also shows that an insecure attachment style of anxious or avoidant attachment increases PTSD severity (Ogle et al., 2015) and affects the quality of parent-child communication (Zhou et al., 2021). This phenomenon was first formulated in the foundational clinical theory of Danieli (1985) as “*The conspiracy of silence*”, which refers to the impact of silence or a lack of communication via emotional withdrawal, emotional numbing or avoidance, which has become an accepted behaviour in military communities and families, and discussed in relation to children as under-disclosure and a lack of explanation for children around the impacts of their parent’s service, leaving a vacuum of curiosity and assumptions (Ancharoff et al., 1998; Danieli, 1985).

PTSD, Relationships and Family Functioning

Of the studies on family members of service personnel with PTSD that have been conducted, several examine impacts on partners and the association between PTSD, relationship difficulties and family functioning (Alrutz et al., 2020; Dekel & Goldblatt, 2008; Knobloch-Fedders et al., 2017; Lawn et al., 2022; McKeon et al., 2021; Samuelson et al., 2017; Sayers et al., 2009). A few studies have explored the role of parenting through the perspective of co-parents. An Australian study on partners of EFR and military personnel with PTSD highlighted significant impacts on partners’ mental health and feeling over-burdened by their role as a carer with additional domestic and parenting roles, where they felt a perceived need to “protect children and the family unit” (Waddell et al., 2020). Another Australian study reported on the experiences of co-parents of veteran partners with PTSD, and also describes challenging experiences of overburden, loss of identity and unpredictability for these co-parents (McGaw et al., 2020).

Parental PTSD and Children of Service Families

Aside from the few studies of parenting from the perspective of co-parents, research specifically focussed on child outcomes has been minimal. One study of UK Armed Forces who deployed to Afghanistan and Iraq confirmed that PTSD, not deployment, increased the children’s risk of behavioural and emotional mental health conditions (Fear et al., 2018). This is consistent with other studies highlighting emotional and behavioural symptoms as major impacts of parental PTSD (Boričević Maršanić et al., 2014;

Hisle-Gorman et al., 2019; Krešić Ćorić et al., 2016; May et al., 2023; Selimbasic et al., 2017; Wells et al., 2022a). Some research has interviewed adult children, retrospectively about their childhood (McCormack & Devine, 2016). Another recent qualitative Australian study of adult children on military transition experiences, describes impacts on children including emotional distress due to a parent’s PTSD, mental health illness for the children and their siblings, a culture of “stigma” around help-seeking for mental illness in the military, resentment for becoming a carer of their parent and also some positive findings about new skills and confidence to advocate for their own needs (Wells et al., 2022a).

One qualitative interview study in Australia has explored the experiences of youth aged 12–17 years, with a veteran parent with PTSD and raised important findings of: silence, family disconnection, self-reliance and taking care of parents, as well as strong bond (McGaw & Reupert, 2021). There is no equivalent research on children of EFR families and most research of children of EFR families has been quantitative and focussed on post-disaster experiences in the US such as the World Trade Centre terrorist attack and Boston Marathon Bombing and confirmed mental health impacts including PTSD in children of EFRs exposed to trauma, not necessarily diagnosed with PTSD (Comer et al., 2014; Duarte et al., 2006; May et al., 2023; Uchida et al., 2018). A systematic review which examined available qualitative data on family members of EFR’s with PTSD found just 1 study including data directly from children in the USA after the World Trade Centre terrorist attack and 4 about children from the parent’s perspective (Linkh, 2006; May et al., 2023).

Service Families, Culture and Identity

Being a child from a service family involves impacts on family lifestyle, culture, identity, and sometimes mental health. Studies have shown that military and emergency service vocations, with their demands of irregular hours, deployments, dangers, and trauma exposures, can have significant negative impacts on family members and family lifestyle, as well as some protective factors (Alrutz et al., 2020; Kishon et al., 2020; Regehr, 2005; Rogers-Baber, 2017; Wells et al., 2022a). There is a cultural conditioning that occurs for the serving member (English, 2004; Lane & Wallace, 2020). An understanding of military culture and identity has been recognised in the literature as important when working with military and their families to understand unique risks and protective factors in these service families which would seem to translate to EFR families as well (Ohye et al., 2017; Rogers-Baber, 2017; Tam-Seto et al., 2019; Tanielian et al., 2014). An Australian study focussed

on the narrative and rituals of military families and found that a process of acculturation occurs in the family using stories, symbols, props, events such as ANZAC Day and other rituals to affirm the cultural identity and values in children within these families (Baber, 2016).

Both military and EFR are trained with high levels of discipline and regimentation to perform duties automatically under intense pressure and to invoke or suppress emotional reactions to mental distress and these behaviours are intended to protect the team or enable the service member to complete the task or mission in dangerous life-or-death settings (Lane & Wallace, 2020). For example, “anger” which is a learned response in training to a combat threat for service members such as military and police, channelling the automatic fear response to action (Lane et al., 2021). This aspect of service training is significant in relation to research which shows that being “quick to anger” has a much higher symptom prevalence for veterans with PTSD, than civilians with PTSD, when triggered by an intrusive memory or perceived threat (Lawrence-Wood et al., 2021; Van Hooff et al., 2018a).

A recent Australian study found that children of military families who had transitioned, attributed much of their mental health difficulties and family challenges to military culture and identity (Wells et al., 2022a). Another study found that connectedness in Defence communities was a protective factor for family members, which also highlights the need for tailored culturally sensitive and connected interventions (Rogers-Baber, 2017). The values and expectations of service, such as elevated levels of discipline, emotional intensity such as “anger” or emotional suppression, may impact family functioning and compound PTSD symptoms and create unique impacts for children of service families, compared to civilian children experiencing parental PTSD. Service culture and identity and its role in parental PTSD and capacity, as well as the children’s experiences and perceptions has been examined and reported in the findings of this paper.

Children’s Perspectives and Voice in the Research—A Gap

There is currently a gap in research on the experiences of children of a military parent and an even greater gap for children of EFR parents with PTSD, including children from the age of 9 years-old to 18 years-old. It is unclear if these gaps are due to the difficulty in attaining research ethics approval to do high risk studies with child participants of a vulnerable population such as service parents with PTSD, or whether it is because the medicalized focus of PTSD treatment has not encompassed the psycho-social impacts to family relationships of the serving member and

thus research and services have focused on the service member and not the family members. Recent Australian studies also affirm this gap in Australia in both services to support children of service parents with PTSD and the need for tailored support that is designed with an understanding of the specific military or service culture and identity dynamics, including risks and protective factors in service families (Rogers-Baber, 2017; Wells et al., 2022b). A current national independent government commissioned enquiry in Australia into Defence and Veteran Suicide has highlighted the needs of children and gap in support services, (Point 12):

“Families are inexorably linked to the health and wellbeing of serving and ex-serving ADF members, and vice versa. There is insufficient awareness and recognition of the key role families play. Information about available support is limited and the quantity, quality and accessibility to supports too varied. We have heard numerous stories of children and families who have been adversely affected by the death by suicide of a loved one, or by deterioration in their loved one’s mental and/or physical health.”(Royal Commission, 2022).

There is also a gap in knowledge on the specific mechanisms of transmission of trauma in service families living with PTSD, and the specific concerns and vulnerabilities of these children, and their parents to inform and enable practitioners to support their wellbeing. This paper aims to provide the findings of children’s experiences of parental PTSD in service families, expressed by them and their parents to enable a deeper understanding of the phenomena. It discusses how the parent’s trauma is transmitted to children, specific impacts for the children and the areas of greatest concern for the children. It also examines their perspectives on the ways in which help-seeking could be established or improved to support them.

Methods

We worked from an ontological position of *Critical Humanism*, which values epistemologies of social constructivism and phenomenology in a holistic social context (McIntyre-Mills, 1995). This theoretical framework informs the qualitative methodology utilising a hermeneutic approach to capture each individual’s experiences in their own language and expression, with a strong focus on the life history context and enabling the participation of children (Clark & Statham, 2005; Willis et al., 2007). The approach values hearing the authentic voice of the children and parents in the data, which is an important novelty of this

study. To support this approach, the method was naturalistic or narrative-style in-depth interviews, with verbatim transcription of audio-recordings of this data. Interviews were conducted individually and face-to-face where possible or via online video conferencing during the COVID-19 pandemic, which also allowed for a broadening of scope to recruit participants regionally and nationally across Australia.

The lead researcher (KM) conducted all the interviews. In terms of reflexivity (KM) reflected on her insider and outsider perspectives and communicated aspects of these to participants. The lead researcher has insider or lived experience and outsider experience as a researcher and practitioner. The insider experience enhanced the lead researcher's compassion and empathetic understanding, motivating and better equipping her to capture the detail and meaning of individual and collective experiences of service family members. The lead researcher was mindful not to allow her insider experience to problematically bias the research, openly discussing this issue with the other researchers as part of the reflexive analysis (Braun & Clarke, 2019). The other researchers also reviewed thematic analysis and supported discussion.

Participants

We recruited children aged 9 to 17 years old. We chose the lower age limit because at 9 years children's social and emotional development stage typically enables greater self-confidence, with continued moral development having occurred since the age of 7 years and enabling decision making independent from parents with respect to deciding whether to meaningfully participate in interviews (Malik & Marwaha, 2021). Parents were also recruited, both service parents with PTSD and co-parents, to gain their perspectives and insights about their children's experience, because parents are an important source of knowledge about their children's lives (Rogers & Boyd, 2020). All interviews were conducted individually to enable confidential disclosure. We purposely treated each sample of children, service parents and co-parents as separate groups, and therefore they were not required to be from the same family. Data from all three samples were combined for analysis.

Recruitment was delayed by the COVID-19 pandemic's enforced community lockdown periods and restrictions. We successfully recruited an equal number of male and female participants and an equal number of military and EFR service parents with PTSD, encompassing Navy, Army and police participants. Seven children participated, from regional and city locations, and there was an even spread of younger and older children in the age range of 9–17 years. Four children's service parents were separated single

parents, while the other children had two biological parents living together.

Procedures

The University of Adelaide's Human Research Ethics Committee (H-2020-052) approved the study. Parents provided informed consent for themselves and for a participating child, under 16 years of age via a consent form after a process of discussing a detailed information sheet, and again at the beginning of the interview process, verbally which was recorded. Children aged 9–17 years also provided their own consent which was recorded after the process was explained at the beginning of the interviews. Children above the age of 16 years could consent to participate independently of their parents, based on the Gillick principle for informed age of consent (Dyer, 1985).

Measures

The minimum sample size for this style of in-depth interviewing study of 4–6 participants per cohort (Guest et al., 2006) was used as purely as an indicator, and we were able to determine that data saturation and exhaustion of themes was reached when we generated no new themes after the 5th child interview was analysed, from 7 child interviews and 10 parent interviews (Braun & Clarke, 2019).

We used *reflexive thematic analysis* to examine the data in terms of patterns of meaning, which is congruent with our critical humanist approach (Braun & Clarke, 2019). Using NVivo software, we generated codes to denote patterns of meaning in the interview transcripts and grouped these 44–77 codes into themes. The children's interviews were coded first to ensure the data analysis was child-centric, with the children's voices and experiences forming the primary data, followed by the parent interviews.

Results

The four main themes we found in the data were: 1) parental emotional extremes, volatility, and unpredictability, 2) changes in home and family relations, 3) impacts on child well-being and 4) PTSD awareness and help-seeking for children.

Parental Emotional Extremes, Volatility, and Unpredictability

Intense and volatile emotions

Lack of emotional stability for the children was a key issue raised in all interviews, sometimes discussed by participants

in terms of “emotional safety.” Participants spoke of strong or intense emotions, commonly anger, and associated behaviours such as yelling. These intense emotions also had a volatile occurrence, demonstrating labile affect; that is, the parent with PTSD displayed a sudden change of emotional state, commonly described as a mood swing or anger outburst. This volatility also created a sense of unpredictability from one moment to the next, as children and parent participants described not knowing what mood to expect and when to expect it.

Participants explained that when the parent with PTSD expressed emotions in a hyper-aroused state (with intense emotions and behaviours), this was often followed by the parent entering a hypo-aroused state, becoming avoidant or “withdrawn,” and “emotionally numb”. Although, both of these emotional states were distressing to children, the hyper-aroused state and specifically “anger” presented more frequently in the data as a major concern or fear for children, resulting in them feeling worried, scared, and frustrated. When asked during an interview, “What do you think might have helped you or your family?,” a nine-year-old child said,

“Making it stop. Yeah, like no more yelling – no more yelling.”

A Father with PTSD described his awareness of how his behaviour affects the children:

“They’re worried that you’re going to get angry or yell at them and stuff like that. Whereas before – it’s normal behaviour for kids to give you the shits, but I just couldn’t tolerate it. Just sent me nuts, just lose my mind. Then that makes you feel bad because you think, oh I’m a bad dad, can’t even look after my kids and entertain them. I just get so that I don’t want to be there, grumpy and emotional.”

This quote illustrates a parent’s awareness of his PTSD behaviours, the children’s avoidance of him, his reduced parental capacity and associated feelings of guilt and shame, with a subsequent response of avoidance and withdrawal.

The yelling associated with intense anger was also a major concern for co-parents due to worries about how PTSD symptoms would affect the children’s emotional stability and well-being:

“I think the impact of being around someone who was always so angry and yelling and the extreme moods, living and walking on broken egg-shells with someone, you just don’t know what you’re going to get every minute of every day. It’s more, I guess it’s the emotional effect on them.” (Co-parent).

Mood swings—intense to numb

Sudden mood or arousal changes from intense to emotional numbing, withdrawal and disengagement of the parent with PTSD were also reported to impact children. Children and parents described intense emotional behaviours of the parent with PTSD that involved outbursts such as crying or sobbing and making statements about suicidal ideation in front of the children. Sometimes the parent with PTSD was emotionally upset or “triggered” by their child crying, for example. The parent was subsequently avoidant and unable to respond to their child’s needs. This emotional numbing impacted some children where they felt that they could not get the emotional response they were wanting or needing, such as attention, closeness, affection, or calming of their own emotional distress. A co-parent spoke about a 9-year-old child seeking affection, but the parent with PTSD being unable to respond:

“(Parent with PTSD) can’t focus on anything outside of themself and very short fused, so (child) doesn’t have to do a lot to trigger (parent) and get yelled at or you know, (Parent) doesn’t like to be like physically constrained when feeling symptomatic, so (child) trying to get affection and stuff is quite hard.”

A service parent with PTSD described her withdrawal behaviour when she felt depressed:

“And basically, when I was in that – the black segment, you know, I mean my behaviours with everyone, including (children) would be withdrawal, self-loathing, inability to communicate, just – constantly defensive, just thinking the whole world hates my guts, is out to get me.”

The participant illustrations in this theme demonstrate how the PTSD symptoms of emotional dysregulation and fluctuating arousal states from intense and hyper-aroused to emotionally numb and hypo-aroused, created reduced parental capacity, experienced as emotional extremes such as anger, with sudden or volatile changes from anger to withdrawal in communication and engagement, and an unpredictability of occurrence.

Theme 2—Changes in Home and Family Relations

The second theme relates to the perceived changes in home and family dynamics brought about the service parent’s PTSD. These changes exceed the standard upheaval of moving houses, schools and sometimes states, or countries for military, which generally occurs with military or some

EFR posting cycles. Several families reported moving interstate so extended family could assist them in caring for children and the service member with PTSD.

Upheaval and change with diagnosis

Periods of domestic change featured uncertainty and tension in the family for children, as parents navigated health appointments, the logistics of moving house, new financial pressures and sometimes challenges with injury management or compensation schemes. Children said that their parents appeared stressed and worried during these periods and described hearing their parents talk about financial concerns. The children likewise felt financial concerns. A parent with PTSD explained about his child:

“He didn’t want to take his pocket money for his chores because I wasn’t working and he didn’t know how we were going to pay for things.”

One father, a former police officer, described the difficulties experienced in leaving his service due to PTSD and feeling unsupported by colleagues and the organisation. This led to him and his family being required to leave police housing in a regional area, which exacerbated his PTSD and impacted his children:

“So, we ended up with an eviction ... If you want to fight it you are on your own, and obviously I wasn’t able to take on the police legally. I was discarded by the police when I said I wanted to take time off to get better. For my wife, I said if we move, you will have to work. So, there was a lot of tension over that, and obviously I was becoming shorter with the kids, getting more frustrated.”

Some families reported experiencing a lack of support from extended family, when they needed it. Children described overhearing parents talk of extended family members’ negative attitudes about their parent’s PTSD, which reduced their willingness to support the family dealing with domestic changes and upheaval.

Changes in family roles and functioning

Children experienced changes in family roles when the parent with PTSD was unwell and unable to support domestic tasks in the home. This often resulted in the co-parent taking on a carer role and more domestic or parenting tasks, as well as working. Some children described their parent being so busy looking after their parent with PTSD that they felt they could not bother them with any of their needs or concerns and would consequently take on some of

the typical parent roles themselves which is known as *parentification* (Van Loon et al., 2017). A co-parent explained how her 9-year-old became fiercely independent, so as not to make demands on her while she was caring for the parent with PTSD:

“And then there were little things where he might need, he may have needed help with something, but I’d say “mate I’ve just got to help daddy at the moment, I’m sorry. Just let me help daddy and then I’ll come help you.” So, then we found that he started shutting us out. So, I’ll go “oh mate, do you need some help with that?”, “Yes, no it’s fine, I’ll work it out”, and that was really hard and that’s continued and like we’re having trouble reversing that.”

Some children in this study felt more responsibility or more need to take on an adult or carer role in their family than others. All the child participants who felt this described feeling a need to reduce the impact of PTSD symptoms on the affected parent or other family members, including younger siblings. This occurred in both single and dual parent families, though some child participants in single-parent families felt this more intensely. The forms of parentification encompassed cooking meals, managing domestic chores, trying to help fix things in the house, feeling responsible for averting potential triggers, managing younger siblings, and supporting medical needs such as checking on the parent or reminding the parent with PTSD about treatment. A child aged 14 answered a question of “Is there anything you worry about?” with:

“Her not putting her mask on when she goes to sleep. Or her having a, not an episode, like a breakdown when I’m at school.”

Children experienced significant worry for the wellbeing of one or both parents and often siblings as well. A few children expressed concern for and protectiveness of the co-parent, being aware of them feeling overburdened and a sense of loss of relationship between parents. Family and parental relationship breakdown was commonly experienced by children and created another source of distress for families to manage. Children also spoke about being distressed by parental conflict, independent of parental separation.

Theme 3—Impacts on Child Wellbeing

The interviews revealed numerous examples of vicarious and secondary trauma. The examples encompassed much general anxiety, separation anxiety and loss, a mirroring of parental emotion and behaviour, adoption of the parent’s

worldview and attitudes, parentification and the associated feelings of needing to protect family members, feelings of shame and difference. Military and EFR cultural expectations were also transmitted to children and interacted with the parent's PTSD in specific ways.

Mental health impacts

Anxiety or “worry” was by far the feeling most frequently reported by children. This was followed by feeling: abandoned, angry or frustrated, hopeless, like they had no control, upset, withdrawn, numb, resentful, scared, sad, like they had lost their parent, confused, guilty, agitated, and tense. A sore tummy or achy legs were also mentioned.

The mental health issues experienced by the children were often described by participants as “emotional and behavioural issues.” Several children were reported to internalise their emotions, repressing and denying their thoughts and feelings and often displaying withdrawal-type behaviours. In contrast, other children were reported to externalise their emotions, displaying anger, breaking or smashing things, self-harming, and adopting risky behaviour such as substance use. These emotional and behavioural issues often caused social problems, particularly at school.

All children in this study experienced problems with their mental health, described in terms of their: “emotional dysregulation,” “anger outbursts”, “low self-esteem”, “anxiety”, “depression”, “PTSD”, “ADHD”, “borderline personality disorder (BPD)”, “self-harming”, or “suicidality”. Both children and parents described how they perceived schools or other practitioners incorrectly labelled their child's emotional problems and behaviours as ADHD in the male children and BPD in the female children. One regional co-parent with an EFR describes their uncertainty around the suggestion that their son has ADHD and the difficulties gaining expert advice to validate this:

“There's no one to talk to, so I get on the computer. And I'm like there's I think 5 or 7 main symptoms, he only had 2 and I was like, and they could be for anybody of his age. I'm like maybe he is, but maybe he's not. Maybe it's because he's had a lot going on the last 2 years and we haven't had this behaviour before, but everybody's very quick to say, put him on this, do this, and I'm not. And the other ... psychologist's \$120 an hour and for an initial consult \$300 and I have to drive to Adelaide to do it, so yeah.”

Emulation and identification

Many children normalised their parent's PTSD behaviours and would emulate or/ mirror their parent's behaviours.

Numerous examples of parental modelling, emulation and identification were found in the data. A co-parent described their 9-year-old child's emulation of their parent with PTSD, who was their primary carer:

“(The child) picks up on it naturally and you know, if (the parent with PTSD) was off or upset or angry or anything like that, (the child) would often mirror those same kind of emotions.”

Some children closely identified with and adopted their parent's hyper-vigilance, for example always needing to know where the exits are in a building or crowded event. One child aged 17 explained how she had identified with the same mindset as her parent:

“I find myself always trying to almost have like an escape plan in situations.”

A co-parent described how their 15-year-old learned to feel anxious and unsafe from the parent with PTSD's persistent nightmares, hyper-vigilance, and over-protectiveness, where the parent feels the need to sleep with the child to protect them, even though the child says they don't need this.

Parents described the way in which their children also mirrored denial and avoidance behaviours. This included emotional unavailability, hypo-arousal and emotional withdrawal from the parent with PTSD. A 17-year-old described herself learning to deny feelings and not react to her emotions:

“It used to scare me. And I used to get upset. But over time I kind of stopped reacting. Even now when I get yelled at, a lot of the time I don't react.”

A number of children who were reported to internalise and suppress their feelings would eventually have emotional outbursts, often at school, bursting into tears easily, having fights with other children, or getting frustrated and angry in the classroom. One parent with PTSD described his concerns about his 9-year-old as follows:

“Yeah, I don't know whether he's, yeah, he's probably adapted in a bad way to sort of keep his feelings or problems to himself, I suppose, because I'm not well and Mum was struggling, so I don't want to burden Mum with more things so I'm not going to tell her what's going on at school or I'm not going to tell her what's going on with me, so basically bottled it in.”

Child participants also described experiences of externalising emotions, such as expressing themselves through

music, drawing, creative writing. Others had coping skills of distraction such as gaming, fidget toys, watching TV, or working hard at school. Some children found ways to soothe their emotions by cuddling a pet or a teddy when upset. Some children would be more destructive in their expression of emotions, including with aggressive outbursts, self-harming, drug use and suicidal ideation. A 9-year-old said:

“I go outside and smash things”, and “I act out to see if anyone noticed.”

Reminders, triggers and curiosity

Some children mentioned not wanting to study any topics at school or watch anything on television to do with war, explaining how they would become very sensitive about the way other children or teachers talked about wars or EFR or military service. A 17-year-old reflects on feelings about seeing the service parent with PTSD's photos of military deployment and coping with discussion about war topics at school:

“Like I've seen some photos. I accidentally found them. Just seeing it was very confronting. But even in the school, I'd get really upset when we'd talk about that stuff, because not that people disrespected it. People would just say little things about it. And I'd be like you don't even know. You don't understand. And I used to get really heated about it. And I still get really upset (sobbing) – sorry. It's just thinking about it, kind of always makes me still anxious. And I don't even know why.”

Some children were curious about the experiences that caused their parent's PTSD, having limited or disjointed information or parental disclosure about what their parent may have experienced and so consequently imagined or accessed news, online videos or movies to create a view of what trauma their parent might have been exposed to which gave them PTSD.

Affection and proximity

Children were also impacted by the varied affection, closeness or proximity with their parent with PTSD, who was sometimes emotionally intense or “uptight” and unapproachable and at other times withdrawn and emotionally numb. A co-parent reflected on their 9-year-old child seeking affection, but the PTSD parent being emotionally unavailable, unable to respond and the consequent impacts on the child:

“Because (the parent with PTSD) doesn't want, (child) in their space, but you know, (child) obviously wants that affection and it's definitely inhibited which often makes (child) close off more because they've been pushed aside so to speak. Not intentionally obviously, but it's definitely there. So then (child's) mental health obviously gets worse. (Child) gets more anxious because (child) doesn't have (parent) around and (parent's) getting worse because (parent) knows the effects and feels guilty by it and is trying to stop it.”

Separation anxiety and fear of loss

Children expressed fear of losing their parent through parental separation, estrangement, hospitalisation, or death by suicide. The fear of loss and separation anxiety was sharpened by the parent's service, with its inherent dangers. Current fears of separation extended the fear and anxiety of previous periods when the parent was deployed to a war zone or to a local incident or accident as a Police officer in the middle of the night. For children whose parents were distanced by periods of hospitalisation, which was sometimes precipitated by periods of emotional withdrawal and suicidal ideation, children were impacted by intense feelings of anxiety, detachment and fear of loss. A co-parent describes their 9-year-old child's fear:

“(Child) had so much worry about (Parent with PTSD). I remember (child) was so scared that (parent) was going to die all the time.”

A 9-year-old boy with separation anxiety due to past emergency hospitalisation of his suicidal parent explained:

“Some kids are just really sad that their parents have PTSD, but they want to stay with their parents and they don't want to leave them. And they just want to stay with them and try and make them as happy as they can.”

Children in single-parent families whose parent was hospitalised reported staying with other family members. This period of hospitalisation created mixed feelings for child participants. Some children described feeling some relief, since they could now “have a break,” comforted to know that their parent was safe and being looked after. A 9-year-old shows this internal tension:

“I've, I've been in this situation before, and I know how it feels. And ... don't want to be in it again. But I love living at my (grandparents), but....I miss my (parent) all the time.”

Service culture and identity

Another finding was that some of the military and EFR cultural aspects underpinned children's interpretations and reactions or exacerbated PTSD symptoms. In theme one the intense anger was cited as the biggest concern which impacted them emotionally, inciting fear for child participants in these service families. Awareness of dangers of the job combined with periods of absence created anxiety in children which was then reinforced and exacerbated when their parent became unwell later and was hospitalised due to suicidality, affirming their fear of loss of that parent, which they understood was caused by their "job". Children expressed the expectation by their parent for them to do jobs and the strictness or discipline of their parent around things like this. Values such as discipline, punctuality and the use of anger to induce action are cultural aspects of service conditioning and identity which uniquely impacted the child participants in this study.

"Time anxiety" and being "strict" was mentioned, where children described feeling that their service parent's approach to such disciplines was stronger than in other families, to always be ready at short notice and to always be early for appointments and social events, no matter how trivial. A 9-year-old described his parent's time anxiety making him anxious each morning before school:

"Yeah, in the morning sometimes he – he gets angry, like – like if it's school time, he's trying to make us rush out the door. It's pretty early and he's trying to make us rush out the door."

Some of the children also reflected that their family's service culture and identity instilled a sense of pride and was sometimes expressed as a protectiveness over their parent and their values of service. It also raised a feeling of difference in their service family, from other civilian families.

Shame and difference—social difficulties

Participants described how the child's mental health was affected by feelings of "shame and difference." Children reported feeling self-conscious or different from other kids, as a service family or due to their parent's PTSD, with a protectiveness or defensiveness about their parent. Social problems for children occurred mainly at school but also at sporting or social events with family friends. Children expressed feeling different from their peers and difficulties to trust others and form attachments or friendships. The social problems included being bullied, having few friends, having low self-esteem, feeling awkward, over-sensitive behaviour, acting out, running away, being over-protective

of friends, and fighting. A co-parent talked about his son's social issues at a new school and the lack of support he received:

"It was pretty prevalent [son's social problems], we mentioned to the school that (parent) had severe PTSD and stuff like that. And they alienated her a bit, when our son had issues like, (our son) had a lot of bullying going on the last couple of years at school, it was really bad."

Theme 4—PTSD Awareness and Help-Seeking

Psychoeducation needs

Parents reported finding PTSD hard to understand themselves and so they expressed not feeling ready or equipped to explain PTSD to their children. In an attempt not to distress children, some parents made up alternative explanations:

"When I first got diagnosed, we didn't actually tell the kids that I had PTSD. Every time I went away to hospital, we just told them I was going to police school."

Children reported that their parents would downplay what was occurring, which the children perceived as inconsistent with what they were observing and experiencing.

Children expressed a lack of understanding about what was happening for their parent and family, especially at a younger age. A 9-year-old said, "I didn't know what was happening or why" and this resulted in him feeling confused and worried. Some parents attempted to explain what was happening to their children but found it very difficult and emotional. A parent with PTSD describes:

"They didn't even know that I was sick, and it was only that last time in (year) that we explained to them that I had PTSD and trying to explain to them what that is."

Q: How did you go with that?

A: I found a book that was written by someone in the UK called "Cranky Pants". And so, I gave them a copy of that, and I basically used that to explain to the kids what was going on, and they could see the similarities between the character in the book and me. (Parent sobs).

Q: It must have been pretty emotional?

A: Yeah, that was pretty hard.”

Some children blamed themselves when they didn't understand what was happening. A service parent with PTSD explained:

“She (co-parent) was trying to understand it as well, I suppose, as to what was going on. She also noticed our son's reaction. (Our son) started believing that, or he was making statements that he thought he was the reason that I wasn't working.”

Some children reported finding out about their parent's PTSD indirectly or accidentally, namely from changed behaviour, from a parent's need for treatment (such as hospitalisation), or from overhearing parents or other adults (such as grandparents) discussing their parent's PTSD and wellbeing. A lack of understanding of PTSD and mental health resulted in feelings of shame for children, especially when parents would avoid the topic and the children assumed it was something shameful. Awareness and understanding were also described by older children to change and increase as they got older, and experienced the impacts over time, with access to more information. A 17-year-old said:

“I think more awareness did help, because it made me understand that this isn't something I can control. It's something that dad needs to help himself with. And maybe understand that not everything was my fault. That things happen, people do things for different reasons. People say things that they don't necessarily mean to say. And I know when Dad's in his moods. I know how to kind of filter myself, does that make sense?”

Gaining access to information or knowledge about PTSD led to help-seeking. Children expressed a desire to have access to more information on PTSD and an earlier explanation about what was occurring for their parent and family. Parents said they didn't receive any psychoeducation about PTSD and what they could expect, especially in terms of impacts on their family life. A co-parent explained that initially they had very little information about PTSD from the treating psychiatrist, which made it hard for them to understand it or explain it to the children:

“(Parent with PTSD) would break something and then get frustrated and we couldn't understand what was happening. And no one, not even the psych,

nobody said to us, hey, this is going to affect (parent's) cognitive functioning. We didn't know that.”

A lack of support for families

Parents with PTSD described the difficulties they experienced finding help both during service and following transition from service. Some participants reported encountering difficulties getting their PTSD recognised and faced battles with their employer or compensation schemes. They described difficulties finding information and effective health providers for themselves, let alone for their children or partners. Parents and children emphasised a lack and inadequacy of services to support family members, especially for EFR families. Regional EFR families seemed to have an even tougher experience, with schools and communities ill-equipped to understand or support families, and the families felt a lack of privacy and shame due to the perceived mental health stigma in a smaller community. A parent with PTSD from an EFR background explained how he tried to get his family help but was unsuccessful:

“I mean I tried through the insurance company to get counselling for the kids, but the insurance company said “no, our obligation is to you as the injured worker, not to the kids”. I mean we tried to argue that their injury is a result of my injury so they should be entitled to it, but I guess the biggest thing was getting help for the kids along the way and we still haven't got that and it's definitely something that I think we need, that being able to talk to someone at their level, to say okay this is what PTSD is – because I mean I have done my best to explain it but at the end of the day I'm the injured person – I don't have the expertise to explain it.”

A co-parent of a military partner explains how her partner's PTSD has impacted her mental health and the whole family and that they all need help but cannot seem to access it:

“Everything is aimed at the veteran, and nothing is aimed at the family. So, with (parent with PTSD), I've recognised that he has triggered my PTSD, and that's why I need to get help to recentre myself. And so, if I'm having a period of time off. And then, of course, (10-year-old child) mimics what (parent with PTSD) and I do, how we are, and it's just, once again, collateral damage. Like the suicide rate amongst veterans, I know that it's way higher if they're single than if they have a family, but if you have a family,

what's there to support the family, like we're just expected to take care of them, but who takes care of us?"

A veteran parent with PTSD explains his feeling of immense distress, due to his family's relationship issues and feeling unable to get help for himself and his family:

"I just feel alone and felt I wasn't getting support, my family wasn't supported, everything was getting affected, my relationship with my wife, relationship with my kids and it's just like you're losing grip of everything."

How family capacity and structure can impact child help-seeking

Some children felt that either they could not bother their parents with their own feelings or issues because the parents were already struggling to manage the PTSD impacts, and other children experienced their parents being ill-equipped to respond when children raised issues or asked for help. Single-parent families faced difficulties in having fewer resources in terms of parental capacity and finance. However, respite came up for both single-parent and dual-parent families, where family members felt the need for some time away from the dysregulated home environment. Hospitalisation of the parent with PTSD occasionally provided some respite for family but also caused significant worry, especially if hospitalisation came as a result of suicidal risk or substance abuse.

The capacity of schools to support children of service families with PTSD

The school environment highlighted children's mental health and wellbeing issues. Schools were the first place the child participants attempted to seek help or received help, prompted by a teacher or parent. Problematic behaviours, emotional issues, social issues, or inconsistent performance of school-work were usually raised by teachers to parents or sometimes only with the children themselves after being referred to the school counsellor. Teachers or school counsellors identified issues, such as children frequently turning up late, not concentrating, being disruptive, having anger outbursts, being overly emotional, and having social issues. Both children and parents reported that schools could have been more helpful if the schools had a better understanding of the needs of children experiencing parental PTSD and been more able to offer support or referrals. Many participants identified that help-seeking through the school would have been the best way to instigate support

for the child or family. In one case, where the school provided a positive intervention, this was well-received. A 9-year-old explained how her new school's approach was better:

"Miss (teacher), my helping teacher, helps get my feelings away."

Some parents said that they relied on the teachers to give them some clue about how their child was doing, as they were so busy coping with PTSD at home. Where the school was unaware of service life and PTSD impacts, or where the school was aware but not skilled to manage it, the children and parents experienced significant distress and felt isolated. The school's perceived lack of understanding and compassion for a child's issues added more stress for the child and parents. A co-parent commented on her frustration with the lack of support for her child at school, despite informing them, of the service parent's recent PTSD diagnosis and also the loss of a loved grandparent during this period:

"It feels like there's still no support there. Like you get in there and oh, we've had such a bad day with (your son), he hasn't listened, he's distracted the class you know, we've punished him."

Children expressed finding it difficult to get help through school and feeling that there was a lack of understanding around their experience of having a service parent, and some of the service cultural aspects of "strictness" or discipline, in addition to the emotional and mental health challenges, and wishing that help was more proactively offered to them. A 17-year-old said:

"I just wish school knew, okay I've got a military (parent), things might be a bit harder. I wish they asked me more questions, and kind of got me to talk about it, because I'm only really talking about it now. I've never actually talked about it. Even counsellors now, I briefly say yep, my (parent) was in the army. Yep, it was strict but, I don't talk about it. I wish someone kind of got me to do it. So that it would be more okay now. I wish (there was) almost like a lesson I could have gone to. I had to learn by myself, to make it up. So, I wish I didn't have to do that."

Parentification and protectiveness as a barrier to help-seeking

Some children were reluctant to seek help and concealed their issues to protect parents, and other children felt guilt for causing additional stress to their parents. A 17-year-old

denied her own needs at school to protect her parent with PTSD:

“But again, being respectful for (parent with PTSD), I didn’t want to also go and blurt out all my stuff about what (parent) was doing, and how (parent) was acting, because then that might bring more stuff to home. I didn’t want to put that on (parent), because that would make (parent) feel bad for making me feel bad. So, I kind of left it.”

Such protectiveness and parentification were common in the data, and they functioned as a major barrier to children seeking help. Children feared that their parent’s behaviour might be misunderstood or judged, or that their parent might be angry at them or distressed and worsen their PTSD, which was especially concerning for children whose parents had been suicidal in the past.

Discussion

This study examined the experiences of children (aged 9–17) living with a service parent with PTSD, from the perspective of the child, the parent with PTSD and the co-parent. Overall, the perspectives of child and parent participants were complementary and contributed to a coherent set of findings. Parents reported being aware of how living with parental PTSD impacts their child’s mental health and wellbeing and openly explained that they wanted more support for their children. Children discussed their experiences of parental PTSD and were respectful, caring and protective of their parents.

As reported in a number of studies to date, the pervasive psycho-social impacts of PTSD include “significant impairment in personal, family, social, educational, occupational or other important areas of functioning” (WHO, 2018), including parent-child relationships (Banneyer et al., 2017). Reduced parental capacity has been the aspect of intergenerational trauma transmission most discussed in the literature on military families (Banneyer et al., 2017). There was clear evidence in this study of reduced parental capacity where dysregulated emotions and arousal states of the parent with PTSD created a lack of emotional stability for children. Children in this study experienced parental emotions that were extreme, volatile, and unpredictable, expressing concern in relation to the anger expressed by their parents and parental behaviours such as yelling. The anxiety of children around these behaviours and the way in which children were observed to emulate these behaviours was consistent with the literature on secondary trauma and intergenerational transmission of symptoms via emulation and identification (Diehle et al., 2017).

Reduced parental capacity had a significant impact on the attachment style of the parents in this study. Some children experienced a parent who had an avoidant attachment style, being emotionally numb and not accessible for children seeking affection or support on other needs. Other children experienced a parent with an anxious attachment style, being over-protective or even paranoid, but the parent could also change to become withdrawn and reject affection, creating an anxious-ambivalent attachment style. Attachment style is an important factor influencing how children developmentally learn to manage distress (Bowlby, 1979) and affects the quality of parent-child communication (Zhou et al., 2021).

On attachment theory, children who find it hard to interpret, access or trust the emotions and behaviours of their parents can also struggle in their other social relationships as a consequence of insecure attachment styles (Pearce, 2016). Findings of this study reflected this, with a number of children experiencing social issues expressed as emotional dysregulation (crying easily or displaying anger outbursts) or feelings of social disconnection and emotional withdrawal. The findings of insecure attachment among participants of this study reinforce the literature on the relationship between parental PTSD and insecure attachment, and they further urge the development of therapeutic interventions addressing secure attachments for children of service parents with PTSD (Rhona, 2018).

Related to attachment theory and quality of communication, the findings of this study also complemented literature about how the transmission of trauma from parent to child can occur directly through communication and behaviours or a lack of communication (Ancharoff et al., 1998). Parental under-disclosure of past trauma exposures and/or of a diagnosis of PTSD provides evidence of this mechanism of trauma transmission, where the parents’ under-disclosure resulted in children becoming curious about what their parent has experienced to cause PTSD. Children were reported to actively seek out evidence online, in news, movies or other media, or to imagine a parent’s traumatic exposures, which may not produce accurate depictions, and to ruminate on these depictions and even experience them as their own nightmares. Our findings also featured examples of vicarious trauma, with trauma being transmitted through over-disclosure of trauma memories or parental disclosures of suicidal ideation, and also through children gaining access to a parent’s traumatic materials, such as photos, causing distress and fear.

Children mentioned being aware when a parent downplayed their mental health or gave “made-up” explanations for emotional outbursts or absences, and this inconsistency or perceived “cover up” made them feel anxious. Children expressed that they would like more disclosure, namely more explanation and information about PTSD, its causes

and how it affects their parents and their family. This highlights the importance of providing developmentally appropriate explanation or psychoeducation, ongoing over the lifespan, since the impacts can change over time, which is supported by recent studies affirming a lack of age and culturally appropriate resources, for children of military families, to give them agency through recognisable narratives (Rogers & Bird, 2020; Rogers et al., 2019). There has recently been a suite of resources created for 2–8-year-olds on military life that includes a resource on parental PTSD (Rogers et al., 2022; Rogers, 2022).

The findings also highlight that the children need parents to strike a balance between under and over-disclosure of past trauma exposure, namely by providing children with context, but minimal details of traumatic content. Importantly, the context of the parent's trauma exposure provided to children should include the purpose and meaning of the service-related task and setting (Bruning, 2018). This would support the child's curiosity and understanding, helping them to make sense of their parent's PTSD. It would also help to prevent children from attaching false imagery (imagined or sourced from media) to their parent's pain and therein help to protect them from vicarious traumatization. This way, the exposure is more controlled, contained and meaningful, and could be supported by therapists (Bruning, 2018).

Indirect transmission of trauma was evident in this study as a result of a changed home environment including family dynamics, parental conflict, changed roles and modelling. This supports the literature on indirect transmission from family context (Dekel & Goldblatt, 2008; Sayers et al., 2009). Evident in this study was the phenomenon of children becoming carers or taking on parental or adult responsibilities, known as parentification or adultification, which has been shown to commonly occur for children of a parent with a mental illness (Van Loon et al., 2017). Parentification was evident to a greater or lesser degree in all the children, but it was more intense in single-parent families and ranged from taking on a carer role (supporting medical treatment compliance or protecting younger siblings), to children learning not to surprise a parent suddenly with a touch or loud noise, which children often called "managing triggers". Parentification appeared to be an adaptive or coping behaviour of children, however the extra responsibility was also found to increase the children's own stress or anxiety. The children's protectiveness of their parent (another form of parentification) interfered with help-seeking. Children explained that they were nervous about seeking help, not wanting to cause their parents more stress by inadvertently bringing attention to their parent's problems. This made the children less open to seeking help, which is a finding that ought to inform policy and services for these children.

Another key finding of this study was the evidence of impacts on child wellbeing. The feelings that children associated with their experiences of parental PTSD, predominantly anxiety, resulted in emotional and behavioural issues, which supports previous literature (Daraganova et al., 2018; Fear et al., 2018; Linkh, 2006; May et al., 2023). A novel finding was that children and parents in this study doubted the accuracy of the child's formal or suggested mental health diagnosis, which was commonly ADHD for primary school aged boys and BPD for teenage girls. These are common misdiagnoses for trauma conditions (D'Andrea et al., 2012; Van der Kolk, 2017). This is likely because boys are most frequently diagnosed with 'externalised' disorders and girls with 'internalised' disorders (Mayes et al., 2020), which accentuates the importance of future studies including prevalence to establish the risk, types and rates of disorder for these children.

There have been no comprehensive prevalence studies of children of service parents with PTSD (military or EFR), and secondary or vicarious trauma psychometric tools and assessment are not readily available or established in clinical practice. We know that parental mental health issues increase the risk of child mental health issues in the general population (Weissman et al., 2016). We also know of increased mental health issues in adult children of military parents with PTSD (O'Toole et al., 2017). And we know that emotional and behavioural issues are more readily identifiable in children of EFR or military parents with PTSD (Daraganova et al., 2018; Fear et al., 2018; Linkh, 2006; May et al., 2023). But this knowledge base is inadequate to guide widespread policy, support services and intervention.

Children in this study experienced anxiety and fear of separation post-service, just as children did in a study of families of EFRs impacted by the 9/11 World Trade Centre Attacks (Linkh, 2006). The children have prior experiences of fear of the dangers inherent in their parent's service and prior experiences of separation anxiety when their parent was absent due to deployments (local or overseas) (Rogers, 2020; Siebler, 2009; Wells et al., 2022a). The absence of parents, emotionally or physically, post-service due to PTSD reinforces the children's memories and heightens the associated feelings of anxiety and fear (Brooks, 1981). This needs to be recognised in supporting these children.

Children's fear of loss and experiences of parental suicidality are traumatic for them, even without the tragedy of completion. This is especially important to highlight in view of the Australian Royal Commission into Defence and Veteran Suicide, a national enquiry. This study supports the literature on suicide risks through moral trauma and interpersonal impacts (Jamieson et al., 2020). It shows how difficulties interpersonally for service parents with PTSD, feeling guilt around the impacts on their children and

partner and frustration at the difficulty of accessing help for them, increases distress and risk of suicide, and consequently distresses the children. EFR families had even greater difficulty accessing help for their children or partners, due to there being no established government funding for EFR families of injured members during or post-service. Supports have improved for veteran family members who can access some counselling through the Department of Veteran Affairs agency; Open Arms in Australia, with limitations to eligibility, but EFR family members have very few services, in a state administered EFR structure with support systems for current members through an organisation's mental health service for employees, usually called Employee Assistance Programs (EAP) or injured members via insurance schemes, which is similar in New Zealand, Canada and United States of America (Alruz et al., 2020; May et al., 2023).

The findings of this study are some of the first to explicitly identify the mechanisms of inter-generational transmission of trauma in service families, detailing the direct and indirect mechanisms and the outcomes of vicarious, secondary and moral trauma for children. The transmission of moral trauma from parent to child (Jones, 2018) was also identified in this study, where some children mirrored their parent's worldview of feeling ashamed, betrayed, discarded, misunderstood, unappreciated, disconnected from their community, and felt hopeless or powerless to change this (Jamieson et al., 2020). Meaning making to improve their understanding, sense of purpose and narrative behind their experiences of parental PTSD, needs to be part of interventions for children of service families to address moral trauma and support their well-being (Bruning, 2018).

Within our findings on help-seeking, an area of focus was the school setting, which is consistent with the literature (Esqueda et al., 2012; Garner & Nunnery, 2018; Macdonald, 2017; Macdonald & Boon, 2014; Rogers et al., 2021; Wells et al., 2022b). Parents described that they often did not realise fully that their children were experiencing emotional or behavioural issues until teachers and school staff raised it. Parents described many examples of schools not understanding or providing support for their child's and family's difficulties, even when they disclosed this to the school, raising the issue of a lack of capacity in schools and school counsellors. Improving the capacity of schools to support children of service families was also a finding supported in the literature and includes the need for service cultural knowledge and practice within schools (Macdonald, 2017). Some children said that participating in this research was the first time they had been asked about how their service parent's PTSD affected them, by anyone, and they explained that more information and help for them and their parents would have made talking about it easier. This

supports the parents' identification of a need for policy and practice to equip schools and service providers with more information guides and programmes on parental PTSD in service families.

The recently developed resources for educators and families of 2–8-year-olds on military life and parental PTSD will help support some of this knowledge in Australia and hopefully EFR families in the future (Rogers et al., 2022; Rogers, 2022). The Australian Defence Force have also funded a programme previously called Defence School Transition Aides and more recently named Defence School Mentors, which focuses on children of current Defence members, and primarily deployment periods, however research supports that this programme could be expanded to support other children with parents who are away for long periods such as children of EFR families (Macdonald, 2017) and also needs to be expanded, to support for children of injured veterans or EFRs with PTSD for example.

This study reveals the additional impact of service culture and identity on the way a child is impacted by parental PTSD in service families. With intense emotions such as "anger" being a trained combat response to threat for service members such as military and police, it becomes an automatic response to traumatic memories (Lane et al., 2021). In this study, children reported that anger and yelling is one of their greatest concerns. Fluctuating arousal and emotional states, such as high levels of anger in service parents with PTSD, effectively fatigue the nervous system and become automatic reactions, which are hard to change for adults (Lawrence-Wood et al., 2021; Van der Kolk, 2015) and are ultimately being modelled or transmitted to children in the parenting environment (Diehle et al., 2017; Parsons et al., 2018). This important finding needs to be implemented using service cultural awareness in the design of interventions for children of service families and parents, to support them to learn new skills to manage and regulate their emotions and behaviours.

The help-seeking family members in this study reported that they had experienced a major gap in the lack of culturally attuned and appropriate services for their child and family. The literature also confirms that there is a paucity of research into therapeutic interventions designed and evaluated to support the well-being of children of service parents with PTSD (Ohye et al., 2017; Rogers et al., 2021). Understanding "military or service cultural competency" is recommended in the literature to be a key aspect of the design and development of effective treatments for service members and their families (Cramm et al., 2021; Lane et al., 2021; Ohye et al., 2017; Tam-Seto et al., 2019).

There are several strengths and limitations of this study. The COVID-19 pandemic hampered recruitment and whilst the sample size of 17 participants was sufficient for the study design, a larger study may support greater confidence

and transferability of the findings. We also recommend a larger mixed-method study of experiences and also prevalence of intergenerational transmission in children of service families to enhance understanding of risk, types and rates of disorder. While age range of children in this study was limited to children aged 9–17 due to methodological and ethical reasons, this is not considered a major limitation as children's voices in general are very rarely incorporated into research of this type, with most studies of military or EFR families focused on adult children.

There are very few studies published worldwide that have examined the experiences of children from the perspective of the child, the service parent with PTSD and the co-parent. Parental PTSD in this study was ascertained based on self-report and did not require proof of diagnosis for participation. This approach was taken to increase participation and reduce risk of distress to the family. Given the focus on parental PTSD, the findings of this study cannot be generalised to PTSD comorbidities or other mental health conditions of service. A major strength of this study is the participants who gave candid emotional accounts of their own personal experiences as children and parents. The participants, including children as young as 9 years, expressed that they wanted to participate in the research with the hope and aim that sharing their stories may inform improvements in support services for other children and families living with service-related PTSD.

Conclusion

This study provides novel empirical findings on children's experiences of parental PTSD in service families, integrating perspectives from children, service parents with PTSD, and co-parents. It also highlights the role of reduced parental capacity in the transmission of trauma from parent to child and enriches our understanding of the mechanisms of trauma transmission in service families, including unique mechanisms relating to service culture. Especially important for future research and intervention design is the impact of military and EFR service conditioning and culture on exacerbating PTSD symptomology, especially emotional dysregulation and consequent impaired family functioning. The findings on a lack of available supports that are specific and culturally targeted towards children of service families imply the need for further research and policy amendments to support the development of therapeutic interventions and programmes for service families with PTSD and their children.

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