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“I don’t want a handout, I want a hand”:
Exploring Mental Health Service
Engagement among Partners of
Veterans with Post-Traumatic Stress Disorder

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“I don’t want a handout, I want a hand”: Exploring Mental Health Service Engagement among
Partners of Veterans with Post-Traumatic Stress Disorder

by

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A THESIS

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Abstract

This study incorporated ecological systems theory, systems of care, and social justice principles to explore mental health service engagement among *partners of veterans with post-traumatic stress disorder* (PoPVs). Using the exploratory method of the Enhanced Critical Incident Technique, 16 PoPVs were interviewed about the factors that hindered, facilitated, or would have facilitated, mental health service engagement. Data analysis revealed 13 categories: (a) Beliefs and Attitudes; (b) Skills, Competencies, and Roles; (c) Veteran's State of Readiness; (d) Support from Peers/Family; (e) Media and Communication Technology; (f) Support from First-Contact Care; (g) Health Care System Management; (h) Service Characteristics; (i) Institutional Accountability and Transparency; (j) Cultural and Organizational Influences; (k) Family-Centred Care; (l) Provider Expertise/Competencies; and (m) Therapeutic Alliance and Change. The findings are discussed in relation to the literature on PoPVs' and PTSD-affected military and veteran families. Recommendations for key stakeholders involved in the care of PTSD-affected veteran families are offered.

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Dedication

This thesis is a tribute to Canadian military and veteran families. This work honours the sacrifices you have made, and the invisible wounds inflicted upon you in service to our country. To the spouses and partners who generously offered their time and experiences to this project, your wisdom, courage, and perseverance has helped shape the researcher and clinician I aspire to be. Thank you for entrusting your stories to this project, and for sharing a part of your life with me.

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List of Abbreviations

APA	American Psychiatric Association
ASD	Acute Stress Disorder
CAF	Canadian Armed Forces
CFMAP	Canadian Forces Member Assistance Program
CFREB	Conjoint Faculties Research Ethics Board
CI	Critical Incident
CIT	Critical Incident Technique
COPE	Couples Overcoming PTSD Everyday
CPA	Canadian Psychological Association
CPTSD	Complex Post-Traumatic Stress Disorder
DESNOS	Disorders of Extreme Stress, Not Otherwise Specified
DND	Department of National Defence
DSM-5	Diagnostic and Statistical Manual for Mental Disorders – 5 th ed.
EAT	Equine Assisted Therapy
ECIT	Enhanced Critical Incident Technique
EST	Ecological Systems Theory
FIL	Family Information Line
HBM	Health Belief Model
IB	Institutional Betrayal
IPV	Intimate Partner Violence
MFRC	Military Family Resource Centre
OSI	Operational Stress Injury
OSISS	Operational Stress Injury Social Support
PoPVs	Partners of Veterans with Post-Traumatic Stress Disorder
PTSD	Post-Traumatic Stress Disorder
SOCs	Systems of Care
STS	Secondary Traumatic Stress
VAC	Veterans Affairs Canada
WL	Wish List

CHAPTER ONE: INTRODUCTION

Our families live the missions with us, and they suffer similar trauma, before, during and after. Our families are inextricably linked to our missions, and they must be supported accordingly.

General Romeo Dallaire (2004, p. xvii), *Shake Hands With The Devil*

This study is a qualitative exploration of mental health support and service engagement among cohabiting *partners of veterans with post-traumatic stress disorder* (PoPVs). More specifically, this research sought to uncover the hindering and facilitating factors that influence seeking, accessing, and utilizing mental health services and supports among PoPVs in a Canadian context. Drawing from aspects of ecological systems theory (EST), systems of care (SOCs), and a social justice approach to research, I used qualitative methods to elicit the experiences of PoPVs through personal interviews. These interviews gleaned rich accounts of the events that precede PoPVs' help-seeking, and their experiences of navigating multiple systems and communities in an attempt to address their mental health needs.

This chapter provides an introduction to the current study, beginning with a description of the context of the problem. To follow, the purpose, objectives, research questions, and assumptions of the current study are outlined within a framework that bridges EST, SOC, and social justice principles. Key terms, my personal interest in this topic, and the significance of this study are then described. This chapter concludes with an overview of how the thesis is organized and presented.

Context of the Problem

According to the *Survey on Transition to Civilian Life*, 42.5% of Canadian veterans experience posttraumatic stress disorder (PTSD) because of their military service (Thompson et al., 2011). While it is evident that combat exposure negatively affects military and veteran

personnel, service-related PTSD also has profound effects on military family functioning, mental health, and well-being (Dekel & Monson, 2010). Due to the high prevalence of PTSD among veterans and its significant impact on family members, it is necessary that Canadian healthcare systems are equipped to address the needs of veteran families in the after-effects of traumatic deployment experiences.

The negative impact of PTSD on military veterans has long been the focus of empirical research (Rose, Aiken, & McColl, 2014). However, only in the past 25 years has attention turned to PoPVs and military family systems (Calhoun, Beckham, & Bosworth, 2002; Yambo & Johnson, 2014). Due to the debilitating and pervasive nature of service-related PTSD and the need for families to adapt to this injury (Erbes, Meis, Polusny, Compton, & Wadsworth, 2012), PoPVs often assume the role of caregiver (Mansfield, Schaper, Yanagida, & Rosen, 2014). Although the emergence of PTSD is a potential source of stress for veteran families, research has established a positive relationship between the support provided by PoPVs and PTSD veterans' mental health service utilization, retention, and treatment outcomes (Falloon, Roncone, Held, Coverdale, and Laidlaw, 2002; Meis, Barry, Kehle, Erbes, & Polusny, 2010). Furthermore, military and veteran families affected by PTSD experience improved functioning and cohesion when PoPVs participate in mental health services (Wadsworth et al., 2013).

Although partner involvement is critical to rehabilitating PTSD veterans (Schumm, Fredman, Monson, & Chard, 2013), PoPVs endure their own unique stressors and experiences that warrant significant attention (Mansfield et al., 2014). Research has confirmed that living with a PTSD veteran can have adverse effects on the mental health of PoPVs (Yambo & Johnson, 2014), including high levels of secondary traumatic stress (STS; Ahmadi, Azampoor-Afshar, Karami, & Mokhtari, 2011), marital distress (Sautter, Armelie, Glynn, & Wielt, 2011),

depression and anxiety (O'Toole, Outram, Catts, & Pierse, 2010), and suicidal ideation (O'Toole, Orreal-Scarborough, Johnston, Catts, & Outram, 2015). To address the mental health needs of PoPVs, conjoint-couples therapy and family-based interventions targeted toward military families have been implemented in Canada and the United States (Ohye et al., 2015; Sautter et al., 2011). Despite these efforts, access and utilization of mental health services remain low among PoPVs (Link & Palinkas, 2013; McLean, 2006; Tam-Seto, Cramm, Norris, Eichler, & Smith-Evans, 2016). Studies conducted in North America, predominantly in the United States, have revealed that PoPVs experience a range of barriers to accessing governmental and non-governmental (i.e., public) mental health services. These barriers include financial cuts to healthcare, limited availability of services, a lack of information on where to obtain support, veterans' reluctance to involve PoPVs in treatment, lack of specialized services for PoPVs, social isolation, unresponsive health providers, inefficient Veterans Affairs case management practices, and stigmatizing attitudes entrenched within military culture (Mansfield et al., 2014; McLean, 2006; Sherman, Blevins, Kirchner, Ridener, & Jackson, 2008; Tam-Seto et al., 2016). Therefore, PoPVs may be facing barriers to involvement that are inherently related to the structural, cultural, economic, geographical, political, and relational systems of which they are embedded.

The integration of EST and SOCs provides a useful framework for understanding the multiple systems within which PoPVs live, including the more distant settings (e.g., political and economic systems) in which PoPVs may or may not directly participate in but by which their lives and experiences are shaped (Wadsworth et al., 2013). Furthermore, the ability of PoPVs to engage both governmental and non-governmental mental health supports and services is a function of the interactions between these multiple systems. Based on these principles, examining the impact of PTSD on partners, as well as the systemic factors that contribute to

mental health service engagement, provide valuable insights into facilitating support, healing, and adaptive coping among PTSD-affected veteran families (Wadsworth et al., 2013).

Furthermore, by integrating a social justice perspective, the experiences of PoPVs' may be examined more closely to better understand how systemic factors lead to oppression and/or inequities in care (Fassinger & Morrow, 2013). By uniting exploratory qualitative methods and social justice principles, the findings derived from this research not only inform future mental health service delivery and design, but also serve as a conduit for advocacy, awareness, and consciousness-raising as to the systemic challenges facing PoPVs in need of mental health support and services (Fassinger & Morrow, 2013).

Purpose, Objectives, and Research Questions

The current research proposed to investigate the factors that facilitate and impede PoPVs' ability to seek, access, and utilize mental health services and supports through a qualitative methodology. With the paucity of research on Canadian PoPVs' mental health service engagement, a qualitative method is considered the most suitable means of gaining insight into a relatively unexplored phenomenon (Palys & Atchison, 2008). Moreover, there is growing evidence to suggest that PoPVs have traditionally faced systemic challenges to accessing support, which may lead to inequities, oppression, and isolation (McLean, 2006; Outram, Hansen, MacDonell, Cockburn, & Adams, 2009). Therefore, using a qualitative methodology that explores PoPVs' experiences of navigating governmental and non-governmental mental health services and supports, while also integrating a social justice perspective that privileges the voices of PoPVs and examines the impact of systems on PoPVs' ability to engage with supports and services, may illuminate factors and issues that are overlooked when using conventional quantitative methods.

This exploratory study employed the Enhanced Critical Incident Technique (ECIT; Butterfield, Borgen, Maglio, & Amundson, 2009) to examine the self-reported experiences of Canadian women who identified themselves as PoPVs and experienced situations and/or circumstances that necessitated engagement with mental health supports and services. The primary aim of this study was to explore the factors, events, or experiences that helped or hindered PoPVs' ability to seek, access, and utilize mental health services and supports. A secondary goal of this research was to understand the range of experiences and events that precipitated PoPVs' recognition that formal or informal support was needed or desired to manage or alleviate the impact of service-related PTSD on their lives. Therefore, this study was guided by the following research questions:

- 1) What experiences precede the need or desire to seek help among PoPVs?
- 2) What incidents have helped and hindered PoPVs' mental health support and service engagement (i.e., seeking, accessing, and utilization)?
- 3) How have these incidents affected PoPVs' mental health support and service engagement?
- 4) What would have helped PoPVs' engage with mental health services and supports?

Definitions of Terms

The main concept in this study is *partners of PTSD veterans (PoPVs)*, described as those who have been maintaining cohabitation status with PTSD-affected veterans for 12 consecutive months in accordance with federal common-law. *Veteran* refers to any person who has previously served in the Canadian military, but is no longer actively serving. *Posttraumatic stress disorder (PTSD)* refers to a mental health condition preceded by a traumatic event(s) and characterized by symptoms of re-experiencing, avoidance, and hyperarousal as outlined in the *Diagnostic and Statistical Manual for Mental Disorders-5 (DSM-5; American Psychiatric*

Association [APA], 2013). *Service-related PTSD* refers to a specific type of PTSD in which the precipitating traumatic event involved combat, peacekeeping experiences, and/or witnessing civilian atrocities in the context of military employment but in the absence of active combat (Litz et al., 2009). *Systems of care (SOCs)* refers to a network of structures, processes, and relationships embedded within an individual's community that includes but also transcends traditional and formal models of care, such as cultural and family resources (Cook & Kilmer, 2010). *Mental health services and supports* refers to formal supports (i.e., government, professional, or lay services) and informal supports (i.e., family, peers) operating at a dyadic, community, national, or international level to assist with PTSD and its systemic impact on families (Cook & Kilmer, 2010). *Health service engagement* refers to the individuals' efforts to locate, participate in, and benefit from health care services and supports available to them (Center for Advancing Health, 2010). In the current study, the framework of engagement with mental health services and supports occurs along a continuum, including: (a) identifying the need or desire for mental health services, (b) finding appropriate services or supports (i.e., *seeking*), (c) making contact with an identified service or support (i.e., *accessing*), and (d) continuing to participate in that service or support (i.e., *utilization*) to obtain benefit from it (McKay, Stoewe, McCadam, & Gonzales, 1998). Collectively, these key terms and their corresponding definitions allowed me to maintain my ecological disposition while also ensuring that the study retained its focus on a specific group of individuals with a shared identity.

Research Assumptions

According to Butterfield et al. (2009), it is critical that researchers state their assumptions prior to data collection. From study inception to the discussion of findings, this study involved several assumptions that shaped the questions asked, the intended use of the data, and the choices made at each juncture of the research process.

In regards to epistemology, the present study was guided by a post-positivist, social constructivist paradigm, which emphasizes a scientific approach to research, a plurality of perspectives, and the subjective meanings and understandings individuals develop through their interactions with others and about the world in which they live (Creswell, 2007). In practice, the participant and researcher both bring their subjective meanings, understandings, perceptions, and values to the research process, thus co-constructing the research findings. By presenting the findings to participants, their voices and perspectives are honoured. These assumptions subsequently informed the selection of EST and SOCs as the theoretical framework, the choice of ECIT as the research methodology, and the incorporation of social justice principles into the research methods (see “Epistemology, Theoretical Framework, and Methodology” section, Chapter 3).

A number of additional assumptions were made with respect to participants and the research process. First, it was assumed that by living with a PTSD-affected veteran, cohabiting partners would inevitably be affected by PTSD as well and would seek formal or informal help to alleviate their distress. Second, it was also presumed that PoPVs would have both hindering and facilitative experiences in their attempts to engage with mental health services and supports, which also influenced the selection of ECIT as the methodology. Third, it was assumed that PoPVs’ are embedded in multiple overlapping systems (e.g., cultural, economic, geographical, political) that interact to create both barriers and facilitators to engaging in mental health services and supports. Fourth, it was assumed that each PoPV navigates a physical and psychological community composed of structures, processes, and relationships that influences the nature and extent of their participation in mental health services and supports. Finally, based on a

preliminary literature review, it was assumed that there is limited literature on the experiences of Canadian PoPVs and their encounters with mental health services and supports.

Personal Background

I arrived at this research topic through personal exposure to a Canadian veteran family affected by service-related PTSD. Over the past several years, I witnessed the impact of deployment-related trauma on their lives, first on the veteran following his tour to Afghanistan, and subsequently on his partner's well-being. Through listening to their experiences, I learned about the daily challenges of living with the post-traumatic effects of deployment and the injury inflicted upon the family. I observed that his partner, although she did not experience the deployment-related trauma itself, experienced the after-effects of trauma in ways that were equally challenging and distressing. Trauma and its sequelae left no aspect of their life unscathed. Although his symptoms were assigned a diagnosis of PTSD, these same experiences were viewed as a painful, yet natural expression of a wound that occurs when one is exposed to numerous assaults and injustices inflicted upon humanity within a specific socio-political context. Thus, PTSD was not viewed as illness existing within the veteran, but rather as an emotional, social, psychological, physiological, and moral burden that the entire family shared and experienced in their own way. Furthermore, the impact of the trauma was influenced by the responses of family, community, and broader society.

Through listening to the partner's accounts of navigating the complexities of the Canadian government and health care systems, I gained a closeness to her reality – the hardship, isolation, and injustice she endured, as well as her resilience in the face of such adversity. It is for this reason that I became determined to unearth and give credence to the experiences of PoPVs. Subsequently, I engaged the literature on this topic and discovered that research on Canadian PoPVs was relatively limited. Nevertheless, the extant literature suggested that PoPVs

experience high levels of distress, yet several systemic barriers to accessing and utilizing mental health supports and services were noted across studies (Mansfield et al., 2014; McLean, 2006; Sherman et al., 2008; Tam-Seto et al., 2016). From these early observations, I became interested in understanding more about the factors that accounted for variations in mental health service engagement among Canadian PoPVs.

Significance of the Study

Given the high rates of PTSD among Canadian active service members and veterans (Thompson et al., 2011) and its systemic impact on PoPVs (Yambo & Johnson, 2014), it is important to gain an improved understanding of unmet needs for mental health-related information, supports, and services from the perspective of PoPVs. Furthermore, veteran families affected by PTSD benefit from increased engagement of PoPVs in mental health services (Ohye et al., 2015). Therefore, mental health services and supports that are both accessible and responsive to the needs of PoPVs are critical to the well-being of PTSD-affected veteran families.

Previous studies on PoPVs' have not examined the full scope of barriers influencing mental health service engagement, nor has research investigated the ecological factors that facilitate engagement with services and supports among this population. Furthermore, the majority of research informing our understanding of the mental health needs of PoPVs has focused on populations outside of Canada (Yambo & Johnson, 2014). Thus, without an in-depth understanding of the factors that contribute to seeking, accessing, and utilizing mental health services and supports, the responsiveness of Canadian mental health services and supports is compromised and the mental health needs of PoPVs who face barriers to care are likely to persist.

This study is anticipated to contribute to the limited literature on the experiences of Canadian PoPVs, as well as the body of evidence on caregiver/partner stress and burden. Comparing the current findings to existing concepts and literature may highlight factors that have not been detected or measured by quantitative research. Furthermore, the information gleaned from this study will be useful in identifying the unmet needs of Canadian PoPVs and has the potential to improve engagement with information, supports, and services for PTSD-affected Canadian military and veteran families. Understanding more about the challenges faced by Canadian PoPVs will provide direction for future research and clinical practice.

It is also anticipated that the findings from this study will provide useful insights to key stakeholders (i.e., military and government officials, mental health and primary care providers, community agencies) who work with or are involved in the care of PTSD-affected military and veteran families. The barriers and facilitators identified in the interviews may inform future strategies for counselling/psychotherapy and highlight promising practices in the area of peer support, SOCs, military and government operations, and resource allocation. Additionally, this information will have implications for the development of Canadian social policy related to military and veteran families affected by PTSD. Thus, the provision of future strategies and promising practices is expected to enhance the responsiveness of key stakeholders with respect to the mental health needs of PoPVs and their families.

Organization of the Thesis

The present thesis begins with a review of the scholarly literature regarding theoretical and research-based concepts relevant to Canadian PoPVs and their engagement with mental health services and supports. To follow, the processes and protocols used to bridge ECIT methodology with SOCs and social justice principles are described. In the next chapter, sampling characteristics, research findings, and the results from the nine credibility checks used to increase

trustworthiness are presented. The thesis closes with a detailed discussion of the findings, implications for stakeholders, study limitations, and directions for future research.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides a summary of the relevant scholarly literature informing the current study. This review begins with a discussion of the key principles of EST and SOCs, complemented by research that emphasizes the importance of approaching PTSD-affected military families from a systems perspective. This is followed by a review of the unique cultural factors and occupational characteristics that influence Canadian military families. Subsequently, the literature examining PTSD, its distinct expression among military personnel, and its impact on military partners will be discussed. A summary of mental health systems of care of relevance to PoPVs is provided, followed by a discussion of the distinct processes of seeking, accessing, and utilization and factors known to facilitate or hinder each process. This chapter concludes with an outline of how the current study seeks to advance this body of literature.

Ecological Systems Theory

The theoretical framework for the current study will draw from aspects of Bronfenbrenner's ecological approach (Bronfenbrenner, 1969; Rosa & Tudge, 2013). Initially posed as a theory of human development, EST views the developing person as influencing, and being influenced by, the environment in which he or she resides (Rosa & Tudge, 2013).

Bronfenbrenner defined the *ecology of human development* perspective as:

. . . the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (Bronfenbrenner, 1969, p. 21)

An examination of the foregoing definition provides three important characteristics of EST worthy of further explanation. First, a developing individual is a dynamic person that influences and shapes the ecology in which he or she lives (Bronfenbrenner, 1969). Second, the ecology also influences the individual, thereby creating a two-directional, reciprocal interaction between the individual and the environment (Bronfenbrenner, 1969). Because each environment consists of elements that function interdependently as a whole, change in one aspect of an environment affects other aspects within the environment. Thus, individuals are viewed as influencing, and being influenced by, their environment (Rosa & Tudge, 2013). Third, the environment is not restricted to a single proximal setting, but is also influenced by the broader ecology constituting multiple, overlapping, and interconnected systems (Bronfenbrenner, 1969). In this way, individuals represent a unit nested within multiple, interrelated systems (Bronfenbrenner, 1969).

The ecological environment is broken down into four interrelated structures: *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*. The *microsystem* is defined as “a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (Bronfenbrenner, 1969, p. 22). Bronfenbrenner (1969) emphasized the importance of the word *experienced*, in that the scientific understanding of an individual in his or her setting should include both objective and subjective properties. Bronfenbrenner (1969) maintained that the majority of factors influencing human behaviour emanate from the personal meanings and perceptions attributed to any given event or situation. Thus, the microsystem involves the most proximal settings in which a person is embedded, such as the home or workplace (Rosa & Tudge, 2013).

Bronfenbrenner (1969) defined the *mesosystem* as consisting of “the interrelations among two or more settings in which the developing person actively participates . . .” (p. 25). In other

words, a mesosystem is a system of microsystems which intersect, such as the relationship that emerges when home and workplace interact (Bronfenbrenner, 1969; Rosa & Tudge, 2013).

Microsystems expand or become smaller whenever the individual enters a novel setting or leaves a constituent setting, respectively (Bronfenbrenner, 1969; Rosa & Tudge, 2013).

The *exosystem* refers to “one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person” (Bronfenbrenner, 1969, p. 25). The developing individual does not reside in the exosystem and does not participate actively within it, but indirectly influences and is influenced by it at times (Rosa & Tudge, 2013). Thus, an example of an exosystem is when a policy is introduced at an individual’s workplace and has a subsequent, indirect effect within the home (Rosa & Tudge, 2013).

The *macrosystem* is defined as “consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies” (Bronfenbrenner, 1969, p. 26). The macrosystem is distinguished from the other three systems in that it involves the established systems of a culture or subculture. Macrosystems influence the other systems, an effect manifested in how the three lower systems function (Rosa & Tudge, 2013). Macrosystems are characterized by involving a central ideology or set of beliefs, and include systems such as social, educational, legal, and political systems (Rosa & Tudge, 2013).

Bronfenbrenner (1969) also emphasized the term *ecological transition*, which “occurs whenever a person’s position in the ecological environment is altered as the result of a change in role, setting, or both” (p. 26). Bronfenbrenner (1969) maintained that ecological transitions are normative changes or events that serve as both a catalyst and product of developmental change,

occurring throughout the lifespan and within any of the four structures of the ecological environment. Furthermore, ecological transitions affect both the developing person as well as the systems in which that individual is embedded (Rosa & Tudge, 2013).

In summary, EST emphasizes the interdependence between individuals and the ecological environment in which they reside (Rosa & Tudge, 2013). Ecological environments develop as a result of processes and relationships between people, and the reciprocal interactions that take place between people and the multiple, interrelated systems that constitute their ecological environment (Rosa & Tudge, 2013). When events or changes occur in one part of the ecological environment, it serves as both an instigator and product of developmental change in the person (Rosa & Tudge, 2013). Although the interactions, events, and changes that take place at every level within the ecological environment remain essential components of EST, it is the perception and meaning ascribed to these interactions, events, and changes that is termed the most powerful in shaping human development and behaviour (Rosa & Tudge, 2013).

EST provides a framework for understanding how individuals influence and are influenced by multiple levels of their environment. As such, EST considers any aspect of an individual's environment to be a factor in development. However, within any given ecological milieu, a particular constellation of systems interact with one another to either promote or inhibit an individual's health and their health behaviours. This constellation of systems, referred to as SOCs, is of central importance in understanding the factors that influence seeking, accessing, and utilizing mental health services and supports.

Systems of Care

According to Cook and Kilmer (2010), SOCs are defined as “an adaptive network of structures, processes, and relationships embedded within the community and grounded in

system-of-care values and principles. A system of care provides families with the services and supports needed to enable them to live, work, learn, and participate fully in their communities” (p. 20). The original concept of SOC s stemmed from strategies to improve children’s mental health at all levels of society, but has since been applied to the mental health of a wide range of individuals and communities, including military and veteran families (Hodges, Ferreira, Israel, & Mazza, 2010; Wadsworth et al., 2013). This perspective recognizes that SOC s must go beyond traditional models of care, which were restricted to the identified individual experiencing symptoms and the formal services established to assist them (i.e., counselling, therapy, support groups), to consider the community, cultural, and family context (Cook & Kilmer, 2010). As such, SOC s underpin two important principles warranting explanation. First, the definition of SOC intentionally excludes the words *mental health* to acknowledge that the needs of individuals beyond their immediate mental health needs are important and contributing factors to their overall mental health (Cook & Kilmer, 2010). Second, informal supports (e.g., family ecologies, neighborhoods), in addition to formal supports (i.e., mental health services) must be considered as important and direct influences on individuals’ and families’ mental health outcomes (Cook & Kilmer, 2010). Bronfenbrenner’s EST serves as useful framework for examining and understanding the wide range of factors and dynamics that influence an individual embedded within SOC s (Cook & Kilmer, 2010; Wadsworth et al., 2013). Furthermore, EST provides a structure through which SOC s can be examined and cultivated, attending to the ways that relationships among people, programs, processes, and contexts influence mental health (Cook & Kilmer, 2010).

Ecological Systems Theory, Systems of Care, and the Current Study

The tenets of EST/SOC s outlined above provide a framework for understanding the immediate settings within which PoPVs live, but also more distant ecological systems in which

PoPVs may or may not directly participate in but by which their lives and experiences are shaped (Wadsworth et al., 2013). As such, the EST/SOCs framework informs the current study by conceptualizing the experiences of PoPVs as embedded within multiple overlapping systems and settings. Whereas the family system represents an immediate setting, larger ecological systems might include government policies, economic wellbeing, cultural norms, and healthcare models (Wadsworth et al., 2013). Furthermore, the ability of PoPVs to engage both governmental and non-governmental mental health services is a function of the interacting elements between the family and broader systems. Based on these principles, examining the impact of PTSD on military partners, as well as the systemic factors that contribute to mental health service engagement, provides useful insights into facilitating support, healing, and adaptive coping among military families (Wadsworth et al., 2013). This is supported by the fact that several scholars have applied the principles of EST/SOCs to military family mental health concerns, particularly with regards to the systemic impact of PTSD on families (Baker, 2009; Cozza, Holmes, & Van Ost, 2013; Paley, Lester, & Mogil, 2013; Wadsworth et al., 2013). Proponents of EST/SOCs maintain that an examination of systems are of critical importance in identifying barriers to care from the perspective of individual family members, and is particularly relevant for understanding the experiences of families affected by PTSD (Wadsworth et al., 2013). However, prior to discussing the systemic impact of PTSD on family members, it is first necessary to outline the cardinal features of Canadian military life that creates the unique ecology in which military families live.

Canadian Military Life

The Canadian Armed Forces (CAF) is rooted in a history of the two world wars and peacekeeping efforts, both of which remain integral components of both the Canadian military and Canadian national identity (English, 2004). However, significant changes in roles, structural

organization, funding, and political priorities gave way to a Canadian military lifestyle much different from previous professional generations (English, 2004; Rouleau et al., 2013). Since 1990, the CAF has been involved in continuous national and internal operations that have increased in both complexity and tempo (Rouleau et al., 2013). This transition demanded a great deal from CAF members, as well as their families (Tam-Seto et al., 2016). However, before exploring the military family, it is important to understand the unique elements of the CAF culture and lifestyle.

Culture

The *Encyclopedia of Violence, Peace and Conflict* (Burk, 2008) defines military culture as “a symbolic ‘toolkit’ of rituals, ceremonies, assumptions, and beliefs that grow out of and guide a military force” (p. 1). While authors are generally in disagreement as to the specific set of elements that constitute a distinct CAF culture (English, 2004), Burk (2008) proposes four elements to be common among all Western military organizations: *discipline*, *professional ethos*, *ceremonies and etiquette*, and *esprit de corps*. These four elements serve to maintain and reinforce the culture of Western military organizations, and also represent the means by which the uncertainty of conflict is managed (Burk, 2008).

According to Burk (2008), *discipline* refers to the systematic and well-ordered behaviour of military personnel. The goal of orderly discipline is to reduce confusion and uncertainty surrounding combat, thereby providing personnel with the capacity to adapt to and succeed in missions. Burk argues that discipline also gives permission to and reassures personnel that they have authority to use force, violence, and/or killing despite societal norms against such acts. *Professional ethos* refers to a set of norms, ideals, and behaviours that establish the collective identity and social worth of a military organization. It guides military personnel in their

willingness to use force, violence, and killing, as well as to understand the risk of being injured or killed in defense of a nation or its citizens. *Ceremonies and etiquette* are highly visible, officially sanctioned rituals that symbolize and express collective identity, group affiliation, and common purpose. Rituals provide military personnel with a framework to make sense of the structure and chaos of the world. *Espirit de corps* refers to the beliefs and emotional attachments adopted by military personnel, which in turn, form their commitment and willingness to carrying out missions and the larger military institution to which they belong.

While the aforementioned elements are embedded in Canadian military culture (Department of National Defence [DND], 2008), they are by no means exhaustive. Taber (2009) conducted an in-depth analysis of professional CAF documents and found that the dominant narrative of CAF membership is maintained and reinforced by the principle norm of what constitutes an ideal soldier – that is, strict adherence to the four interlocking values of *duty*, *loyalty*, *integrity*, and *courage*. *Duty* refers to the responsibility to complete a mission successfully at the expense of oneself and his/her family. *Loyalty* refers to allegiance and devotion to one's Commanding Officer, comrades, and the people who depend on CAF members for protection and/or survival. *Integrity* characterizes the necessity for CAF soldiers to place personal concerns or challenges second to the mission at hand. *Courage* refers to the fearlessness and strength to make difficult decisions, and to risk one's life or physical and/or psychological health.

Taber (2009) maintains that these values taken together constitute the professional ethos of the CAF, a philosophy that unites members across ranks and roles. This overriding professional ethos promulgated by the CAF establishes acceptable and desirable ways of acting, believing, and interacting within the military (Taber, 2009). These values also reinforce the

notion that the CAF is an indispensable national and societal institution designed to protect the safety of its citizens and that the use of force is both acceptable and reasonable (Taber, 2009). Taber (2009) emphasizes that while adherence to the military professional ethos is a powerful cultural expectation within the CAF, members do not necessarily conform to the “male warrior” (p. 34) norm, but such norms nonetheless affect their way of life, as well as their families. With the elements of CAF ethos in mind, it is important to understand how such values, beliefs, attitudes, and tradition translate to and affect family life. Furthermore, it is important to highlight the interactional relationship between CAF culture and military families.

Military Families

Military families are inextricably tied to military culture in their role of supporting the CAF member and larger institutional goals, but also in that military family functioning is affected and influenced by the unique demands of the military profession (Cramm, Norris, Tam-Seto, Eichler, & Smith-Evans, 2015; Wadsworth et al., 2013). While contemporary military families are described as similar to their civilian counterparts, three characteristics – *mobility*, *separation*, and *risk* - distinguish the CAF way of life, which in turn, creates the unique ecology of contemporary military families (Rouleau et al., 2013). These three factors exert a notable influence on family functioning and well-being for much of members’ military careers (Rouleau et al., 2013). Additional factors, including family rank and base communities, are also discussed.

Mobility. *Mobility* refers to the requirement of military families to geographically relocate repeatedly throughout the CAF members’ military career (Battams, 2016), changing residence three times more frequently than civilian families (“Pulling down the barriers”, 2012). The mobility inherent to military lifestyle is compounded by the fact that the CAF dictates when, where, and the length of time military families will be posted based on organizational,

institutional, and operational needs (Cramm et al., 2015). Consequently, many non-serving military spouses and partners endure employment challenges such as unemployment and underemployment (Urban, Wang, & Dunn, 2012). Furthermore, non-serving military spouses report dissatisfaction with how the demands inherent to the CAF lifestyle, specifically relocation and posting locations, have either interfered with their employment prospects or required them to make sacrifices in career advancement (Battams, 2016; Urban et al., 2012).

Research suggests that mobility also affects access to and continuity of health care for military families (Rouleau et al., 2013). Like civilian families, CAF families rely on provincial health care systems and services. However, military families experience challenges in acquiring longer-term family and/or specialist physicians; an experience that is further exacerbated by frequent relocations. Accordingly, military families spend extended periods of time on waitlists, or experience significant delays in obtaining quality care.

Frequent relocation among CAF families often accompanies a loss of social support and community networks, both of which are important in childrearing and social wellbeing (Dursun & Sudum, 2009). This loss is further compounded by the fact CAF families are often living far from extended family (Dursun & Sudum, 2009). While research suggests that CAF families are proficient at re-establishing a stable environment and relationships with other CAF families upon relocation, this period of re-establishment may take several months and is often characterized by heightened social and emotional vulnerability for all family members (Rouleau et al., 2013).

Separation. *Separation* refers to the requirement of CAF members to be away from their families for various reasons (e.g., domestic operations; international deployments) and for varying durations (up to 15 months) throughout their military career (Rouleau et al., 2013). Military families must adjust and adapt to periods of separation by taking on new or additional

responsibilities in the members' absence (Cramm et al., 2015). Non-serving military partners, especially those with children, take on new roles within the household, domestic, and parenting realm during longer periods of separation, such as deployments and pre-deployment training (Rouleau et al., 2013). As a result, deployments often mean that families spend little to no time together for periods of six months to over a year-and-a half (Cramm et al., 2015; Rouleau et al., 2013). While periods of separation can be challenging, the period of reintegration following deployment can also be a source of stress for CAF families. Specifically, reintegration can be chaotic and confusing as household, domestic, and parenting roles and responsibilities are again renegotiated and re-established (Dursun & Sudom, 2009).

Risk. *Risk* characterizes the chances of CAF members experiencing permanent injury, illness, or death, both in their preparation for and engagement with combat operations (Rouleau et al., 2013). All variations of military work, including training, present a level of risk to CAF members (DND, 2008). However, CAF families tend to endure a considerable, yet understandable amount of worry, stress, and hardship when service members engage in longer-term deployments that entail greater risk of injury or death (Dursun & Sudom, 2009). For non-serving spouses, this worry and uncertainty is compounded by the fact that little is known about the day-to-day experiences of CAF members while deployed (Rouleau et al., 2013).

Family Rank. According to Baker (2009), the socioeconomic status of military families is directly linked to the CAF member's rank within the military. Furthermore, the rank of the CAF member provides a referent point and shapes how each military family is expected to behave and interact within the military community. Baker states that family members may feel pressure to conform to these expectations due to fear of repercussions to the CAF members' career if such norms and expectations are violated. Furthermore, Baker suggests that military

partners may be expected to form relationships with other partners and families of CAF members who belong to the same unit and are of similar rank. These norms and expectations influence, and to some extent dictate, the dynamics of military communities.

Base communities. Military postings to specific geographical areas creates a shared social, psychological, and physical space referred to as base communities (Hoshmand & Hoshmand, 2007). While this process provides a distinct culture, structure, and geographical setting within which military families live, work, and interact, the support of extended families is often lost with postings (Hoshmand & Hoshmand, 2007). At the same time, military communities may be a valuable source of support, interdependence, networking, and belonging for military families (Hoshmand & Hoshmand, 2007). In the early 1990s, approximately 80% of CAF families lived on a base. At this time, the chain of command and the Canadian government began to encourage CAF families to live in civilian communities, as well as to incur assets through the purchase of homes (Rouleau et al., 2013). Today, 85% of military families live away from CAF bases and in civilian communities (Battams, 2016).

Operational Stress. The relationship between the military institution and military families is one characterized by interdependence (Rouleau et al., 2013), in that the military institution depends on well-functioning military families and military families depend on a well-functioning institution. Thus, the interdependence between the military family and the institution becomes especially vital in cases where supports and benefits are needed to address, adapt, and cope with the unique stressors present in military life (Rouleau et al., 2013). Among these extraordinary challenges includes *operational stress injuries* (OSIs), defined officially by Veterans Affairs Canada (VAC) as “any persistent psychological difficulty resulting from operational duties performed while serving in the CAF” (Day & Olsen, 2015, p. 1). OSIs

encompass a broad scope of emotional and psychiatric conditions, including anxiety and major depressive disorders, as well as less severe difficulties that influence daily functioning (Day & Olsen, 2015). PTSD, in particular, is among the most well-known and intensely researched OSIs. It is also among the most common reactions to deployment-related trauma among service members (Thompson et al., 2011), and is associated with increased suicide risk (Ramsawh et al., 2014), addiction (Golub & Bennett, 2013), domestic violence (Taft et al., 2005), and homelessness (Segaert & Bauer, 2016). While PTSD exacts a significant toll on the CAF member's social, emotional, vocational, and behavioural functioning, research has shown that the well-being, cohesion, and interpersonal functioning of the military family is also negatively impacted (Meis et al., 2010). Before discussing the systemic impact of PTSD on CAF families, it is first necessary to review the diagnostic model of PTSD, its proposed subtypes, and the evolution of post-war psychological conditions among military personnel.

Conceptualization of PTSD

Research has consistently demonstrated the negative impact of stress and trauma on health and well-being (Zen, Whooley, Zhao, & Cohen, 2012). Psychological responses to traumatic and stressful life events has profound implications for conducting research with at-risk populations. The growing number of traumatic stress responses among active and retired CAF personnel (Thompson et al., 2011), coupled with increasing evidence of STS among PoPVs (Dekel, Levinstein, Siegel, Fridkin, & Svetlitzky, 2015) and their children (O'Toole et al., 2016), highlights the need for mental health counsellors and researchers to develop competency in the field of trauma and stress. In order to accomplish this, it is necessary to have an understanding of the diagnostic models underpinning contemporary understandings of PTSD.

DSM-5 Model of PTSD

The *DSM-5* is the standard classification system used by mental health professionals in North America (APA, 2013). According to the *DSM-5*, the origins of PTSD begin with meeting the requirements of criterion A, which is “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). One or more identifiable stressors must precede the symptoms of PTSD; however, the perceived nature of the stressors may vary. To meet the full criteria for PTSD and yield a diagnosis, four symptom clusters (which correspond to criterion B through E) and three additional criterion (F through H) must be present after the traumatic event(s). Individuals must experience the presence of one or more intrusion symptoms (Criterion B) associated with the traumatic event(s), enduring avoidance of stimuli related to traumatic event(s) (Criterion C) associated with the traumatic event(s), two or more symptoms consistent with negative changes or shifts in cognitions and mood (Criterion D) associated with the traumatic event(s), and two or more symptoms consistent with noticeable shifts in arousal and reactivity (Criterion E) associated with the traumatic event(s). Symptoms from Criterion B through E must be present for more than 1 month (Criterion F), produce clinically significant distress or impairment in critical areas of functioning (Criterion G), and cannot be attributed to the physiological effects of a substance or a medical condition (Criterion H). The clinician may then specify whether the individual being assessed experiences the PTSD-*with dissociative symptoms* subtype, in which individuals experience persistent depersonalization (i.e., feelings of detachment from oneself) or derealization (i.e., experiences of unreality of surroundings) in the absence of the effects of substances, in addition to meeting core criteria. Furthermore, the clinician may also use the specifier *with delayed expression*, indicating that full criteria for PTSD were not met until six or more months after the traumatic event(s) occurred.

In adults, the onset of symptoms typically occurs three months following the traumatic event(s) (APA, 2013). Acute stress disorder (ASD), a shorter-term response to traumatic event(s), typically emerges within 3 days following traumatic exposure and may transition into PTSD if it persists for longer than one month (APA, 2013). Approximately half of PTSD cases originally present with ASD (APA, 2013). The projected lifetime risk for PTSD is 8% (Kessler, Berglund et al., 2005), with a 12-month prevalence of 3.5% among adults (Kessler, Chiu, Demler, & Walters, 2005).

Classes of PTSD

Many researchers and clinicians in the field of trauma propose that distinct PTSD classifications exist (Resick et al., 2012; Taylor, Asmundson, & Carleton, 2006), in part due to the increasing acknowledgement from the clinical community of auxiliary features of PTSD beyond the core clusters codified in the DSM model (Cloitre et al., 2012; Herman, 1992; Taylor et al., 2006). The distinction between types of PTSD appears to be associated with the duration and nature of the traumatic event(s), and its subsequent impact on symptom expression and severity (Taylor et al., 2006; Wilkins, Lang, & Norman, 2011).

Simple vs. Complex PTSD. Herman (1992) coined the term *complex PTSD* (CPTSD) to describe a syndrome present in individuals who had survived periods of protracted and recurrent trauma, often present in situations where evasion or escape is unattainable due to physical, political, psychological, maturational, family/environmental, or social restraints. CPTSD syndrome is distinguished from *simple PTSD*, which corresponds to only the core features of PTSD explicated in the DSM model (Taylor et al., 2006). Although there has been some variability in the clinical literature in regards to defining CPTSD, the International Society for Traumatic Stress Studies has proposed the following definition: “CPTSD include[s] the core

symptoms of PTSD (re-experiencing, avoidance/numbing, and hyper-arousal) in conjunction with a range of disturbances in self-regulatory capacities” (Cloitre et al., 2012, p. 3). These additional symptoms include disturbances in the five domains of: emotion regulation, relational capacities, attention and consciousness (e.g., dissociation), belief systems, and somatic experiences (Cloitre et al., 2012). It is important to note that the DSM-IV originally included Disorders of Extreme Stress, Not Otherwise Specified (DESNOS; a similar construct to complex PTSD) as an associated feature of PTSD; however, it was later dissolved following research that confirmed that those who met criteria for DESNOS also met criteria for PTSD (Resick et al., 2012).

Civilian vs. service-related PTSD. Anecdotes from military personnel, veterans, and their family members suggest that it is a relatively common practice to draw a line between PTSD experienced by military personnel and that experienced by civilians (Chaplain, 2011; Paulson & Krippner, 2010). However, the clinical and research community distinguish between the two terms only with respect to the nature of the traumatic event(s) experienced by the individual (Wilkins et al., 2011). Specifically, civilian PTSD is framed in terms of “stressful experiences” and service-related PTSD in terms of “stressful military experiences” (Wilkins et al., 2011, p. 596). Other authors have proposed that the intersection of military culture and trauma gives ways to unique auxiliary features of PTSD among military personnel that does not exist in the civilian population (Beks, 2016a; Hoge, 2011; Nash et al., 2013). Nevertheless, the term *service-related PTSD* has been adopted for the current discussion for two reasons. First, the term reflects the scholarly trend of distinguishing civilian from military PTSD. Second, the term draws attention to the fact that military-related trauma is not isolated to combat exposure and may include the witnessing of civilian atrocities in the absence of active combat but yet within

the context of military service and conflict (Litz et al., 2009). The following section focuses on the prevalence rates among active and retired CAF personnel, as well as an overview of the evolution of the historical precursors to service-related PTSD.

Service-Related PTSD

Prevalence. Canadian rates of service-related PTSD have increased in response to the institutional shift toward increased engagement with active combat among CAF members (Baker & Norris, 2010; Rouleau et al., 2013). However, prevalence rates of PTSD among CAF personnel are complicated by several factors, including assessment and diagnostic criterion, disability and medical release, sampling and methodology, and the relative absence of Canadian research on the mental health impact of pre-Afghanistan deployments (Richardson, Frueh, & Acierno, 2010; Zamorski & Boulos, 2014). As a result, prevalence rates vary considerably, yielding no single number by which to describe the extent of PTSD among CAF personnel and veterans. For instance, Pearson, Zamorski, and Janz (2014) found that among active Canadian Regular Force members (including those who had not been deployed), the lifetime and 12-month prevalence rate for PTSD was 11.1% and 5.3%, respectively. Among those who had been deployed, the 12-month prevalence rate of PTSD was more than double the rate compared to their non-deployed counterparts (Pearson et al., 2014). Among recently released Regular Force veterans, PTSD was reported by 25% of disability pension clients and 43% of veterans under the New Veterans Charter (Thompson et al., 2011). Nevertheless, prevalence rates provide an illuminating representation of the debilitating effects of military service on active and retired CAF personnel.

Historical Evolution of Service-related PTSD

Although it is unknown when the psychological consequences of war were first identified in soldiers, behaviours similar to PTSD have been detected in many early classical literatures, beginning with the battle of Herodotus dating back to 440 BC (Jones, 2006). This does not necessarily imply that service-related PTSD has always existed as it is known today, but rather that post-war psychological conditions have occurred throughout human history, albeit taking on variable terminologies and explanations depending on cultural norms and evolutions in warfare (Crocq & Crocq, 2000; Paulson & Krippner, 2010). Furthermore, the veracity of post-war psychological conditions has generated much debate among medical and military institutions throughout history and remains a source of controversy even today (Crocq & Crocq, 2000; Jones, 2006). While a detailed history of post-war psychological conditions is beyond the scope of this section, a selection of post-war conditions credited with influencing the evolution of service-related PTSD is presented.

The discussion of post-war conditions begins with World War I, where soldiers were returning from the trenches with medically unexplained symptoms, including tics, paresis, tremors, fatigue, headache, difficulty sleeping, nightmares, memory loss, and poor concentration (Jones, 2006; Loughran, 2012). This cluster of symptoms was termed *shell shock*, referencing the after-effects of soldiers' exposure to exploding shells (Loughran, 2012). According to historians of psychotraumatology, shell shock was the pre-eminent condition associated with the trauma and hardships sustained by soldiers during this time (Jones, 2006; Loughran, 2012). In World War II, *acute combat stress reaction*, also known as battle fatigue, combat exhaustion, or operational fatigue, emerged as the pre-eminent term to describe post-war psychological conditions among soldiers (Hyams, Wignall, & Roswell, 1996; Paulson & Krippner, 2010). Acute combat stress reaction carried some resemblance to shell shock, manifesting

predominantly in somatic symptoms such as fatigue, heart palpitations, diarrhea, headache, poor concentration, memory impairment, and disturbed sleep (Hyams et al., 1996). Interestingly, acute combat stress reaction was not isolated to World War II and remained a significant post-war condition among Korean War veterans (Hyams et al., 1996).

The post-war condition that emerged following the Vietnam War perhaps had the greatest influence on contemporary conceptualizations of service-related PTSD (Jones, 2006). The long-term psychological consequences of severe combat stress endured in Vietnam was referred to as *post-Vietnam syndrome* (Jones, 2006). This particular condition was distinguished from earlier post-war syndromes by the tendency for soldiers to experience intrusive combat-related cognitions and nightmares, numbed responsiveness, and specific behaviours such as drug dependence, depression, anxiety, and rage (Friedman, 1981). It was this congregation of symptoms and the increasing number of soldiers diagnosed with post-Vietnam syndrome in the 1970s that ultimately prompted the development and recognition of PTSD as a diagnostic category in 1980 (Crocq & Crocq, 2000).

Cultural Considerations in Service-related PTSD

Jones (2006) maintains that post-war conditions and their corresponding labels are inextricably linked to culture. Physicians and soldiers throughout history may have been more aware of or more likely to express symptoms in ways that reflected current cultural beliefs, values, or priorities (Jones, 2006). However, descriptions of post-war conditions have revealed an increasing trend toward psychological attributions as opposed to neurological explanations (Jones, 2006). Thus, it is possible that specific symptoms associated with post-war conditions are overlooked or disregarded at any given point in history in favor of the model or popular attributions held by larger society at the time (Jones & Wessely, 2005).

A systematic review of the literature suggests that the DSM model of PTSD reveals little variability across cultures (Friedman, Keane, & Resick, 2014); however, with some exceptions. Research has revealed that Latinos, African Americans, and Native Americans in the U.S. are at higher risk of developing PTSD, which may be due to the compounding effects of racism and discrimination, predisposing vulnerability factors, and cultural expressions of distress (Alcántara, Casement, & Lewis-Fernández, 2013; Pole, Gone, & Kulkarni, 2008). In contrast, lower rates of PTSD have been identified among Japanese American Vietnam veterans, a finding that has been linked to Japanese cultural values that emphasize acceptance of one's destiny or fortune and resolution in response to suffering (Friedman, Schnurr, Sengupta, Holmes, & Ashcraft, 2004). A study by Shore, Orton, and Manson (2009) found higher rates of nightmares among Native American veterans compared to those of other ethnic backgrounds, a finding that may be associated with cultural meanings of distressing dreams. According to Friedman et al. (2014), PTSD may reveal cross-cultural applicability as a universal response to traumatic events, but the expression of PTSD in different cultures may vary with respect to symptom clusters and individual experience.

Partners of Veterans with PTSD

Given that military personnel are at particularly high risk of developing PTSD (Rose et al., 2014), active and retired members continue to be the target of both individual and group psychosocial interventions (Wadsworth et al., 2013). While service-related PTSD has been formally recognized since the 1970s among active service members and veterans, the current era of PTSD-affected veterans are distinguished from earlier cases on the basis that today's veterans are more likely to be married and to have children (Rouleau et al., 2013; Yambo et al., 2016).

Given the increasing trends toward young military families, the military research community has turned their attention toward PoPVs, their children, and the provision of services

tailored to their distinct mental health needs (Mansfield et al., 2014; Sherman, Perlick, & Straits-Tröster, 2012). Research has confirmed that living with a veteran with PTSD can have adverse effects on the mental health, well-being and functioning of partners (Yambo & Johnson, 2014). Furthermore, due to the debilitating and pervasive nature of service-related PTSD and the need for partners to adapt to the traumatization of the veteran (Erbes et al., 2012), PoPVs often assume the role of caregiver and endure their own unique stressors and challenges (Mansfield et al., 2014). The following section offers a review of the existing literature on the effects of PTSD on military partners, with a particular focus on the mental health of PoPVs. It is important to note that the overwhelming majority of this research has focused on intra-individual factors contributing to mental health outcomes among non-Canadian populations (Yambo & Johnson, 2014). Nevertheless, these findings provide an illuminating portrait of the experiences, challenges, and hardships of PoPVs.

Burden

Cohabiting PoPVs are an essential support to veterans with service-related PTSD (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). Due to the impact of PTSD on areas of social, occupational, and interpersonal functioning, PoPVs often assume the role of caregiver, head of household, and primary provider (Mansfield et al., 2014; Yambo & Johnson, 2014) and in turn, play a pivotal role in the veterans' mental health and rehabilitation (Meis et al., 2010). However, the increased demands that accompany this transition to caregiving, among other roles, often leads PoPVs to feel that their daily lives are dictated by the veterans' PTSD and that their own needs, desires, and sense of self are neglected (Beks, 2016b; Mansfield et al., 2014). The research community has defined this experience as *caregiver burden*, referring to the objective degree of difficulty managing the demands of caring for another with a chronic illness, but also

the subjective experience of stress and responsibility (Calhoun et al., 2002; Klarić et al., 2010). While the concept of caregiver burden originated from the literature on caregivers of relatives with psychiatric conditions (Grad & Sainsbury, 1966), it has since been applied to many caregiving situations, including PoPVs (Beckham, Lytle, & Feldman, 1996; Dekel & Monson, 2010). Authors in the field have been diligent to point out that caregiver burden is not a fixed state, but rather fluid, dynamic, and temporal in nature. For instance, research has found a positive association between the degree of caregiver burden experienced among PoPVs and the severity of veterans' PTSD symptoms (Beckham et al., 1996; Calhoun et al., 2002; Manguino-Mire et al., 2007). As subjective and objective burden increases, PoPVs experience increased psychological distress, anxiety, and depression (Beckham et al., 1996; Calhoun et al., 2002), thereby further influencing the level of burden experienced. Research has also found that levels of caregiver burden among PoPVs increase over time (Beckham et al., 1996). Other factors have been implicated in increased levels of caregiver burden among PoPVs, such as veteran-perpetrated intimate partner violence (IPV; Calhoun et al., 2002) and veterans' diminished engagement in PTSD treatment (Manguino-Mire et al., 2007).

Research suggests that the caregiver burden experienced by PoPVs may be experienced in discrepant or compounding ways. Yambo et al. (2016) found that PoPVs endured one or both types of caregiver burden: a material, physical type emanating from the demands and responsibilities of the caregiving relationship, and a covert, psychological type. The material, physical burden involved the duty felt by PoPVs to cope with the changes in their lives brought on PTSD, including changes in key roles or domestic obligations. However, the psychological type of burden endured by PoPVs was characterized by feelings of guilt for the veterans'

deployment experiences, the trauma they endured, and the debilitating impact of PTSD on their life and relationships.

Secondary Traumatic Stress

As PoPVs become a central support to veterans, their proximity to the experiences of the veteran inevitably increases the likelihood that they will be exposed to the veteran's painful memories and suffering. Previous research suggests that PoPVs often endure adverse psychological effects due to repetitive exposure to the veterans' traumatic events and/or symptoms, known as STS or vicarious trauma (Ahmadi et al., 2011; Bride & Figley, 2009; Dekel & Solomon, 2006; Francisković et al., 2007). Researchers have proposed that STS becomes a pathway by which PoPVs are at increased risk of experiencing PTSD symptoms bearing a striking resemblance to the veteran, in addition to other psychological correlates such as depression, anxiety, guilt, and sleep disturbance (Dekel et al., 2005; Renshaw, McKnight, Caska, & Blais, 2011). However, research by Ahmadi et al. (2011) found that STS among PoPVs was positively correlated with the length of exposure to the veterans' PTSD symptoms, suggesting that early intervention is critical for PTSD-affected military couples. Several other factors have been implicated in symptoms of STS among PoPVs, including poor quality social support (Dirkzwager, Bramsen, Adèr, & van der Ploeg, 2005), unemployment (Francisković et al., 2007), chronic pain (Koić et al., 2002), and depression and anxiety (O'Toole et al., 2010).

Social Isolation

Feelings of loneliness and social isolation has been a major theme in the literature on PoPVs for over 20 years (Dekel et al., 2005; Maloney, 1988; McLean, 2006; Woods, 2010; Yambo et al., 2016). Research has shown that the experience of isolation and loneliness is due to a combination of factors directly related to PTSD. The pervasive nature of PTSD resulted in

veterans' difficulty socializing, their desire to be alone, and at times, the tendency to control PoPVs' daily activities (Dekel & Solomon, 2006; Sherman et al., 2012). Consequently, PoPVs often experience a loss of identity and autonomy, contributing to feelings of loneliness and isolation (Woods, 2010). Emotional numbing and distancing often accompanies PTSD, which has also been found to be a contributing factor to PoPVs loneliness and isolation (Woods, 2010). The avoidance behaviour associated with PTSD that often leads veterans to isolate themselves can also result in PoPVs isolating themselves (Sherman, Zanotti, & Jones, 2005; Solomon & Dekel, 2008). Furthermore, PoPVs' isolation may be exacerbated by feelings of helplessness and perceived inability to cope with the effects of PTSD (Polizzi, 2007). Loneliness may be further intensified by the fact that PoPVs report emotional and social disconnection from their peers who do not understand the experience of living with and caring for a veteran with PTSD (Woods, 2010).

Psychological Distress

Research has confirmed that PoPVs often experience some form of psychological distress, including extreme fear and concern (Yambo et al., 2016), anxiety and depression (O'Toole et al., 2010), and suicidality (O'Toole et al., 2015). PoPVs often endure significant fear and concern associated with the veteran's suicidal thoughts and intentions, as well as how the veteran's PTSD symptoms and related behaviours were affecting their children's well-being, safety, and functioning (Yambo et al., 2016). Research conducted by O'Toole et al. (2010) found high rates of anxiety and recurrent and severe depression among PoPVs, in part due to the tendency of PoPVs to neglect their needs, emotions, and health as they care for the veteran. More recently, in comparison to the general population, Australian PoPVs reported higher rates of

suicidal ideation, planning, and attempts, a phenomenon that may be linked to the high prevalence of mental health concerns and experiences of social isolation (O'Toole et al., 2015).

Ambiguity, Unpredictability, and Attenuating Behaviours

PoPVs often experience ambiguity and frustration as they attempt to understand the behavioural, emotional, and cognitive changes associated with the traumatization of their loved one (Mansfield et al., 2014). Research has shown that more covert trauma symptoms (i.e., numbing/withdrawal symptoms) are more easily misinterpreted by PoPVs as an indication of the veterans' negative feelings about their partners or their intimate relationship (Renshaw et al., 2011). Furthermore, such negative misinterpretations often lead to increased psychological distress among PoPVs (Renshaw & Caska, 2012) and threatens the cohesiveness and functioning of the marital relationship (Renshaw, Allen, Carter, Markman, & Stanley, 2014).

The daily experience of living with a veteran with PTSD has been described as bearing the resemblance of "walking on eggshells" (Beks, 2016b, p. 651; Yambo et al., 2016, p. 546). This finding is corroborated by previous research in which PoPVs described their lives as tumultuous and unpredictable, coupled with feelings of uncertainty, apprehension, and confusion about how best to respond to the veteran (Mansfield et al., 2014; McLean, 2006; Renshaw & Caska, 2012). The unpredictability of PTSD results in PoPVs attenuating their behaviours, interactions, and feelings to offset the veterans' triggers or to avoid conflict (Beks, 2016b; Yambo et al., 2016).

Research has also revealed that PoPVs consistently report feelings of loss with respect to their veteran partner, their relationship, and their anticipated future together (Baker, 2009; Beks, 2016b; Dekel et al., 2005; Dekel & Monson, 2010; Yambo et al., 2016), a phenomena known as ambiguous loss (Boss, 1999). The model of ambiguous loss was originally proposed by Boss

(1999, 2007) to characterize the ongoing uncertainty and lack of closure that accompanies living with an individual who is physically present, but psychologically and emotionally absent. Such situations lack closure and leave individuals in a state of unresolved grief (Boss, 1999). As a result, individuals must generate their own meaning of the relationship in order to deal with the ambiguity and grief they experience (Boss, 2007).

Marital/Common-Law Relationship Quality

Research has shown that PTSD symptoms, particularly numbing and withdrawal, have an aversive effect on couple relationships in terms of functioning and cohesion (Dekel & Monson, 2010; Sautter et al., 2011). Lack of open, empathic, and effective communication within the couple dyad can impede PoPVs' attempts to better understand PTSD and its associated symptoms (Polizzi, 2007). At the same time, PoPVs often feel incapable of communicating their needs to veterans (Polizzi, 2007; Sones, 2014). These findings are supported by earlier research which found that PoPVs reported more relationship dissatisfaction than partners of veterans without PTSD (Dirkzwager et al., 2005). Collectively, these factors may negatively affect or dissolve family relationships and attachments and, in turn, lead to feelings of anger, resentment, or hostility (Cozza, Goldenberg, & Ursano, 2014).

Intimate Partner Violence

Research suggests that rates of IPV perpetrated by veterans with PTSD occur approximately 2-3 times more frequently than in the general population (Byrne & Riggs, 1996; Sherman, Sautter, Jackson, Lyons, & Han, 2006; Taft et al., 2005). Given the strong association between service-related PTSD and increased rates of IPV, violence perpetrated by veterans presents challenges not only at the community level but also in clinical settings (Slep & Heyman, 2008). Despite growing concerns among researchers and clinicians, our understanding of IPV

occurrences among PTSD veterans and their cohabiting partners emanates almost entirely from the perspectives of veterans (Finley, Baker, Pugh, & Peterson, 2010). However, one study conducted by Finley et al. (2010) examined the personal accounts of PoPVs who have experienced IPV perpetrated by veterans with PTSD and found that three patterns of IPV emerged: *violence committed in anger* (i.e., violence and aggression perceived as deliberate and abusive); *dissociative violence* (i.e., violence and aggression that occurred when the veteran was experiencing dissociative episodes or flashbacks); and *parasomniac/hypnopomic violence* (i.e., violent or aggressive episodes that occurred during sleep-like states, including sleepwalking, night terrors, falling asleep, or preceding waking up). Of particular importance, during periods of dissociative violence, PoPVs described being temporarily unknown to their veteran partner, and the violence and aggression bore a striking resemblance to combat-like behaviour (Finley et al., 2010). Furthermore, these early findings suggest that PoPVs may view distinct patterns of violence and aggression as related to specific clusters of PTSD symptoms (Finley et al., 2010). However, concerns are raised among researchers and clinicians who caution that the tendency to adopt this understanding of violence and aggression may lead PoPVs to rationalize or excuse violent behavior (Finley et al., 2010; Sherman et al., 2006).

Adjustment, Adaptation, and Resiliency

Although the majority of research on PoPVs has focused on distress and mental health outcomes, several studies have highlighted the ways in which PoPVs adapt, adjust, and cope with the demands of their daily life (Beks, 2016b; Dekel et al., 2005; Yambo et al., 2016). PoPVs have reported devising novel ways of organizing and functioning within the home environment to improve stability for their families (Yambo et al., 2016). PoPVs have also described personal strengths to cope with the demands of their daily situation, including developing advanced

empathy for the veterans' suffering, reframing their experiences and those of the veteran, and giving meaning to various aspects of their relationship with the veteran and the care they provide (Beks, 2016b; Dekel et al., 2005; Yambo et al., 2016). Additional research is warranted in this area, as an understanding of the resilience that PoPVs and families bring to their daily challenges has important implications for not only enhancing family functioning but also informing potential interventions.

Mental Health Services and Supports for Partners

The provision of supports and services for PoPVs is critical to not only their own mental health, but also the well-being of their family and the veteran (Meis et al., 2010). The following section provides an overview of well-known established services, supports, and interventions available in Canada to address PoPVs' needs and mental health concerns, broken down by: (a) government-affiliated supports and programs, (b) programs operated independently of military but targeted specifically to military families, (c) conventional, civilian approaches, and (d) emerging, alternative supports.

Government-Affiliated Supports and Services

The Government of Canada (i.e., DND, VAC) provide a range of services and supports to partners of serving and retired Regular and Reserve Force members (Family Force, 2016). The following programs target family members of serving or retired CAF members with OSIs (including PTSD) specifically, including tutorial-based psychoeducation, trained peer support, and professional psychosocial services (Family Force, 2016):

- Operational Stress Injury Social Support (OSISS), a partnership between DND and VAC, provides a nationwide peer support network (63 support personnel in 33 locations nationwide) for family members of serving and retired CAF members who experience an

OSI. Peer supports are screened and trained, bringing their lived experience and first-hand knowledge to help families connect to resources.

- Canada Forces Member Assistance Program (CFMAP), is a confidential, voluntary tele-counselling program that offers short-term, acute services (up to 8 sessions) to members and their families experiencing a broad range of concerns.
- CAF Mental Health Services Program provides individual, couple, and family counselling to CAF personnel and their families. Service teams are composed of primary care physicians, psychiatrists, psychologists, social workers, and mental health chaplains. Service centres are located across Canada, with size and locations varying based on population.
- Family Liaison Officers provide support and resources to family members of injured or ill CAF members who are posted to a Joint Personnel Support Unit.
- The Mind's the Matter is a series of online tutorials designed specifically for partners of CAF members or veterans with an OSI, covering a range of topics including dealing with anger, coping with daily challenges, and managing new roles in the family system.
- Family Information Line (FIL) is a 24 hours a day, 7 days a week service that provides confidential assistance, support, and information to family members of CAF members.
- Operational Stress Injury Resource for Caregivers is a web-based resource that provides information to family members of serving and retired CAF members with an OSI.

Military-Focused Independent Supports and Services

Nongovernmental programs have also been established to support and assist partners of serving and retired CAF members (Tam-Seto et al., 2016). Two well-known programs that target

family members affected by OSIs include the Military Family Resource Centres (MFRCs) and Couples Overcoming PTSD Everyday (COPE):

- MFRCs play a pivotal role in providing psychosocial support for serving military families (Rouleau et al., 2013). Contrary to public perception, MFRCs are independent organizations governed by local boards of directors composed of military family members (Rouleau et al., 2013). MFRCs provide shorter-term support and counselling with respect to a broad range of concerns related to military family life, including the impact of OSIs on cohabiting partners. Services are typically delivered in the form of individual counselling for partners or the provision of support groups (Gumiela, 2013).
- COPE is an independent non-profit program comprised of two phases. Phase One consists of a five-day program designed to train military and veteran couples dealing with service-related PTSD how to cope and adapt to the injury (COPE, 2016). Phase Two consists of a six-month Family Coaching Model that involves weekly contact with a family coach who mentors the couple in practicing their new skills and strategies (COPE, 2016).

Conventional Approaches

While a number of OSI- and PTSD-focused programs and services exist for PoPVs, conventional, civilian approaches to addressing the impact of PTSD are also viable options (Family Force, 2016). These approaches include: (a) individual-, couples-, and family-based counselling and/or therapy available through private, provincial, or community-based services; (b) acute and/or emergency mental health units within hospitals; and (c) community-based crisis and/or distress lines (Family Force, 2016).

Emerging and Alternative Supports

Equine-assisted therapy. Recent Canadian research has revealed that equine-assisted therapy (EAT) is particularly effective in assisting PTSD-affected military and veteran couples (Duncan, Crichtley, & Marland, 2014; Russell, 2013). EAT adheres to an experiential learning model, in that through interactions with horses PTSD-affected military and veteran couples are empowered as they modify their behaviour, learn how to re-establish effective communication, and develop trust in themselves and their relationship (Duncan et al., 2014). The key element of EAT for PTSD-affected military and veteran couples is that partners are involved in the treatment process (Duncan et al., 2014). While EAT is not yet sanctioned or funded by the government to aid PTSD-affected couples, VAC and DND have partnered to sponsor pilot testing and evaluation of its effectiveness (Russell, 2013).

Mobile applications. *OSI Connect* is a freely accessible application developed to enhance understanding of and manage OSIs, and connect families to the OSI treatment centres across Canada (VAC, 2016). The application includes specific strategies for addressing the unique challenges associated with PTSD among other OSIs (VAC, 2016).

Social networking. In recent years, several options for support via social networking (e.g., Facebook groups, online forums) have emerged specifically for PoPVs (Anderssen, 2012). Previous Australian research suggests that online support groups, including those offered via Facebook, reduced feelings of social isolation among PoPVs (Ruiz & Stadlander, 2015). Given the extensive use of social networking among Canadians, the potential for social media to provide complementary support to Canadian PoPVs remains a priority for future research.

Mental Health Service Engagement

Health service engagement refers to the “actions individuals must take to obtain the greatest benefit from the health care services available to them” (Center for Advancing Health, 2010, p. 2). In the current study, the framework of engagement with mental health services

includes a trajectory, beginning with one identifying the need or desire for mental health services, followed by finding (i.e., *seeking*) and engaging with the appropriate services (i.e., *accessing*), and continuing to participate in that service (i.e., *utilization*) to obtain benefit from it (McKay et al., 1998). Much of the extant literature on mental health service engagement made little or no mention of the process or action of *seeking* (Cauce et al., 2002), whereas *accessing* and *utilization* have traditionally been the foci of health services literature (Hiscock, Pearce, Blakely, & Witten, 2008). While this body of literature is illuminating and informative, one possible repercussion of limiting investigations to access and utilization is that health services are designed in the absence of a complete understanding of the barriers and facilitators present at each stage of mental health service engagement (Center for Advancing Health, 2010). More recently, the international research community has focused on the *seeking* phase within several domains of health care (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2015; Doocy, Lyles, Akhu-Zaheya, Burton, & Burnham, 2016; Tieu & Konnert, 2014), suggesting that seeking, accessing, and utilization are related but distinct constructs that necessitate specific consideration (Cauce et al., 2002).

Barriers and Facilitators to Mental Health Service Engagement

Three important points must be made surrounding the current state of knowledge on mental health service engagement among Canadian PoPVs. First, the ability of an individual to engage mental health services is influenced by and occurs within a political, economic, cultural, geographical, and social context (Faezipour & Ferreira, 2011). Yet, American research has largely informed our current understanding of PoPVs (Yambo & Johnson, 2014). Given the important differences between Canada and the U.S., it is unfavorable to draw conclusions about Canadian PoPVs' mental health service engagement based on this body of literature. Second,

little or no information about the evidence-base underlying programs and services targeting Canadian PoPVs is available (Tam-Seto et al., 2016), raising questions and concerns about the effectiveness and relevance of these supports for the unique struggles faced by this group. Third, research has revealed that many of the programs and services available to PoPVs cover a broad range of concerns faced by military families, and few services specialize in the unique needs and challenges of PoPVs (Tam-Seto et al., 2016). Nevertheless, it is important to highlight what is known about the barriers and facilitators to mental health service engagement among Canadian PoPVs.

Two Canadian studies have been conducted in which PoPVs have made cursory mention of mental health service engagement. Baker (2009) found that PoPVs cited a number of barriers to accessing psychosocial supports, including a lack of awareness of available supports, the requirement for a referral from the veteran's psychologist to qualify for a service, and long commute times to attend support groups. Another study conducted by McLean (2006) found that PoPVs reported a general absence but strong need for peer support groups, a mismatch between their needs and what CAF agencies were offering, dismissal or abandonment from the military or governmental institutions upon asking for help, and a lack of involvement in the veteran's care.

Tam-Seto et al. (2016) conducted an environmental scan of psychosocial programs and services available to Canadian family members of veterans with OSIs. This study found that most OSI-focused programs and services are limited to specific geographical regions and tend to be delivered in person. With the exception of online supports and services, the large geographical distances between services and veteran families may create additional barriers to accessing care. In addition, the authors proposed that the absence of information on the clinical effectiveness of such programs may present challenges to family members when seeking information and making

decisions about accessing services. Furthermore, because programs and services for family members of veterans with OSIs tend to be offered in combination with other general services, interventions may lack sufficient specialization to meet the unique needs of OSI-affected families or, alternatively, may compromise the effectiveness of OSI-interventions.

Overall, these few studies highlight that Canadian military families face a number of barriers and challenges when engaging with mental health services. However, these studies did not explicitly focus on identifying barriers or facilitators to mental health service engagement among PoPVs, nor did they distinguish between issues of seeking, accessing, and utilization. Nonetheless, this early body of literature serves as a point of departure for directing future research, and confirms the urgent need to investigate the factors influencing mental health service engagement among Canadian PoPVs.

Summary and Conclusions

The increasing rates of PTSD among Canadian active service members and veterans (Thompson et al., 2011), coupled with emerging evidence of mental health concerns and caregiver burden among PoPVs (Baker, 2009; McLean, 2006), highlight the need to examine PoPVs unmet needs for information, supports, and services. Given that veteran families affected by PTSD benefit from increased engagement of PoPVs in mental health services (Ohye et al., 2015), programs and supports that are both accessible and responsive to the needs of PoPVs are critical to the wellbeing of PTSD-affected military families. Previous studies in this area have not examined the full scope of barriers faced by PoPVs, nor has research investigated the systemic factors that facilitate seeking, access, and utilization of services within this population. Furthermore, the majority of research informing our understanding of PoPVs' mental health behaviours have focused on intra-individual factors conducted on non-Canadian populations

(Yambo & Johnson, 2014). Thus, an examination of extra-individual aspects of PoPVs' mental health service engagement is needed in order to address this gap.

In conclusion, Canadian PoPVs' mental health service engagement is uniquely positioned within an ecological milieu influenced by military culture and lifestyle, the sequelae and systemic impact of service-related PTSD, and the broader social, political, economic, and geographical context. Therefore, without an in-depth understanding of how these factors contribute to seeking, accessing, and utilizing mental health services among Canadian PoPVs, the capacity and responsiveness of Canadian mental health programs and services to address the unique issues faced by PoPVs are compromised, and the mental health needs of PoPVs who face such barriers are likely to persist. Using an EST/SOCs framework, the current study seeks to address this gap by examining the barriers and facilitators to mental health service engagement among Canadian PoPVs. The application of EST will help to elucidate both intra- and extra-individual factors that are uniquely tied to PoPVs' SOC, service-related PTSD, military culture and lifestyle, and broader ecological influences.

CHAPTER THREE: METHODOLOGY

This chapter offers a detailed description of the selected methodology for the current study. This section begins with a rationale and overview of the study design, followed by a description of the foundation and development of the ECIT. Next, the procedures involved in sampling, data collection, and data analyses are explained, as well as a detailed account of the credibility checks performed to strengthen the trustworthiness of the findings. This chapter closes with a discussion of the ethical measures taken to protect the rights and well-being of study participants.

Rationale and Overview of Study Design

This research sought to explore the factors that influence seeking, accessing, and utilizing mental health services among cohabiting PoPVs. Previous studies have not examined the full scope of barriers faced by PoPVs nor have they explored factors that facilitate partner access and utilization of services. Furthermore, the majority of research in this area has focused on military populations outside of Canada (Yambo & Johnson, 2014). Thus, this study was exploratory in nature in that it sought to gain novel insights into a phenomenon (i.e., mental health service engagement) in order to formulate future directions for research and practice (Palys & Atchison, 2008). Through the ECIT, a qualitative research method, this study aimed to yield rich data on the experiences of PoPVs through a series of semi-structured, audio-taped interviews. Prior to commencing interviews, participants completed informed consent procedures and demographic questionnaires. Participants were asked to answer questions pertaining to the factors, events, or psychological experiences that helped or hindered their ability to seek, access, and utilize mental health services, within the context of recognizing that support was needed to manage or alleviate the impact of PTSD on their lives and personal well-being (Butterfield et al., 2009).

This qualitative study is grounded in the social justice perspective, an approach that aims to examine how systemic characteristics, policies, and practices lead to inequities and oppression, with the ultimate goal of promoting social change and justice (Fassinger & Morrow, 2013). The current study aligns with the social justice perspective in that the findings derived from this research are anticipated to be immediately beneficial to the target community, as well as to those who serve the target community, with dissemination activities serving as a conduit for advocacy, awareness, and consciousness-raising (Fassinger & Morrow, 2013). This principle of the social justice perspective contrasts with more historical aims of research, in which participant exploitation and alienation occurred in the name of researchers gaining status, recognition, and notoriety (Cokley & Awad, 2013). Furthermore, this study embodies the aims of the social justice perspective in four ways: (a) through a commitment to developing the ability to navigate a culture (i.e., military culture) different from my own; (b) the research question espouses practical utility and originated from the anecdotal needs and desires expressed by PoPVs (see Introduction, Chapter 1); (c) the study aims to empower participants by helping them share their stories and by honouring their strengths, needs, wisdom, and values; and (d) the research procedures provide thorough explanations and education on the research process, including the potential risks and benefits to participants (see section “Ethical Considerations”; Fassinger & Morrow, 2013).

By giving credence to the voices of PoPVs, it is hoped that this research will add to the existing body of literature on the experiences, challenges, and resilience of PoPVs. It is hoped that the information gleaned from this study will be useful in identifying the unmet needs of PoPVs and improving access to information, supports, and services for Canadian military families affected by PTSD. The findings from this study may also provide useful insights to

institutions, healthcare providers, and human service professionals who work with military families. Additionally, these findings will have implications for the development of Canadian social policy related to military families affected by PTSD. Finally, it is anticipated that the findings from this study will provide direction for future research in the area of Canadian military families affected by unique military life stressors, particularly PTSD.

Overview of ECIT

The ECIT represents a qualitative methodology designed to explore critical events, incidents, and factors that help or impede the experience or performance of a particular activity (Butterfield et al., 2009). ECIT yields two forms of data: events and factual happenings known as *critical incidents* (CIs), and information, supports, or programs that would have been helpful if available to participants, referred to as *wish list* (WL) items (Butterfield et al., 2009). The ECIT, an extension of Flanagan's (1954) Critical Incident Technique (CIT) method, appended a systematic, robust series of nine credibility and trustworthiness checks to improve the findings derived from the original CIT method (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield et al., 2009).

History of CIT. The CIT was first used for the purpose of selecting and classifying aircrews in the Aviation Psychology Program of the United States Army Air Forces during World War II (Flanagan, 1954). It was defined as “a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles” (Flanagan, 1954, p. 327). The philosophical assumptions of the positivist paradigm, which emphasizes objectivity and the scientific method, was the dominant force in psychological research at this time in history (Ponterotto, 2005). On the other hand, qualitative research was traditionally viewed as a less

valid and credible research method by comparison (Sciarra, 1999). As such, through its emphasis on direct human observation, objectivity, reductionism, and the capacity to make predictions derived from critical incidents, CIT was both designed and promoted to uphold positivist principles (Butterfield et al., 2009; Chell & Pittaway, 1998). According to Flanagan (1954), as CIT advanced in the research world it continued to be used extensively within the U.S. Air Forces and Army to address a variety of topics, ranging from the the exploration of effective or ineffective combat leadership (Wickert, 1947) and success and failure in job performance (Fitts & Jones, 1947).

As the interpretive paradigm began to take root in psychological research, CIT expanded to several other fields, including nursing, education, medicine, marketing, social work, and counselling psychology (Butterfield et al., 2005; Butterfield et al., 2009; Chell & Pittaway, 1998; Woolsey, 1986). Thus, the major strength of CIT rests in its adaptability and capacity to accommodate a wide range of fields, research questions, and research methods (Chell & Pittaway, 1998). The CIT approach is particularly amenable to the study of a wide range of phenomena in counselling psychology, including relationships, self-actualization, career development and decision-making, elucidating the processes inherent to psychotherapy and counselling, and psychological processes (Butterfield et al., 2005; Butterfield et al., 2009; Woolsey, 1986). According to Chell and Pittaway (1998), whether CIT is a qualitative or quantitative method depends entirely on the paradigm employed by the researcher and the research question. Consequently, CIT has been adapted as a qualitative method (Butterfield et al., 2009; Chell & Pittaway, 1998).

Enhancement of CIT. In reviewing the 50 years of CIT use, Butterfield and colleagues (2005) maintained that despite its rapid growth as a research method, the traditional CIT method lacked

consistency and standardization for establishing the trustworthiness and credibility of findings. To address this limitation, Butterfield et al. (2005; 2009) collated a series of nine credibility checks to strengthen the trustworthiness of CIT findings. The integration of Butterfield et al.'s (2009) nine credibility checks, coupled with the retention of the five core steps that characterize Flanagan's (1954) original CIT, culminated in what is presently referred to as ECIT. To enhance the credibility and trustworthiness of the research findings, Butterfield et al. (2009) proposed the following nine enhancements: (a) audio-taping the interview, (b) interview fidelity, (c) independent extraction of CIs and WL items, (d) exhaustiveness, (e) participation rates, (f) placing incidents into categories by an independent judge, (g) cross-checking by participants, (h) expert opinions, and (i) theoretical agreement. A detailed explanation and account of how each of these credibility checks were implemented in the current study is provided in the "Credibility Checks" section later in this chapter.

Epistemology, Theoretical Framework, and Methodology

In order for social research to be defensible, Crotty (1998) argues that the research process, its interrelated elements, and its underlying assumptions must be clearly articulated. To this end, Crotty (1998) suggests a scaffolding framework that requires the researcher to justify his or her choices and selections with regards to four elements: epistemology (the nature of knowledge), theoretical perspective (the philosophical stance), methodology (the research design), and methods (the concrete techniques or procedures used). Of utmost importance is that the unique constellation of elements selected by the researcher are philosophically and theoretically harmonious (Crotty, 1998). Prior to discussing the central elements of the current study, it is first necessary to explore the degree to which CIT/ECIT are applicable to a variety of research perspectives.

Several qualitative research methods, such as phenomenology or grounded theory, have built-in theoretical underpinnings that serve to guide practical procedures while also considering the context and scope of the research study (Hughes, 2012). In contrast, the epistemological and theoretical underpinnings of CIT/ECIT have not been clearly defined (Hughes, 2012), which at a conceptual level presents both limitations and opportunities for researchers who select this methodology. On the one hand, the lack of philosophical assumptions underpinning CIT/ECIT necessitates that researchers examine their own assumptions and rationalize how the technique can best be applied to their investigation (Chell, 1998). On the other hand, the absence of prescribed philosophical underpinnings offers researchers greater autonomy to position their research within the most suitable epistemological worldview (Chell, 1998). While CIT has positivist roots, descriptions and procedures associated with CIT/ECIT research align strongly with a post-positivist, constructivist philosophy (Butterfield et al., 2005; Creswell, 2007; Denzin & Lincoln, 2011; Kain, 2004; Sharoff, 2008). The post-positivist framework emphasizes a plurality of perspectives rather than a single reality, but maintains a scientific approach to research in an attempt to reveal patterns that may be applicable to other persons or contexts (Creswell, 2007; Kain, 2004). In fact, Kain (2004) maintains that the cardinal premise of CIT research is that the power to identify, interpret, and create what is most critical in a situation rests with participants. Although the researcher makes interpretations through the provisional formation of categories, these tentative speculations are presented to participants whom have the power to confirm or disconfirm their accuracy and applicability (Kain, 2004). In this regard, the present study is guided by the post-positivist perspective, of which its explication and relationship to the research process follows.

In keeping with the framework outlined by Crotty (1998), the current study is undergirded by a post-positivist, social constructivist epistemology, which in turn has informed the selection of EST and SOCs as the theoretical perspective, the choice of ECIT as the research methodology, and the incorporation of social justice principles into the research methods. As an epistemological stance, social constructivism posits that individuals seek meaning in and understanding of the world in which they live (Creswell, 2007). The meanings and understandings individuals develop are subjective and varied, and formed through interactions with others and through historical and cultural practices in which he or she is involved (Creswell, 2007). In line with this epistemological position, the purpose of research is to make sense of the meanings that others have about the world in which they live (Creswell, 2007). In practice, the researcher attends to the specific contexts in which people live and the interactions that occur among individuals (Creswell, 2007). At the same time, the researcher recognizes that their own personal background, experiences, and interpretation of the world influences the research process, necessitating researchers to expound how their perspective is shaped by their own personal, cultural, and historical context (Creswell, 2007). Thus, research findings are co-constructed in that the researchers' interpretation and participants' perspectives both contribute to the outcomes of the research process. These major elements of social constructivism have shaped the choices made with respect to the current research process.

In line with social constructivism tradition, EST emphasizes reciprocal influences and interactions between the individual and the elements that make up the environment in which he or she resides (McGettigan & Gray, 2012; Rosa & Tudge, 2013). In turn, the environment is influenced by the broader ecology, which constitutes multiple, overlapping, and interconnected systems (Rosa & Tudge, 2013). Most importantly, Bronfenbrenner (1969) maintained that the

majority of factors influencing human behaviour emanate from the personal meanings and perceptions attributed to any given event or situation. Similarly, the concept of SOCs is predicated on the notion that the intersecting community, cultural, and family context within which individuals live and the subjective meanings individuals assign to these relationships must be acknowledged and upheld in order to truly understand an individual's experience and interpretation of mental health and well-being (Cook & Kilmer, 2010). As a research methodology, ECIT is befitting of this constellation of epistemological and theoretical underpinnings in that its primary purpose is to seek and understand the unique experiences and meanings of individuals (Kain, 2004). Finally, the intersecting principles of social justice and social constructivism employed in this study, namely that constructions of experience and meaning occur within a fluid social and cultural context and are therefore capable of change, offers a means to explore the dynamic between agency and structure and the promotion of equality and justice (Bassot, 2012; Fassinger & Morrow, 2013). As such, social constructivist and social justice perspectives, coupled with an EST/SOCs framework and prescribed ECIT methodology, guided the selection of research methods that gave way to honouring participants' voices (i.e., through participant cross-checking and confirmation of the categories) and the ultimate goal of benefitting participants' community and promoting change (Fassinger & Morrow, 2013).

Appropriateness of ECIT

The strengths and unique features that characterize ECIT lend itself particularly well to the context within which the current study was undertaken, providing additional support for its selection as an appropriate methodology. With respect to utility, ECIT has been described as an especially useful method when used as an exploratory instrument in the foundational phases of

research (Butterfield et al., 2005). By their nature, ECIT, and its predecessor CIT, are effective tools to employ when the research inquiry engages events, factors, psychological constructs, or phenomena that are less understood or previously unexplored (Butterfield et al., 2005). With the paucity of research in mental health service usage among Canadian PoPVs, an exploratory study was not only fitting but also necessary to guide future practice and research in this area (Palys & Atchison, 2008). The nature of the ECIT seeks knowledge specific to a group of individuals who have expertise or experience in a particular topic (i.e., PoPVs who have identified themselves as having experiences that would benefit from mental health services), and the factors that help or hinder in the specified experience or activity (i.e., what facilitated or impeded PoPVs' ability to seek, access, and utilize mental health services. Thus, the utility and type of research question facilitated by the ECIT aligns with the nature and intentions of the current research question.

Flanagan's (1954) original CIT enabled researchers to investigate the factors, events, experiences, and incidents that helped or hindered the performance of a particular activity or situation. While this premise is befitting of the current research study, ECIT expanded the scope of CIT by incorporating questions that elicit WL items (Butterfield et al., 2009). WL questions garner information on the people, supports, information, and services that were absent at the time that a particular activity was performed, but are considered to have been helpful in the past or in the future in facilitating the particular activity being studied (Butterfield et al., 2009). The integration of WL items in the current study gives precedence to the experiences and wisdom of PoPVs, which also aligns with the social justice perspective (Fassinger & Morrow, 2013). Furthermore, the application of WL items aligns with the ultimate intentions of the study; that is, to identify ways to improve mental health service design and delivery in order to address the unmet needs and preferences of PoPVs.

ECIT holds historical significance to the current research study. As previously mentioned, Flanagan's (1954) CIT was first used for the purpose of selecting and classifying aircrews in the Aviation Psychology Program of the U.S. Army Air Forces during World War II. According to Flanagan (1954), as CIT evolved it continued to be used extensively within the U.S. Air Forces and Army to address a range of topics. Thus, CIT has long been used to explore the functioning of diverse military systems, making it relevant to the current study and its exploration of the systemic impact of PTSD on military partners.

ECIT also holds practical relevance to the current research study. In particular, the structure and components of ECIT allowed for the systematic exploration of the factors that influence the performance of a particular activity (Butterfield et al., 2009). In the current study, ECIT allows for the systematic examination of the factors that led to PoPVs' helpful or unhelpful encounters with mental health information, supports, and services. This is an important feature of ECIT and its applicability to the current investigation, as it also aligns with the Canadian psychologists *Code of Ethics* (Canadian Psychological Association [CPA], 2000). Specifically, *the Code* stipulates that psychologists have an ethical obligation to ensure that psychological services are accessible and meet the needs of clients (CPA, 2000). For these combined reasons, ECIT is considered an appropriate method for addressing the research questions and practical implications of the current research study.

Participants

Sampling Procedures

Purposive and snowball sampling techniques were considered to be the most appropriate sampling procedures for the current study, as these methods are effective in identifying individuals who share a common experience or expertise in a particular area (Denzin & Lincoln, 2011). *Purposive sampling* refers to the deliberate selection of a small number of participants for

a study as opposed to a larger, representative sample (Denzin & Lincoln, 2011). In *snowball sampling*, primary participants are provided with information to disseminate to other potential participants in their networks (Denzin & Lincoln, 2011). These sampling techniques aligned with the goals of this qualitative study, in that the aim was not to optimize generalizability but to gather rich data on the experience shared by several individuals (Vivar, McQueen, Whyte, & Armayor, 2007). Furthermore, the intermediary process involved in snowball sampling was considered appropriate because, given the high mobility of military families in Canada, primary participants were likely to know other potential participants who lived in other Canadian regions and who likely met inclusion criteria.

According to Flanagan (1954), there are no established quantitative formulas for determining an appropriate sample size in CIT. Rather, the defining factor in sample size relates to exhaustiveness (Butterfield et al., 2009). *Exhaustiveness* occurs when participants no longer identify new CI or WL items, and when no new categories are required to describe incidents (Butterfield et al., 2009; Flanagan, 1954). In the current study, exhaustiveness was monitored in adherence with the protocols outlined by Butterfield et al. (2009). However, in keeping with the social justice perspective of honouring interested participants' wishes to share their stories and contribute to a study that both acknowledged and sought to address their hardships (Fassinger & Morrow, 2013), a total of 16 interviews were conducted.

Participant Eligibility

Participants in this study included 16 Canadian, English-speaking, cohabiting partners of veterans who had been diagnosed with post-traumatic stress disorder due to events that occurred during military service. The inclusion and exclusion criteria outlined below were applied to

ensure that participants had the characteristics and experiences necessary to answer the research questions.

Cohabiting partners must have been 18 years of age or older at the time of the interview. Cohabitation status must have been established for a minimum of 12 consecutive months in accordance with federal common-law legal requirements. Partners and veterans who were currently involved in separation or divorce legal proceedings were excluded from this study as it would compromise the uniformity of the particular activity under investigation. Furthermore, veteran spouses of participants must have either previously received treatment, or were concurrently receiving treatment from a recognized mental health professional to ensure safety for both the cohabiting partner, the veteran, and other family members. Partners who reported significant safety concerns for themselves or their veteran partner were also excluded from this study due to the potential for increased distress and compromised safety. In the event that individuals were excluded from study participation due to safety concerns or distress, a list of appropriate supports and services in their respective communities was provided (see “Ethical Considerations” section for more detail).

Participant Recruitment and Incentives

Prospective participants were directed to contact the primary researcher via several recruitment strategies, including the following:

- Flyers and posters (see Appendix A) were distributed to the Calgary MFRC, an organization that is independent of the military yet assists military families affected by stressors unique to military life (i.e., deployment, grief, PTSD). Flyers and posters included important information about the aim of the study and researcher contact information (i.e., phone number and email address).

- I solicited a magazine article to be published in the Canadian Military Family Magazine, an online community independent of the military. This article featured the rationale for this research, the aims of the study, and researcher contact information for potential participants (see Appendix B).
- Primary participants were encouraged to forward study and researcher contact information to other potential participants in their social networks, with instructions for those interested in participating in the study to contact the researcher directly. This process prevented personal or private contact information from being released to the researcher without potential participants' consent. It was also emphasized to the primary participant that passing on the researcher's contact information was voluntary. No incentives were offered to primary participants for their role in recruiting secondary participants, mitigating any potential for coercion.

For those participants who selected in-person interviews, a cash reimbursement for parking at the University of Calgary was provided. The value of this reimbursement did not exceed the cost of a full-day, long-term parking stall ranging from \$7.00-\$12.00 per visit. Following the conclusion of interviews, participants were entered in a draw to win a \$100 gift card to a restaurant of their choice. Participants had a 1 in 16 odds of winning the prize draw. The prize draw was set at a value of \$100 so that participants were volunteering to participate based on interest in contributing to research, as opposed to a prize so large as to constitute coercion. The prize draw winner was notified via email and directed to retrieve their \$100 gift card available at their chosen restaurant.

Participant Screening

Potential participants underwent a brief telephone-screening interview with the primary researcher prior to being selected to participate (see Appendix C). The purpose of this screening

interview was to ensure that participants met the abovementioned inclusion and exclusion criteria, including a reasonable level of safety in the cohabiting relationship (see “Ethical Considerations” section for more detail). Furthermore, the initial screening provided an opportunity for participants to ask questions, raise concerns, and determine their level of comfort with the researcher and research process. Finally, initial screening provided an opportunity for the researcher to be transparent about the study purpose and procedures. To facilitate transparency, consent forms (see Appendix D) and interview questions (see Appendix F) were provided by email to prospective participants prior to screening. Once participants were deemed eligible to participate via the screening process, an interview was scheduled to take place in one of three ways (i.e., in-person, via telephone, or via Skype) to accommodate participants’ geographical location, schedules, and personal circumstances.

ECIT Procedures

The following section provides a comprehensive description of the procedures that have been used to carry out ECIT in counselling psychology research, as outlined by Butterfield et al. (2009). An explanation of how the current research study followed the specific guidelines and protocols delineated by Butterfield and colleagues (2009) is also provided.

Step 1: Ascertaining the General Aims of the Activity Being Studied

The initial stage in ECIT involves establishing the general aims of the particular activity or phenomena being studied (Butterfield et al., 2009). According to Butterfield et al. (2005), this step requires that the researcher answer two questions: (a) “what is the objective of the activity”; and (b) “what is the person expected to accomplish who engages in the activity” (p. 478). The general objective of the current research was to reveal how PoPVs experience the trajectory of interacting with mental health services, beginning from the recognition that they may benefit from mental health services to seeking, accessing, and utilizing mental health services. More

specifically, the four objectives of this study were to: (a) examine the events or factors precipitating the need or desire to seek, access, and use mental health services among PoPVs; (b) identify incidents, events, or factors that PoPVs believe to have facilitated seeking, accessing, and utilizing mental health services; (c) identify incidents, events, or factors that PoPVs believe to have hindered seeking, accessing, and utilizing mental health services; and (d) identify programs, supports, or services that, if available in the past, present, or future, *would* facilitate seeking, accessing, and utilizing mental health services among PoPVs.

Step 2: Making Plans and Setting Specifications

According to Butterfield et al. (2009), the second step involves: (a) “deciding what to observe or ask about, (b) creating an interview guide or set of protocols for interviews to follow, and (c) training people in the purpose of the study, the intent of the questions, and how to conduct CIT interviews” (p. 269). Following this guideline provides a mechanism for confirming that everyone involved in the research comprehends the aims of the study and follows similar protocols to maintain consistency across members of the research team. Butterfield et al. (2009) advise that an interview guide be used in CIT research for a number of reasons. The interview guide functions as (a) a detailed record of the interview, (b) a substitute source of data in the event of equipment malfunction, (c) a mechanism for maintaining interviewer focus on the participant’s story, (d) and a tool for referring back to previous comments made by the participant that necessitate further exploration or probing. The interview guide also serves as a check to ensure that all research questions have been asked, responded to, and sufficiently explored.

To accomplish the required criteria outlined in this section, my academic/research supervisor and I attended a full-day training seminar instructed by Dr. Butterfield to ensure that I

fully understood my responsibilities as the interviewer. In this training seminar, Dr. Butterfield provided in-depth coverage of the ECIT protocols and procedures as outlined in the article published by Butterfield et al. (2009). Furthermore, I was able to ask specific questions pertinent to the current study and clarify procedures and methods to ensure the current study was being carried out in a consistent manner.

The ECIT approach is comprised of an initial interview, which serves as the primary source of data collection, and a second interview in which the participant cross-checking credibility check takes place (Butterfield et al., 2009). ECIT requires that a separate interview guide is developed and tailored toward the specific research questions under investigation. In this section, I will describe the interview guide that was developed and used for the purpose of the initial interview. The participant cross-checking interview guide will be described in the section “Credibility Checks.” In accordance with the template outlined by Butterfield et al. (2009), the initial interview guide for the current study consisted of the following five sections: (a) introduction, (b) contextual questions, (c) critical incident and WL questions related to seeking mental health services, (d) critical incident and WL questions related to accessing mental health services, and (e) critical incident and WL questions related to utilizing mental health services (see Appendix F). As previously mentioned, the demographic questionnaire was administered immediately following informed consent and prior to the interview, whereas rapport was established during the participant screening phase.

The interview commenced with an introduction to the objectives of the research and an opportunity for participants to ask questions or raise concerns. Following the introduction, two contextual questions were asked: (a) What is the context of the current living situation (i.e., employment status, family composition)? and (b) What events or experiences preceded the desire

or need to seek mental health services (e.g., counselling, therapy, support groups)? Participants were asked follow-up questions as needed. Following the contextual component, I elicited the helping and hindering CIs and the WL items that participants recognized as influencing their ability to seek mental health information, supports, and services. Next, I elicited the helping and hindering CIs and the WL items that participants recognized as influencing their ability to access mental health supports and services. I then prompted participants for helping and hindering CIs and WL items that influenced their ability to continue using mental health supports and services. The interview ended with participant debriefing and an opportunity for participants to comment or provide feedback on the interview experience.

Step 3: Collecting the Data

Data collection in an ECIT study involving psychological constructs is mainly accomplished through in-person or telephone interviews (Butterfield et al., 2009). The primary source of data collection is the first interview, in which contextual, CI, and WL items are elicited. The ECIT interview commences with the informed consent process, allowing ample time for participant questions to be answered. The initial interview is considered to be the most important element of ECIT data collection for three reasons: (a) “it serves as an opportunity for the participant to tell his or her story and feel heard and understood, (b) provides the background information against which the CIs and WL items can be understood, (c) elicits the CIT data, and (d) gathers the demographic data that describe the sample” (Butterfield et al., 2009, p. 270).

Butterfield et al. advise researchers to take their time with the interview process to ensure all sections have been covered and to ask any necessary clarifying questions. Butterfield et al. also emphasize the importance of exploring the same subject at the same level of detail with all participants to ensure that participants are given equal opportunity to provide additional details.

While it is ideal to ask follow-up and probing questions during the initial interview, additional details can be elicited in the second interview as well.

As previously noted, interviews continue to be conducted until the point of exhaustiveness, which refers to the time at which participants identify no new CIs or WL items and no new categories are required to accommodate the data (Butterfield et al., 2009). Exhaustiveness as a credibility check is discussed in more detail in the “Credibility Checks” section later in this chapter. Butterfield et al. (2009) emphasize that reaching exhaustiveness indicates to the researcher that an adequate number of participants have been interviewed; however, participant interviews may continue for other reasons (e.g., because interviews had previously been scheduled).

I performed all 16 interviews over the course of 10 months (November 2015 to September 2016). Due to the geographic variability within this nationwide study, 15 participants engaged in Skype/telephone interviews and only 1 participant engaged in an in-person interview. The in-person interview took place in a quiet, private room in the Werklund School of Education tower at the University of Calgary. Skype/telephone interviews took place in a quiet, private space in each of the participant’s and researcher’s homes, respectively. All interviews were audio-taped and saved on a password-protected computer. Detailed notes of the interview were recorded by the researcher, including the start time, the date, the participant’s selected pseudonym, and a participant code which was used for data analysis. The initial interviews took an average of 2.5 hours to conduct.

The initial interview commenced with the informed consent process (see Appendix D) and the collection of demographic information (see Appendix E). For Skype/telephone participants, informed consent was completed via DocuSign, a secure file-sharing software.

Participants were then asked to construct a pseudonym for themselves which would be used to identify them in the interview recording and when reporting the results of the study. All participants selected a pseudonym for the audio-recording and agreed to the use of a pseudonym in reporting the results. Participants were also asked if they would be willing to participate in a second interview and if they wished to receive a copy of the findings. At this time, the in-person interview participant was offered a reimbursement for her parking costs, but declined the offer. This phase of the interview terminated with the participant and the researcher signing the consent form.

Following the informed consent process, I introduced the interview by reading the purpose of the study verbatim from the interview guide (see Appendix F). The introduction served to reorient participants to the focus of the study and cue participants to the experiences under examination. Immediately following, I initiated the contextual component of the interview whereby I asked participants to describe their current living situation as well as the events or experiences that preceded their need or desire to seek mental health services. I used follow-up questions (e.g., what led up to you making that appointment?) to elicit more powerful descriptions from participants and to confirm my understanding of participant responses.

In the next section, participants were asked to name the incidents (i.e., events, experiences, or factors) that facilitated their seeking mental health information, supports, and services. For each CI identified, I garnered additional details, including: (a) the importance and meaning of the incident (i.e., how it helped the participant to seek information about mental health services), and (b) an example of a time when the identified incident was helpful, including the events that led up to the incident and the outcome of the incident. Next, participants were asked to name the incidents that hindered their seeking information about mental health services.

For each CI identified, I gathered additional information, including: (a) the importance and meaning of the incident (i.e., how it hindered the participant in seeking information about mental health services), and (b) an example of a time when the identified incident made it more difficult to seek information about mental health services, including the events that led up to the incident and the outcome of the incident. Following hindering incidents, participants were asked to identify things that *would have* been helpful, or would be helpful in the future, in facilitating the process of seeking information about mental health services. For each item identified, I collected additional details, including: (a) the meaning or importance of the item (i.e., how the support, program, or service would help the participant seek information), and (b) when the support, program, or service would be helpful to the participant. These three steps were repeated in precisely the same way to elicit CI and WL data regarding access and utilization of mental health supports and services, respectively.

Once all three sections (i.e., seeking, accessing, and utilizing) had been completed, participants were asked if there was anything else they wanted me, the researcher, to know. This gave participants an opportunity to identify any incidents they forgot to mention earlier, as well as to share additional elements of their story if necessary. The interview concluded by thanking the participants for their time and effort, as well as their willingness to share their experiences. Immediately following, a debriefing took place where participants were given the opportunity to provide feedback, comment on the experience, or ask questions (see Appendix G).

Step 4: Analyzing the Data

During this step of ECIT, the researcher is responsible for completing three tasks: (a) “determining the frame of reference, (b) formulating the categories derived from grouping similar incidents, and (c) determining the level of specificity or generality to be used in reporting

the data” (Butterfield et al., 2009, p. 271). The frame of reference is determined by how the data will be used. In the current study, the results will be used to inform mental health information, support, and service design and delivery, including program and service visibility, accessibility, and relevance to target population, as well as approaches to counselling, therapy, and support groups. Furthermore, the results will be used to identify systemic factors that either facilitate or hinder seeking, accessing, and utilizing mental health supports and services among PoPVs. To formulate the categories, Butterfield et al. (2009) emphasize the importance of experience, judiciousness, and a strong understanding of the data. The level of specificity or generality to be used in reporting the data is based on feasibility, including the research project budget, the human resources available to assist in data analysis, and whether more general or specific categories will be useful (Butterfield et al., 2009). Although I was the sole individual responsible for analyzing the data, the extent to which categories were useful and informative was a determining factor in establishing the level of generality or specificity in the current study. Following data analysis, it was determined that reporting the data in correspondence with the multiple levels of EST would be most useful. Thus, categories were reported at a high level of specificity to facilitate the positioning of each category within the level it best exemplified.

Organizing the raw data. Butterfield et al. (2009) recommend organizing the raw data in one of two ways: (a) through the use of a qualitative data analysis software program, or (b) through a manual method. Based on preference, I opted to use the manual method in the current study. I began by printing and placing the interview transcripts into a three-ring binder with tabs to divide each interview. I selected several different coloured highlighters and selected a colour scheme to correspond to the various components of the interview guide.

Identifying the CIs and WL items. Butterfield et al. (2009) emphasize the importance of analyzing CIs and WL items first as they are required to undergo extensive credibility checks. CIs and WL items were extracted in batches of three randomly selected interviews (Butterfield et al., 2009; Flanagan, 1954). Beginning with the first randomly selected interview transcript, I highlighted, with its corresponding colour scheme, any text that was a helping CI within the *seeking* core area that was also supported by the meaning/importance and an example. Any item that appeared to be a helping CI but did not have supporting evidence was highlighted in a different colour and was asked about in a follow-up interview with the participant (see “Participant Cross-Checking” section). Next, hindering CIs and WL items were extracted from the *seeking* core area using the same protocol. Once all CIs and WL items had been extracted from the *seeking* core area, the same extraction procedures noted above were performed consecutively for *accessing* and *utilizing* core areas. Analyzing each core area separately but in succession allowed for the identification of differences and similarities across core areas. This same process was applied to the first, second, and third transcript, and continued in this manner until the final 10% of transcripts remained.

Creating the categories. Once the first batch of three randomly chosen transcripts were analyzed for CIs and WL items, I then proceeded to create the categories (Butterfield et al., 2009). This phase requires the researcher to use inductive reasoning, persistence, and the aptitude to recognize relationships among the CIs and WL items identified by participants (Butterfield et al., 2009). I began this process by extracting the helping CIs from the first randomly selected transcript in its electronic format and copying the passage into a new word document with headings for helping CIs, hindering CIs, and WL items. I then examined the CIs to identify patterns, themes, and relationships (i.e., similarities or differences) among the incidents. If CIs

exhibited similarities, I created a broader category to encompass the related CIs. Otherwise, all CIs remained as stand-alone categories at this stage. I then repeated this process for hindering CIs, and then WL items. By copying and pasting CIs and WL items into a new document, I was able to track the number of new categories formed after each interview and to determine when I had reached exhaustiveness.

I then extracted the CIs and WL items from the second randomly chosen transcript. I placed helping CIs that corresponded to existing categories into their respective column and I created new categories for those helping CIs that did not correspond with existing categories. I then applied this same process to the hindering CIs and WL items from the second transcript. Once this process had been completed, I updated the tracking table to reflect the number of new categories formed from the recently analyzed transcript. I then proceeded by undertaking the same process for the third transcript of the first randomly selected batch. Upon completing CI and WL item extraction and categorization for the first batch of three transcripts, I began to analyze the next batch of three randomly selected transcripts using the same process. At various points throughout this process, some categories required refining or renaming to accommodate related CIs or WL items.

The process of CI and WL item extraction and categorization continued until I had all but 10% (i.e., two) of the interviews placed in categories. Butterfield et al. (2009) emphasize the importance of finalizing the categories at this time and constructing a written operational definition for each category. After this point, it is presumed that no new categories are needed to accommodate CIs or WL items from the remaining 10% of interviews. Following the creation of operational definitions, I placed the final 10% of interviews into the categories and concluded this phase of data analysis.

Analysis of contextual component. The purpose of the contextual component of data collection is to highlight common themes and patterns that exist within two areas of PoPVs' experiences: (a) the context of their current and various life roles, as well as how these life roles both influence and are influenced by the veterans' PTSD; and (b) the context within which PoPVs identified the need or desire to seek, access, and utilize mental health information, supports, and services (i.e., the precipitating events). Given the purpose of the contextual component, thematic analysis was considered a suitable approach to answer the research questions, particularly for its utility in identifying themes and patterns of meaning in a qualitative dataset (Braun & Clarke, 2006). To guide the process of analyzing the contextual component, the thematic method outlined by Braun and Clarke (2006) was employed. According to Braun and Clarke (2006), thematic analysis is a flexible and straightforward method for analyzing qualitative data. Furthermore, thematic analysis is denoted as a procedure that may be used within other major analytic methods (Ryan & Bernard, 2000). Specifically, the approach to thematic analysis outlined by Braun and Clarke (2006) was selected for its systematic fashion, its careful delineation of the steps involved in data analysis, and its commitment to upholding the original meaning of the data. Consistent with the process laid out by Braun and Clarke (2006), thematic analysis proceeded with the following six stages of analysis: (a) familiarizing oneself with the data, (b) generating the initial and provisional codes or categories, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report.

Familiarizing oneself with the data. According to Braun and Clarke (2006), the initial phase of thematic analysis involves transcribing the audio-recordings, reading and re-reading the data, and taking note of initial impressions of the data. During this first phase, I extracted the contextual data from the interview transcripts and arranged them in a word processing document.

I printed the document and read the entire dataset once through (Braun & Clarke, 2006). Next, I reread the document several times while noting my preliminary ideas or interesting features in the data (Braun & Clarke, 2006).

Generating initial and provisional codes. In this second phase, interesting features of the data are coded systematically (Braun and Clarke, 2006). After I established more solid impressions of the contextual data, I developed interim codes represented by specific words and phrases (e.g., “crisis”, “became full-time caregiver”). To facilitate this process, I arranged interim codes in tabular format and used this document as a reference throughout the coding process. Next, I conducted a line-by-line analysis of the contextual data, cataloguing every 1-2 sentences on average as an interim code (Braun & Clarke, 2006).

Searching for themes. According to Braun and Clarke (2006), this phase involves organizing and assembling codes into potential themes. Following the line-by-line analysis, I began arranging the interim codes into provisional themes based on strong relationships with one another (Braun & Clarke, 2006). I began copying and pasting the original data under a table for each provisional theme. As such, each excerpt retained its interim code status, but also connected to a larger theme.

Reviewing themes. In this phase, a thematic map is constructed by reviewing the coded extracts that constitute each theme to ensure that themes accurately reflect the codes (Braun & Clarke, 2006). During this phase, I reviewed each theme with respect to its relationship with its underlying interim codes (Braun & Clarke, 2006). Each interim code was revisited at its original source and was considered in the context of the larger passage of the transcript from which it was extracted. Furthermore, I also checked whether the theme related to the original passage in the

transcript. This process of checking served as a way to confirm that the original meaning and context of the data was maintained.

Defining and naming themes. This phase involves refining each theme to be consistent with the overall analysis, in addition to establishing definitions and names for each theme (Braun & Clarke, 2006). In accordance with the protocol outlined by Braun and Clarke (2006), I reviewed each of the themes, their interim codes, and original sources in the transcript to produce a theme name that would adequately reflect the meaning of the account. Where appropriate, I used the direct words of participants to define the themes, as this strategy is often more telling and powerful for readers. Next, I carefully described each theme and the experiences that characterized that theme. According to Braun and Clarke, theme descriptions should include those features that are considered necessary and unchanging across participant transcripts.

Producing the report. The final phase of thematic analysis involves the selection of extract samples that support the established themes in order to create a report of the findings (Braun & Clarke, 2006). As such, I reviewed the original passages to make meaningful selections to support the unique descriptions that constituted each of the themes. The culmination of these procedures produced the contextual findings from this study, which are discussed in Chapter 4.

Step 5: Interpreting the Data and Reporting the Results

As previously stated, ECIT involves nine credibility checks that are performed at specific junctures throughout the course of a research study (Butterfield et al., 2009). In studies that report the perceptions of experiences (i.e., counselling psychology research), such as the current study, credibility checks are a critical element of interpreting and reporting the results. Thus, to enhance the rigour and trustworthiness of the research findings, I applied all nine credibility

checks as outlined in the ECIT approach. The culmination of these credibility checks serves to verify the research before disseminating the findings through relevant scholarly activities. In the following section, I provide a description of how each check was undertaken in the context of the current study. The results of all nine credibility checks are reported in Chapter 4.

Credibility Checks

Audio-taping interviews. This credibility check serves as a descriptive validity check as it ensures the accuracy of the dialogue that occurred between participant and researcher (Butterfield et al., 2009). In the current study, all 16 interviews were audio-recorded to capture the content of participants' dialogue and the researcher worked directly from the transcripts derived from the audiotapes.

Interview fidelity. In order to increase the robustness of study findings, Creswell (2007) and Butterfield et al. (2009) emphasize the importance of adhering to the prescribed method precisely and closely. Butterfield et al. (2005) recommend that interview fidelity checks should be conducted following every third or fourth interview. Thus, in line with Butterfield et al.'s (2009) recommendations, I enlisted an experienced ECIT researcher (who was also a third party external to my research team) to listen to the third, sixth, and tenth interview audio-recording. According to Butterfield et al. (2009), this process ensured that I was following the ECIT method, adhering to the interview guide, and refraining from asking leading questions (Butterfield et al., 2009).

Independent extraction of CIs. This check requires that the researcher recruit an individual external to data analysis (Butterfield et al., 2009). This individual independently extracts what they believe to be the CIs and WL items from a randomly selected 25% of the interview transcripts (Andersson & Nilson, 1964; Butterfield et al., 2005; Butterfield et al.,

2009). Once the independent extraction of CIs and WL items are completed, the researcher calculates the percentage of agreement between the researcher's extraction and the individual's independent extraction (Butterfield et al., 2009). For incidents that do not align, the researcher and independent extractor discuss the inconsistency with the intent of coming to an agreement. It is necessary for a 100% agreement rate to be reached in order for all incidents in question to be used in further reporting and analysis (Butterfield et al., 2009). To adhere to the protocols outlined for this check, I randomly selected four (25%) of the 16 interview transcripts and recruited a graduate student to act as an external independent extractor.

Exhaustiveness. In ECIT, exhaustiveness refers to the point at which participants no longer identify new CI or WL items, and when no new categories are required to describe incidents (Butterfield et al., 2009; Flanagan, 1954). To adhere to the protocol outlined for this check (Butterfield et al., 2009), I maintained a category creation log that monitored each new category that was created and indicated when categories had been exhausted.

Participation rates. Butterfield et al. (2009) recommend calculating participation rates to establish the credibility and strength of a category. Furthermore, a minimum of 25% of participants must contribute incidents to create a category (Butterfield et al., 2009). As per the recommendation of Butterfield et al. (2009), participation rates in the current study were calculated by counting the number of participants who contributed to each category and dividing that number by the total number of participants in the study.

Placing incidents into categories by an independent judge. In this credibility check, an independent person is instructed to place 25% of the total CI and WL items into the categories developed by the researcher (Butterfield et al., 2009). This check serves as a way to ensure the credibility of the categories. To complete this check, I randomly chose 25% of the CI and WL

incidents within each category. I also provided the category headings and their corresponding operational definitions (Butterfield et al., 2009). I then had an independent judge assign each incident to the category that he or she believed it best fit. I then calculated the rate of agreement between the independent judge's placement of CIs and WL items and my own assignment into categories.

Cross-checking by participants. In order to complete this check, all CIT data from the first interview must have been coded, analyzed, and assigned to operationally defined categories (Butterfield et al., 2009). Furthermore, the independent extraction of CIs and WL items and the independent placement of incidents into categories must have been completed with acceptable agreement rates (Butterfield et al., 2009). The second interview, or participant cross-checking phase, allows participants to review the researchers' interpretations of the data and confirm the trustworthiness and accuracy of these interpretations (Butterfield et al., 2009). Participant cross-checking is typically carried out through e-mail or telephone (Butterfield et al., 2009). To complete this check, I e-mailed participants two separate lists: one consisting of the CIs and WL items extracted from their interview transcript and the other consisting of the categories in which their CIs and WL items were assigned. In accordance with the steps outlined by Butterfield et al. (2009), I asked participants to review the findings and provide feedback on the extracted CI and WL items as well as the appropriateness of the categories to which they have been assigned. The final part of participant cross-checking includes following up with participants for whom events discussed in the first interview resembled CI and WL items but supporting evidence (i.e., meaning/importance and example) was not obtained (Butterfield et al., 2009). This phase offers the participants an opportunity to decide whether an item is a helping or hindering CI or WL

item. If the participant provided supporting details, the CI or WL item was coded and added to the appropriate category (Butterfield et al., 2009).

Expert opinions. According to Butterfield et al. (2005), this check requires that the CI and WL categories are provided to two or more experts in the field of study with the request to provide feedback on the usefulness of the categories, and whether or not categories capture their personal and/or professional experiences. In the current study, I submitted the categories to (a) an associate professor in family studies with extensive research experience in issues pertinent to contemporary military partners and spouses; and (b) a military family mental health worker with several years of experience in navigating military families affected by PTSD and addictions through various health systems.

Theoretical agreement. Theoretical agreement involves two steps: (a) identifying and explaining the underlying suppositions of the research study, and consulting and reviewing the scholarly literature to determine whether these suppositions are valid (Butterfield et al., 2009; Maxwell, 1992); and (b) comparing the categories with pertinent scholarly literature to see which categories support previous findings and which categories have revealed novel contributions to the field of study (Butterfield et al., 2009). This credibility check is described in detail later in Chapter 5, where the findings of the current study are discussed within the context of current scholarly literature.

Ethical Considerations

Ethical clearance was granted by the University of Calgary Conjoint Faculties Research Ethics Board (CFREB) prior to engaging in the research study. As an additional measure for ensuring that the research study was undertaken ethically and sensitively, I completed the tri-council training on research ethics prior to obtaining ethical clearance. Each hired transcriber

completed and signed a confidentiality agreement form to ensure that he or she was aware of their responsibilities concerning participant privacy and confidentiality (see Appendix H).

Military partners are an essential component in the holistic care of veterans with PTSD (Yambo, Hamilton, & Johnson, 2014). However, because of the significant demands and stressors experienced by PoPVs, participating in research may add or compound their existing stress. Therefore, PoPVs are subject to marked ethical concerns in PTSD research, especially regarding the informed consent process, privacy and confidentiality, and therapeutic misconceptions. As such, researchers must take additional measures into consideration to protect PoPVs' ethical rights. In the following section, I will elaborate on the additional measures and precautions I took to protect not only the ethical rights but also the safety and well-being of the PoPVs who expressed interest in participating in the current study.

Informed Consent

Although the decision to participate in a study should be a voluntary choice among PoPVs, military cultural values influence how they experience the informed consent process (Yambo et al., 2014). In cases where PoPVs are recruited through the veteran, these cultural influences may diminish PoPVs' sense of having a right to decline participation in a research study (Yambo et al., 2014). To reduce the likelihood of PoPVs experiencing this pressure in the current research study, I employed two strategies during the recruitment process. First, I emphasized in the information packages that the research study was focused on the experiences of PoPVs and not their veteran partner. Second, any recruitment of prospective participants was conducted independent of veterans by recruiting participants through organizations that were independent of military government institutions. While this elongated the recruitment process, the protection of PoPVs ethical rights were considered a priority and a valuable trade-off.

Another ethical concern that warranted attention in the current study involved the concept of therapeutic misconceptions. *Therapeutic misconceptions* among prospective participants refers to the potential misunderstanding that participation in PTSD research enables access to medical intervention (Yambo et al., 2014). To mitigate this ethical concern, I emphasized in the information packages and in the informed consent process that participants would not be receiving therapy from the researchers as part of their participation in the study.

A number of additional ethical considerations related to the informed consent process but not specific to PTSD research were also relevant in the current study. Participants were informed that participation was not mandatory and that they may request to end participation at any time prior to or during the interview without the need to explain why and without prejudice. Participants were also informed that data corresponding to their interview could be withdrawn at any time up to and including the conclusion of the second interview (i.e., participant cross-checking). This limitation to data withdrawal was made explicit in the consent form, and I took appropriate measures to ensure that this was understood by participants. Participants were also informed in the consent form that they would be offered an opportunity to review the findings from the study prior to knowledge dissemination. In-person interview participants indicated their informed consent by signing the consent form. For those who participated in Skype/telephone interviews, a PDF fillable consent form was provided in advance via a secure file-sharing software so that participants could provide an electronic signature to indicate their consent.

Participant Privacy, Anonymity, and Confidentiality

According to Yambo et al. (2014), the main ethical concern in this area is that PoPVs' privacy may be breached when PoPVs are recruited through the veteran, as information about the PoPV is shared with another individual without their consent. As previously mentioned, this

ethical concern was mitigated by recruiting PoPVs independently of the veteran or military government organizations. However, a number of additional ethical concerns specific to PoPVs were identified in the context of the current study, namely that of confidentiality and anonymity.

As the population under study was deemed to be vulnerable and sensitive, given their trauma-related background, several measures and precautions were taken to protect confidentiality. During the informed consent process, participants were informed as to the limitations and possible consequences of participating. Participants were informed that in the following situations protection of confidentiality may be breached: 1) disclosure of child abuse; and 2) disclosure of plans to commit suicide or homicide, or reasonable expectation of harm occurring to the participant or others.

The interviews were conducted in-person or via Skype/telephone and consequently the data collected could expose the participant's identity and private details of their lives. Such an activity had the potential for participants to experience a loss of privacy. To mitigate this risk, once participants had completed the informed consent process they were instructed to devise a pseudonym. This pseudonym was used throughout the audio-taped interview. Once a pseudonym was selected, the audio-recording of the interview began. Consequently, the audio-recording and interview transcript did not contain the identity of the participant. Participants were also given an opportunity to review the final transcript of their interview and identify any direct words or segments that would make them identifiable if read by the public. Any identifiable words or segments selected by the participant were omitted and not used in the dissemination of findings. Following this process, participants indicated their agreement to release their transcript and that the transcript reflected what they said in their interview.

The master list of participants, including their consent forms and contact information,

were stored in a securely locked cabinet. For those who participated in in-person or Skype interviews, a password-protected computer file was used to store the audio-recordings, demographic and background history forms, and interview transcripts. This separation of identifiable information from anonymized information eliminated the chance of master lists being linked to de-identified data.

In-person, audiotaped interviews were conducted in a private room. Audio-recordings were transferred from the recording device to a computer file, which was password-protected, and accessed only by the researcher and the transcriber. Audio-taped interviews were transcribed into a computer word document by the researcher and the transcriber. When audio-recordings were transferred to a hired transcriber or for interview fidelity checks, this was done via a password-protected secure USB. Skype-based/telephone-based audiotaped interviews were conducted in a private setting for both the researcher and the participant. Audio recordings were automatically saved to a password-protected computer file and followed the same privacy and confidentiality parameters established for in-person interviews.

After the initial interviews, debriefing pages and resources were provided to participants via DocuSign. When it came time for participants to review their transcripts, participants were provided a secure file-sharing password which gave them access to their password-protected interview transcript. Participants were provided with a 3-week time-frame to request changes or modifications to their transcripts. Once the transcript review phase had been completed and the modifications were made, the modified transcript was downloaded into a secure, password-protected computer file on the researcher's computer.

Management, Minimization, and Mitigation of Risks

Risks to Participants. One of the primary ethical concerns in conducting research with military partners is ensuring protection from potential household or domestic violence (Yambo et al., 2014). Thus, maintaining military partners' privacy becomes critical in safeguarding against violence (Yambo et al., 2014). By recruiting participants independently of veterans or military government organizations, PoPVs have the right to choose not to participate in research that may increase his or her risk of household violence (Yambo et al., 2014). To address the ethical concern of safety, a screening procedure was undertaken with each prospective participant before consenting to the interview phase. This screening included questions around participant eligibility, with two questions around participants' perceived safety in the relationship (see Appendix C). The first question pertained to the PoPVs' self-reported safety, "On a scale of 1 to 10, 1 being no concern and 10 being extremely concerned, how concerned are you about your safety"? If participants required clarification, I explained that it was my ethical responsibility as a researcher to inquire about safety around household violence and the level of psychological distress. If the prospective participant rated their concern at 6 or above, participants were excluded from the study due to significant distress and/or safety concerns. A rating at 6 or above also warranted that the researcher provide information and referrals to community services and supports in the excluded participants' geographic area. If the participant rated their concern at 5 or below on the first question, participants were then asked the following question, "On a scale of 1 to 10, 1 being no concern and 10 being extremely concerned, how concerned are you about your partner's safety"? If the prospective participant rated their concern at 6 or above, participants were excluded from the study due to significant distress and/or safety concerns. In the current study, no prospective participants were excluded from participation due to significant distress and/or safety concerns.

A number of additional ethical considerations were taken into account in the current study due to the sensitive nature of the research topic (i.e., trauma and mental health concerns). Through the interview process, there was the potential for participants to experience mental fatigue due to the amount and nature of material being discussed. Furthermore, by asking participants about their experiences of mental health service engagement, it was possible that participants would recall distressing or traumatic experiences that: 1) preceded their decision to seek a support/service; 2) occurred during their attempt to obtain support/service; 3) occurred while participating in a support/service; and 4) followed their participation in a support/service. It was also possible that participants could recall distressing or traumatic events experienced by their spouses or children. Recalling these instances or events during the interview process had the potential to result in the participant experiencing emotional or psychological distress.

To minimize the risk of mental fatigue in participants, I provided participants with the option to schedule break times, as well as the option to request a break at any time throughout the interview process. To minimize the chances of participants experiencing emotional or psychological distress, I provided participants with the interview questions in advance of the interview so participants were aware of the questions to be discussed and were in a position to make an informed decision about the relative risk to them. In the prospective information package provided to participants before the interview took place, participants were informed that should they become upset or distressed during the interview process, they would be offered a break, the option to stop and reschedule the interview, and the option to terminate the interview altogether.

In the event that a participant became distressed or upset during the interview, I took measures to ensure that I would be able to debrief with the participant, call a family member or friend and remain with the participant until that person arrived, and provide a referral list of available and accessible supports/services (including 24-hour crisis lines and counselling services) to the participant (see Appendix G). Due to the geographical variability (i.e., representation from 6 Canadian provinces) in research participants, a separate list of 24-hour crisis lines and community supports was devised for each participant prior to the telephone screening and the interview. However, no participants reported distress during interviews or as a result of their participation in this study.

Risks to participants' family members. By asking participants about their experiences in accessing and participating in mental health supports and services, there was the potential for participants to disclose sensitive details about their military veteran partner and other family members. The disclosure of these details had the potential to reflect negatively upon individuals who are not directly involved in the research activity, with the potential to contribute to stereotypes around mental illness and prejudice around military culture.

To minimize the chances of participants disclosing specific sensitive details about their military partner and other family members, participants were encouraged to focus on their personal life experiences and encounters with mental health supports and services. Additionally, the nature and limits of confidentiality were shared with participants prior to the interview process and participants were required to demonstrate a comprehensive understanding of these limits. Finally, the findings reported from this research focus on the barriers and facilitators to seeking, accessing, and utilizing mental health supports among PoPVs. Consequently, sensitive details about military partners and families, if disclosed, were not reported in isolation. Any

experiences that involved military partners and family members that were identified as precipitating factors in seeking, accessing, or utilizing mental health services were aggregated with other interviews and therefore were not identifiable.

Risks to the transcriber. By transcribing the audio-taped interviews, it is possible that the transcriber may become distressed by learning about the experiences of participants. To minimize the chances of the transcriber becoming distressed, he/she was provided a copy of the interview guide in advance of beginning his/her work. Transcribers were made aware of the nature of the questions. In addition, the transcriber was informed that if he or she became upset or distressed at any time during their research-related tasks, he or she would have the option to reschedule their work or terminate their work altogether.

If the hired transcriber became distressed through exposure to participant experiences, a debriefing would be offered to the transcriber, and a referral list of available and accessible supports/services (including 24-hour crisis lines and counselling services) would be provided. This list contained the same information offered to participants in the event of crisis or distress. However, no transcribers became distressed from their exposure to participant transcripts.

Summary of Chapter

This study aimed to explore the facilitators and barriers to seeking, accessing, and utilizing mental health services among PoPVs. Through the use of ECIT, 16 audio-taped, semi-structured interviews were conducted to explore PoPVs' perceptions of the critical events that either helped or hindered their ability to seek, access, and participate fully in mental health services. To enhance the rigour and trustworthiness of the research findings, I applied nine credibility checks as outlined by the ECIT approach. Additional measures and precautions were taken into consideration to protect not only the ethical rights but also the safety and well-being of

participants. Given the systematic nature of ECIT, the findings of this study, to be described in the following chapter, are believed to be both credible and trustworthy.

CHAPTER FOUR: FINDINGS

This chapter describes the findings of the current study beginning with a brief description of the participants. Subsequently, the themes from the contextual component of the interviews are described. Supporting evidence through the use of direct quotations will be used to illustrate the contextual themes. To follow, the CI and WL findings are presented, with examples and direct quotations used to illustrate the importance and meaning of each category. This chapter closes with the results of the nine credibility checks employed to enhance the trustworthiness and robustness of the findings.

Participant Socio-Demographics

The participant sample consisted of 16 women who identified as a partner (spouse/common-law) of a Canadian military veteran (i.e., retired or released from the military) who had been diagnosed with service-related PTSD. All participants were provided a demographic background questionnaire upon informed consent; however, one participant opted not to complete this form. Therefore, this section consists of demographic information provided by 15 participants. To protect the identity of each participant, categorical and numerical demographic data are reported in aggregate. With respect to numerical data, partners ranged in age between 31 and 56 years ($M=39.73$, $SD= 7.51$). The majority of partners reported having children, with an average of 1.85 ($SD = .55$) dependent children per household. Annual household income ranged from \$40,000 to \$200,000 (median=\$80,000). Table 1 provides a summary of categorical socio-demographic information. As part of the eligibility criteria, all participants identified as either married or common-law. The majority of partners ($n=14$) identified as Canadian or Euro-Canadian, and one identified as Caucasian/American-born. With respect to educational background, six partners had completed a Bachelor's degree, five had

completed a college-level program, and four had completed either a Master's or doctoral level degree. All participants were either currently employed or pursuing higher education, with the majority of partners working in a managerial role (n=6).

Table 1
Categorical Data, Partner Demographics

Demographic	Frequency <i>n</i>	Percentage %
<u>Relationship Status</u>		
Married	14	93
Common-law	1	7
<u>Cultural Background</u>		
Canadian/Euro-Canadian	14	93
American-born	1	7
<u>Educational Background</u>		
College	5	33
Bachelor's Degree	6	40
Masters/PhD	4	27
<u>Occupation</u>		
Student	2	13
Managerial Role	6	40
Education	2	13
Self-Employed	3	20
Science/Technical Profession	2	13
<u>Children</u>		
Yes	14	93
No	1	7

The duration between symptom onset and diagnosis of PTSD in veterans ranged from less than 1 to 19 years (M=5.71, SD=5.31). The duration between symptom onset and diagnosis

of PTSD was longest among veterans whose symptoms first began to appear in the 1990s. Table 2 provides a summary of categorical data pertaining to benefits for both veterans and partners. The majority of veterans (93%) received some form of disability benefits from the government, either in the past or currently; however, benefits varied widely among families. Less than half of partners (47%) received some form of spousal or caregiver government benefits related to the PTSD diagnosis or the veterans' disability status. Similar to veterans, the nature and form of benefits varied widely among partners. The majority of partners (67%) were currently engaging in some form of mental health supports or services.

Table 2
Categorical Data, Diagnostic and Benefits Information

Category		Frequency <i>n</i>	Percentage %
<u>Veteran benefits, past or present</u>	Yes	14	93
	No	1	7
<u>Partner benefits, past or present</u>	Yes	7	47
	No	8	53
<u>Partner currently engaged with mental health services</u>	Yes	10	67
	No	5	33

Contextual Component Findings

The contextual component of the interview was designed to do two things: (a) provide a broader understanding of partners' current life circumstances with respect to the family composition, employment status, roles, and responsibilities; and (b) elicit information on the events and/or experiences that precipitated partners' need or desire to seek mental health information, supports, and services. It was anticipated that this information would shed light on how partners' daily lives and well-being are impacted by service-related PTSD, and to provide insight into the diverse ways this impact is experienced.

Context of Life Circumstances

Since partners self-identified as having experiences that affected their life directly related to the veterans' PTSD, it was important to obtain an understanding of how their life circumstances (i.e., family composition, employment status, roles, and responsibilities) have been influenced by or contributed to their overall experience of living with a veteran with PTSD. At the beginning of the interview, partners were invited to elaborate on the nature of their current circumstances, including their family composition, employment status, and various roles and responsibilities. A total of 42 codes were assigned to partners' responses, which were arranged into two themes outlined in Table 3. As proposed by Butterfield et al. (2009), the inclusion of response frequencies and participation rates serves to confirm the credibility of the themes. To follow, the essence of each theme is described and supported with illustrative quotations.

Table 3

Themes, response frequencies, and participation rates for the question: "Can you describe your current situation as a partner of a veteran with post-traumatic stress disorder?"

Theme	Frequency <i>n</i>	Participation Rate %
Managing multiple roles and demands	26	100
Change and adjustment	16	81

Theme 1: Managing multiple roles and demands. The largest theme was "Managing multiple roles and demands" with all partners describing their current circumstances in terms of the various responsibilities, capacities, and occupations they perform. The development of PTSD and its accompanying demands left partners managing several roles and demands simultaneously. Partners identified with the roles of primary or sole wage earner, primary or sole caregiver (to children or the veteran), advocate (on behalf of the veteran and their family), and protector (ensuring the veteran's emotional and physical safety), although the specific constellation of responsibilities performed by each partner varied. For some partners, the

transition into new roles, such as caregiver, advocate, and protector, were more gradual and took shape as the veteran's symptoms emerged or escalated. For other partners, role transitions occurred more abruptly, accompanied by uncertainty about its associated boundaries and responsibilities. As Participant 3 described:

I've never been a caregiver before and suddenly I have this caregiver role. And he doesn't necessarily like that that's the fact, but it's the truth of it... and I don't know what I'm doing. Like I only just learned about PTSD and the military and I don't know whether what I'm doing and saying are the right things.

Regardless of whether the transition to new and additional roles occurred gradually or swiftly, the outcomes were similar across participants' narratives. Symptoms and behaviours associated with PTSD affected the veteran's parental, social, emotional, occupational, and interpersonal functioning, resulting in substantial alterations in familial interactions and dynamics. As a result, partners found themselves in a position that required them to take an active role in managing, attenuating, and alleviating the triggers and effects of PTSD in the home. In some instances, the performance of multiple roles were complementary, offering partners a sense of autonomy and empowerment. However, for other partners, the performance of multiple roles over time competed for their energy and time, leaving them feeling depleted and overextended, yet vigilant.

Theme 2: Change and adjustment. The second largest theme was "Change and adjustment" with 13 partners endorsing experiences depicted under this theme. Partners described their ongoing circumstances leading up to present day as repeatedly oscillating between change and adaptation. For some partners, the time leading up to and/or following the diagnosis of PTSD was characterized by significant alterations in employment status, social networks, geographical residency, financial well-being, and family composition. While some of these changes and stressors followed natural transitions and new life stages, others were

associated with the impact of PTSD, the process of seeking answers and assistance for the veteran's suffering, and the level and nature of support provided by DND and/or VAC. In the following quote, Participant 9 illustrated the co-occurring stress resulting from natural transitions and the veteran's PTSD symptoms:

I think that the major stressors are like moving, being married, having a child, having a death, job change...but I think that we had like 9 out of 10 of the major stressors in like a 3-month period. And we, as a newly married couple who had moved and transitioned jobs willingly...we didn't realize at 27 years old that what we were experiencing wasn't normal life style change stress. We were experiencing what was the beginnings of his PTSD ...because so much of PTSD is being kept in check by the daily routine of the job...But then suddenly when that daily routine is changed...the PTSD unbeknownst to us, reared up...You know, the dust had settled on a lot of parts of our lives, and yet, there were behaviours and actions that were not jiving with what settling into our lives should have looked like.

Some changes, such as the veteran engaging in effective and enduring mental health care, denoted positive shifts toward greater stability for the couple and/or family. Other changes, such as the veteran's release from the military, represented a poignant loss of identity, familiarity, and comfort for both the veteran and partner, producing a cascade of ancillary changes such as relocations, financial instability, and career transitions. With each change or stressor, adaptation was a necessary response from partners. While some responses warranted task-oriented adaptations within the household, others reflected cognitive-oriented adaptations in partners' expectations about their future and relationships.

Context of Precipitating Events

Since partners self-identified that they had endured challenges, hardships, and experiences that led them to seek mental health information, supports, and services (e.g., therapy, counselling, support groups), it was important to gain a coherent picture of the events, experiences, and factors that precipitated their need or desire to seek help. A total of 136 codes

were derived from partners' responses, which were arranged into five different themes outlined in Table 4.

Table 4

Themes, response frequencies, and participant rates for the question: "What experiences preceded the desire or need to seek mental health information, supports, and services?"

Theme	Frequency <i>n</i>	Participation Rate %
Confusion and Uncertainty	51	75
Overwhelmed	24	56
Changes in Oneself	28	50
Mental Health Emergency	20	38
Alterations in Family Relationships	13	25

Theme 1: Confusion and uncertainty. Prior to receiving the diagnosis of PTSD, the help-seeking process for 12 partners was precipitated by a state of bewilderment, misunderstanding, and apprehension regarding the veterans' changing behaviour. Partners described the veteran as "a different person" compared to his pre-deployment self, noting behavioural changes such as extreme anger, withdrawal, depression, and/or elevated drug and alcohol use. One partner described her husband's vacillating behaviour, and the drastic change in his character, akin to the character of "Jekyll and Hyde". With little information or experience, partners felt lost and struggled to understand who their husband/spouse had become. Initially, some partners questioned whether the changes observed in the veteran were the direct result of their own interactions or behaviours. However, over time partners began to recognize that the observed changes were indicative of traumatic aftereffects. As PTSD symptoms progressed, partners began to understand that environmental factors would activate the veteran's symptoms. However, despite this awareness, partners found it difficult to eliminate environmental triggers, let alone predict how new stimuli or events would trigger the veteran's behaviour. Accordingly, partners described being particularly vigilant and apprehensive due to the unpredictability of the

veteran's behavioural responses to the environment, likening the experience to "walking on eggshells". Participant 8 described some of the behavioural changes she observed in her husband, and the resulting confusion:

I would say that the nightmares were the big distinct factor...where he would wake up in the night and you know, run all over the apartment saying "Do you smell that, can you smell that", you know, he'd smell burning bodies is what he expressed afterwards. But at the time, I really didn't know what he was doing and he would be hypervigilant about locking the doors and making sure all the windows were secured and...you know, if he heard a noise, there was always a baseball bat, or a knife, or something readily available should something happen.

The growing unpredictability and apprehension that characterized partners' experiences left partners yearning for answers, explanations, and solutions. Partners identified the need for the veteran to learn tools to manage his symptoms to reduce the impact on the family unit. Furthermore, partners expressed the need to know how to alter, modify, and recreate the home environment to alleviate or prevent the effects of PTSD on the veteran, themselves, and their family.

Theme 2: Overwhelmed. The help-seeking process for nine partners was precipitated by the experience of feeling overwhelmed and overextended, all whilst coping with and managing the impact of PTSD on the veteran and their family. The challenges and demands accompanying PTSD led partners to devote constant attention to the needs of the veteran and their family. Partners' attention and energy was divided between giving support and assurance to the veteran on the one hand and coping with their multiple role responsibilities on the other, leaving little to no time to attend to their own needs. Some partners reached a point where they felt unable to continue functioning in the multiple roles they had assumed and the various demands they faced. Participant 8 described how the overwhelming stress she experienced for years led to her suicide attempt:

I would just say that basically, I got overwhelmed and did see some signs of depression... up until about 2006, I probably quit about 3 jobs over the years due to stress. Because it was...take care of my family, or work, right? Like I couldn't do both, so I did, you know, try other things that I could work from home, or you know, went on sick leave when I could. Because it was just about keeping the peace at home. But I think...it was just that overwhelming feeling and needing to talk to someone...and, you know, I did get to a point...I can't even recall the year to tell you the truth, but it was after he was diagnosed...I took a bunch of pills, and ended up, you know, him taking me to the hospital.

Partners' attributions for the overwhelming nature of their circumstances varied. Some partners expressed having no relief from the multiple stressors they faced, which in turn depleted their mental and physical resources. Other partners felt unequipped to deal with the severity, persistence, and unpredictability of PTSD. For some partners, these factors compounded one another. As time elapsed following the onset of PTSD, the extended and unrelenting stress and responsibility, and the recognition that their ability to continue overextending themselves was unsustainable, provoked partners to begin the help-seeking process.

Theme 3: Changes in oneself. The help-seeking process for eight partners was precipitated by recognition of changes in one's own behaviour, health, and/or well-being. Partners cited changes across a broad range of areas, including social, occupational, physical, emotional, interpersonal, and intrapersonal domains. Some partners described these changes as occurring more abruptly or suddenly, while for others it occurred more gradually over several months or years. However, the decision to seek help tended to arise once partners' physical, emotional, social, or mental health was seriously affected to the point that a distinct constellation of symptoms had developed and endured. In the following quote, Participant 10 described the changes she observed in her response to stress over time:

I knew that I came to a point where...I've always thought that I was very strong mentally, because I've...it's just the way that I am. I don't really understand, or I don't know what my limits are. I just go and keep doing more and more and more. And I don't have that cue that says "no, it's too much" or "no, it's too tiring" or "no, I shouldn't do

it". You know it's something to be done and I'm just doing it. You know, its just how I've always been. But now it's coming to the point where I'm having these physiological reactions to the stress that's accumulating, and its debilitating in some ways, and its making me not function 100%.

Partners indicated that they had developed a range of concerns, including STS, anxiety, depression, suicidal ideation, and chronic physical illnesses. Many partners described the trajectory of change as a "breakdown", in which the negative changes continued to build and accumulate until their health reached a point that was no longer functional. Some partners felt initially immobilized and confused by the changes they were experiencing, whereas others described it as an "awakening" that compelled them to act swiftly.

Theme 4: Mental health emergency. The help-seeking process for six partners was precipitated by events where the veteran experienced intense personal distress and suicidal behaviour. In these situations, immediate action and attention from partners and the mental health community were required to avoid serious psychological or physical harm, and in some cases, life-threatening injury. Partners recounted the experience of either witnessing (inadvertently), preventing, or intervening with the veteran's suicide attempt(s). While partners recognized that they too were impacted by the event, partners initially entered a task-oriented survival mode in which their priority was to secure the safety of the veteran and their children. For some partners, a single suicide attempt was followed by several months of exclusive focus on securing the veteran's safety. For others, this process occurred over several years and involved multiple, repeated attempts. Partners described how their lives were quickly consumed by the veteran's care, including emergency admissions to the hospital or inpatient treatment centers, providing rehabilitative support for physical injuries sustained in the attempt, coordinating short- and long-term treatment plans with medical teams, and managing new situations and roles as they arose. For some partners, it was not until after the veteran's condition

had reached a reasonable level of stability that partners were able to reflect and process the impact of the event. For others, such as Participant 16, securing quality and consistent care for the veteran was initially thought to be enough support for the entire family:

It was an unfortunate, significant event, it was his first suicide attempt...that really opened our eyes and made us realize that this is in fact PTSD. There was some suspicions, some behaviours, but again...as a wife...you're really trying to find that balance and say, is this who he is or is this because of an experience he had? And I think it all catapulted in 2009 for us and got the ball rolling. So, in terms of seeking supports for myself and my family, I don't know that I initially did that. Our first goal was to seek support for him and in essence that was seeking support for us. Getting him fixed seemed like the first answer, it was the first rule of thumb trying to get him support and thinking that would be enough for me and the kids, and over the course of 2009 to our present day I have recognized that that's not enough. That hasn't been enough, to just get him support...

Regardless of the time that elapsed following the veteran's suicide attempt, partners eventually recognized the inherent trauma of nearly losing their loved one, and the emotional and psychological impact that the event had on their own well-being, culminating in the need or desire to seek support for themselves, as well as their children.

Theme 5: Alterations in family dynamics. The help-seeking process for four partners was precipitated by recognition of changing patterns in intimate partner relationships or parent-child interactions. Partners cited several changes in the veteran which led to alterations in the nature of the marriage, common-law relationship, and/or family, including the veteran's difficulty or inability to communicate, changes in the veteran's character and relational style, the tendency for the veteran to be physically or emotionally distant with his children, and the tendency for the veteran to become angry quickly and lose his temper. These changes not only prompted alterations in how family members interacted and communicated with one another, but also generated concerns about the future. Some partners worried about whether their original relationship with the veteran would ever be restored. Others expressed concern about leaving the

children alone with and under the supervision of the veteran. The following excerpt from Participant 7 depicted how her frustration with her marriage was met with a desire to understand the changes that had occurred:

I honestly was feeling...mad. Depressed. Angry at myself for staying...was one thing. Angry that I couldn't talk to him, I couldn't communicate with him. I got depressed, because of course you're thinking "ok, what's wrong with my partner". You know, what is marriage if you can't talk to your husband or your wife, in my case, my husband. Just being angry at the whole situation. You know, he's very non-committal, very non-communicative. He still is, I'm not going to say he's an open book because he's not...but now I have some depth and understanding. I honestly...I was going to leave, and I said "ok, before I leave I need to find out what's going on, why is this marriage the way it is".

In some cases, partners questioned whether they were engaging in specific behaviours or interactions that either brought on or exacerbated the emerging disruptions in family relationships. For the majority of cases, however, partners attributed the relational changes they observed to the symptoms of PTSD. Common to all partners who endorsed this theme was the desire to seek an explanation as to why familial relationships had changed, with the hopes of obtaining strategies and tools for rebuilding relationships or devising new ways of relating to one another.

Critical Incident Findings

Following the contextual component of the interview, the critical incident questions were introduced. This part of the interview was intended to gather data on three core research questions pertaining to mental health information, supports, and services: (a) What helps or hinders partners in seeking? (b) What helps or hinders partners in accessing? And (c) What helps or hinders partners in utilizing? For each core research area, participants were also asked about what would have been helpful to them in the process, or alternatively, what would be helpful to them in the future.

The first interviews yielded a total of 534 helping and hindering CIs and WL items across all three core areas (i.e., seeking, accessing, and utilizing), broken down as follows: 201 (38%) helping CIs; 235 (44%) hindering CIs; and 98 (18%) WL items. While analyzing the data from the first interviews, 3 potential CIs were flagged for follow-up with the participants during the second interviews. All 3 of these additional items were confirmed by participants as being CIs, and participants provided the required supporting details to allow these incidents to be included in the final results. Therefore, after the second interview procedures, a total of 537 helping and hindering CIs and WL items across all three core areas were identified, broken down as follows: 202 (38%) helping CIs; 237 (44%) hindering CIs; and 98 (18%) WL items were identified. These incidents were organized into 10 categories under the seeking area, 11 categories under the accessing area, and 10 categories under the utilizing area. As shown in Figure 1, seven categories were shared among the three core areas of seeking, accessing, and utilizing, whereas an additional 6 categories applied either to one or two core areas.

Given the considerable overlap in categories, the findings for each of the seeking, accessing, and utilizing core areas were collapsed across categories to facilitate the identification of similarities and differences among all three junctures of mental health service engagement. Each category is first depicted through a table demarcating (a) the name of the category; (b) the total number of CIs and WL items; and (c) the number of incidents in each of the helping, hindering, and WL themes with corresponding participation rates. A definition of the category, description of corresponding findings, and supportive quotes are provided next. For categories in which common CIs and WL items were cited across all three core areas, such overlap is made explicit and findings will be described in aggregate. For categories in which different CIs and

WL items were cited across seeking, accessing, and utilizing, the unique findings for each core area will be indicated and described separately.

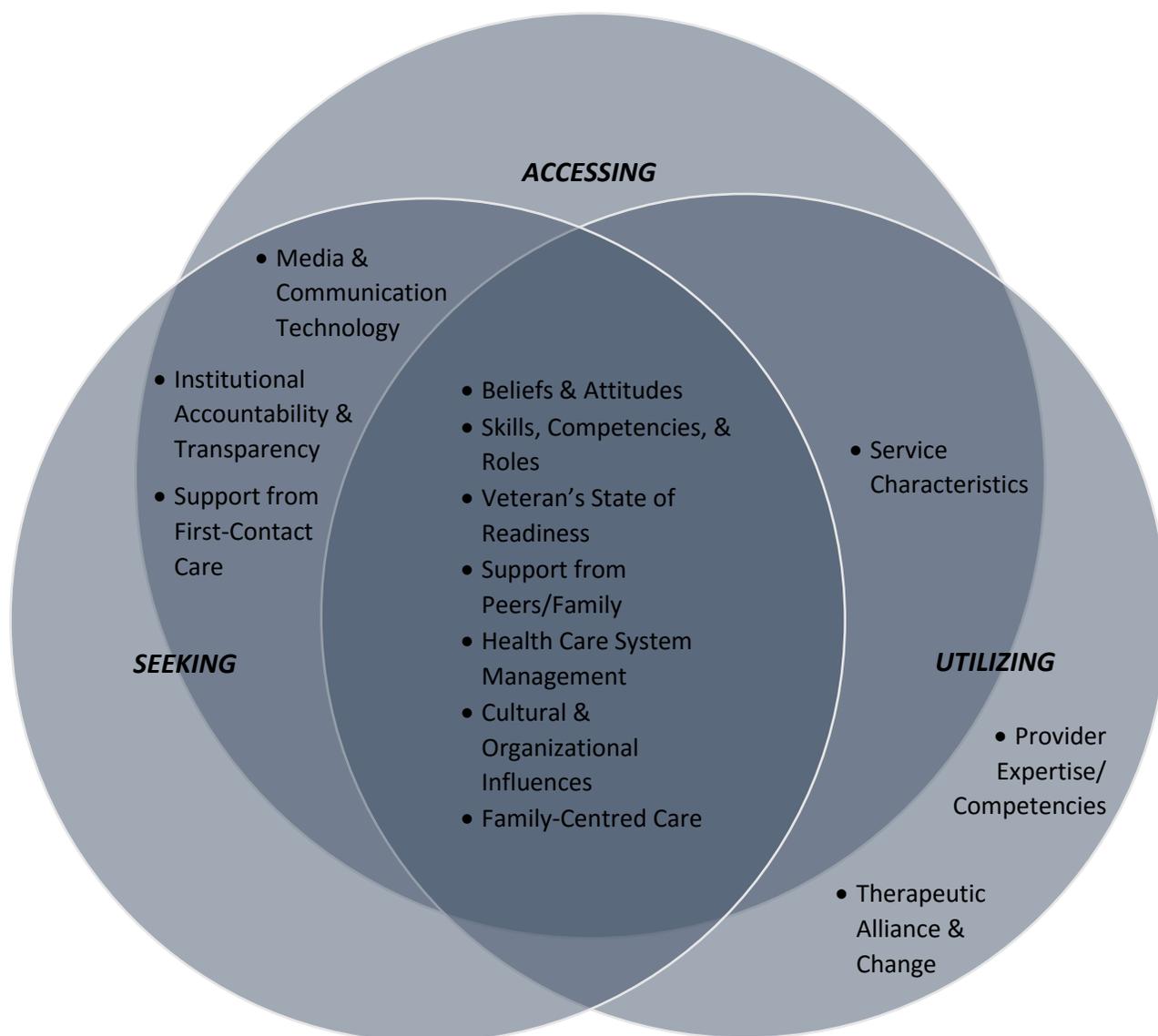


Figure 1. Illustration of the relationships among categories and actions of seeking, accessing, and utilizing.

Category 1: Beliefs and Attitudes

Table 5 provides a breakdown of the findings pertaining to “Beliefs and Attitudes” across all three core areas of seeking, accessing, and utilizing. This category had a total of 53 incidents, including 30 helping CIs, 23 hindering CIs, and no WL items.

Table 5
Beliefs and Attitudes Critical Incidents and Wish List Items

	Helping Critical Incidents (N=30)			Hindering Critical Incidents (N=23)			Wish List Items (N=0)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Seeking	9	56	15	5	32	10	0	0	0
Accessing	6	38	9	6	38	6	0	0	0
Utilizing	6	38	6	4	25	7	0	0	0

Helping CIs. The helping category included incidents where participants described their personal beliefs, feelings, attitudes (either personal or public), and awareness as being helpful to them in seeking, accessing, and utilizing mental health information, supports, and services. Beliefs and attitudes were perceived to be helpful across all three core areas. Incidents common among seeking, accessing, and utilizing included partners': positive attitudes and expectations surrounding mental health supports and services; perseverance, optimism, and will; belief that professional help is desired or needed; and acceptance and/or awareness of PTSD and its impact on the family.

With regard to seeking and accessing, positive beliefs and attitudes about receiving psychological help translated to greater expectations about the helpfulness of services and fewer expectations about potential risks or negative outcomes. The following quote from Participant 13 provided an illustrative example of the facilitative effect of her normalizing attitude toward mental health challenges and receiving psychological help:

I do believe that my attitude towards it is that, you know, psychology is there to help you, so it made me... I didn't fear seeking help in that regard...I knew that something was wrong and I knew that I didn't have the ability at the time to fix it. And so, to me it was no different than if I fell down and broke my arm and I have to go get it fixed by a doctor...I don't feel that accessing mental health has any stigma attached to it whatsoever. And so, I feel it's there to help me when I need it, and I don't have a problem getting help when I need it.

During the utilizing phase, the propensity toward positive expectations about continued participation in counselling/therapy strengthened partners' commitment to regular, longer-term engagements. As such, these incidents lessened the apprehension and period of vulnerability that often accompanies searching, making contact, and engaging with a support or service once it was located.

Partners described how their perseverance, optimism, and will provided them with a sense of direction, strength, responsibility, empowerment, and/or resilience during the seeking phase. Once supports and services were located, partners' described their persistence and positivity as imparting them with the courage to access specific supports and services. Once engaged with supports and services, partners' sense of hope that change would occur generated the belief that one would find a pathway to reach their desired goal, thereby encouraging ongoing service utilization.

The belief that professional help was desired or needed to address or to manage the challenges accompanied by PTSD also played a facilitative role in all three core areas. This belief increased the urgency for and necessity of supports and services, quickly propelling partners into the seeking and accessing phase. With respect to utilizing, partners' awareness that they had not yet reached their envisioned goals, or that new concerns had evolved over the course of therapy/counselling, propelled them to continue engaging with their mental health care provider.

Partners' also cited that their awareness and acceptance of PTSD and its impact on the family played a facilitative role in seeking, accessing, and utilizing. The combination of awareness and acceptance revealed to partners the indispensability of their role in preserving and/or healing the well-being of their family. This recognition led partners to view the act of

seeking, accessing, and utilizing mental health services as both a necessary and worthwhile undertaking.

Exclusive to the accessing phase, partners cited the facilitative effect of believing that one has inherent value and worth as a human being. The following excerpt from Participant 16 illustrated the important role of self-worth:

Finding your own self-worth is crucial to accessing services...I think it's because you can get in your own world when you live with someone with PTSD, where you have just accepted this crazy, up and down world, roller-coaster ride as your normal and you're so accustomed to this that you don't recognize it...Only in reflection sometimes do we see the craziness that we live in, so the validation of our own self-worth...because there are times with my husband specifically, just in our own personal relationship, and some of things that he's done and said that I just took so matter-of-fact and in doing so, devalued myself, not even knowing it...I had just accepted it as part of PTSD without realizing "woah, there's a boundary that needs to be in place here."

Partners' sense of self-worth contributed to the recognition that they too deserved services and supports from a mental health professional. Consequently, this sense of worth and value had a self-validating effect on partners and imparted them with the courage and motivation needed to make contact with specific supports or services.

Exclusive to the utilizing phase, partners' indicated that trusting and believing in the process of receiving help was particularly important in facilitating ongoing engagement with their mental health provider. For Participant 15, trusting in the process was synonymous with trusting in the power of vulnerability:

I know that the only way that I can be helped is by giving information and if I keep information back, if I...I can only be helped to the degree of the information I give, and I have to be 100% honest, and in being 100% honest I have to allow myself to be vulnerable. And only when I allow myself to be vulnerable, and I allow my wall to come down, will I be helped.

By trusting the process, partners observed that their willingness to be vulnerable facilitated their healing and/or alleviated some of their distress. Consequently, partners were

more motivated to continue attending appointments and actively engage in the counselling/therapy process.

Hindering CIs. The hindering category includes incidents where participants described their personal beliefs, feelings, attitudes (either personal or public), expectations, and awareness as preventing or impeding them in seeking, accessing, and utilizing mental health information, supports, and services. These incidents shared the common thread of partners' expression of hesitation toward the process of seeking, accessing, and utilizing supports and services. Incidents in this category included self-stigmatizing attitudes and beliefs, skepticism about the helpfulness of services and supports, and apprehension around facing difficult emotions.

Partners cited the adverse effects of self-stigmatizing attitudes, a factor that hindered both seeking and accessing. In the following excerpt Participant 7 described the feelings of powerlessness that materialized from internalizing specific beliefs around help-seeking that she had been raised with:

I felt that I was like an island...in an ocean all around me. And there was...I felt there was no way out...I started feeling like a failure, you know, like "why can't I handle this? Why am I so overwhelmed by this whole situation?". You know, "I should be able to deal with this...not sure how, but I should be able to" because...if you're not, then you're looney right...You come to a point where you're crying yourself to sleep at night.

For some partners, the perceptions that mental health challenges were a signal of personal weakness, failure, or incompetence, or that one should be able to deal with problems on their own, hindered the acts of seeking and accessing. For others, the perception that mental health challenges must be severe and complex in order to receive psychological help resulted in partners questioning or discrediting their own legitimacy in seeking and receiving services. As a result, such beliefs resulted in feelings of shame, doubt, helplessness, and worthlessness, and further delayed the act of seeking and accessing help.

Partners also described how seeking and accessing was hindered by their skepticism about the helpfulness of mental health supports and services. A fractured image of the effectiveness of the broader mental health system imparted a sense of abandonment and feelings of discouragement regarding the prospect of improving their situation. Partners also questioned whether the outcomes of engaging in such services would be worth the time and effort invested in the process. Consequently, partners felt conflicted about beginning the help-seeking process, and whether or not to follow through with a support or service once it was located.

Some partners' indicated that the anticipation and/or apprehension around facing difficult emotions in counselling/therapy hindered their efforts to access and utilize mental health services and supports. In the following quote Participant 14 recounted how the anticipation of talking about difficult topics and the corresponding emotions made it more difficult for her to continue therapy:

There were definitely some bumps that were like "Oh don't go any further, you don't want to talk about that" because in my mind, I would have it as a horror story. But it was just...but once I got it out there, it wasn't as scary as I thought. It was just my body, I don't know if it was trying to protect itself or what, but there were sometimes where the follow through was difficult...I felt like I would...like once I opened up that dam, like once I opened up that gateway, that that would be it, everything would fall apart and I wouldn't be able to handle it, like I couldn't do it. I was scared for my world to kind of crumble, you know?...Things like the resentment and anger I had towards my husband.

Discomfort with experiencing challenging or intense emotions, or discussing one's private life with an unfamiliar person, resulted in apprehension that temporarily immobilized partners' transition from locating to accessing services. Once counselling/therapy had been initiated, some partners' anticipated that it would be difficult to control difficult emotions in-session once they opened up, making them initially reluctant to attend sessions. Other partners anticipated that the emotions they disclosed would be assessed as abnormal or inconceivable, diminishing their enthusiasm to engage in counselling/therapy.

Partners cited two hindering incidents unique to the utilization phase. First, among those who had missed a counselling/therapy appointment, continued engagement was thwarted by a sense of guilt due to feelings of failure and/or the anticipation of reprimand at future appointments. Second, some partners reported discomfort with the idea of engaging in couples-counselling formats due to the belief that expressing some concerns in front of their partner would exacerbate issues at home or that the veteran would not follow through with counselling homework. Such beliefs reduced their desire to engage in this form of support when it was offered, and for some, halted their engagement with services altogether.

Category 2: Skills, Competencies, and Roles

Table 6 shows the distribution of CIs and WL items for the category “Skills, Competencies, and Roles” across all three core areas. This category had a total of 45 incidents, including 35 helping CIs, 10 hindering CIs, and no WL items.

Table 6
Skills, Competencies, and Roles Critical Incidents and Wish List Items

	Helping Critical Incidents (N=35)			Hindering Critical Incidents (N=10)			Wish List Items (N=0)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Seeking	12	75	22	4	25	4	0	0	0
Accessing	6	38	9	6	38	6	0	0	0
Utilizing	4	25	4	0	0	0	0	0	0

Helping CIs. The helping category included incidents where participants described personal skills, abilities, competencies, previous encounters with mental health challenges (personal or vicarious), and roles (either familial or professional) as being helpful to them in seeking, accessing, and utilizing mental health information, supports, and services. These incidents shared similarities in that partners described the application of their knowledge and

capacities, acquired through experience, as assisting their efforts. Each partner possessed a unique set of skills, knowledge, and experience that not only helped her to cope with the effects of PTSD on a daily basis, but also identify and engage in crucial steps that resulted in locating resources, finding answers, and reaching solutions. Incidents in this category pertained to four central themes: advocacy; research skills; prior knowledge/experience; and role flexibility.

Partners' ability to advocate on behalf of oneself and/or others was the most frequently cited incident in this category, proving helpful to partners' at all three junctures of seeking, accessing, and utilizing. Partners' reported that their capacity to speak or write in support of themselves or others, and make requests and recommendations supported by knowledge, experience, and/or evidence was critical at every stage of mental health service engagement.

Participant 13 recounted how her ability to communicate the urgency of the situation she was facing to providers helped her advocate for and receive much-needed support:

Impressing on them the urgency of the matter I'm dealing with. I don't think people seek help when things are good...it can be a significant wait to get in to see a specialist. And sometimes you don't have that time. You don't have the luxury of that time. But you know, when I wanted to see a psychiatrist a couple of years ago, that's the strategy I was using...it was a three week wait. They can find a way to fit you in. They find a way to fit you in. There definitely was a couple of times where...I felt the matter was extremely urgent...My son called me one day, and he said "Mom you have to come home" and I said "what's wrong?" and he said "dad's locked himself in the bathroom and I think he's going to hurt himself"...So after that settled down, the next day I called and I said "I have to talk to somebody now", right? I just said "Look, I'm in an emotional crisis right now, and I need to see somebody now". That usually is...that's the only way that I found that you could access things in a timely manner.

Partners' ability to advocate enabled them to exercise their rights, vocalize their needs, and express their concerns while seeking and accessing services. Once services or supports had been accessed, partners' stated that their capacity to articulate the continued need for support to both their mental health providers and VAC afforded them greater choice over when to terminate therapy/counseling and greater control over their own well-being.

The ability to independently research, self-educate, and apply acquired knowledge facilitated the processes of seeking, accessing, and utilizing supports and services. During the seeking phase, partners' research skills helped them gain additional knowledge, select the most viable options amidst a surplus of information and advice, and be actively involved in decision-making around their own care, as well as their family's. With this knowledge, partners' felt more capable of navigating the plethora of information online or in print and increased their sense of control over the process of seeking help. During the accessing and utilizing phase, partners' proclivity for research and self-education assisted them in selecting an effective and compatible mental health provider. In the following quote, Participant 16 shared how her background research helped her find an appropriate counsellor, and how her competence in finding the right counsellor contributed to her investing in a sustainable therapeutic engagement:

Finding the right counsellor who is going to challenge what I think is crucial. If you don't have the right counsellor you're going to quit, and then I don't know, honestly, if I had to go through a lot of them I would have given up...I had done my research beforehand, I found out what their speciality was, what their background was, what kind of behaviours their like, because I wanted someone specific...I wanted someone who had some tried, tested and true experiences...I probed her to say "Can you give examples where you've met this and actually been able to show some improvement?" And if I got the message back that gave me what I was looking for, then I went with them, and if not, I didn't.

The forethought and decision to research compatible and effective providers early in the process resulted in partners feeling more confident and invested in the provider they selected, thereby increasing their desire for and commitment to counselling/therapy.

Partners identified prior knowledge of and/or experience with mental health challenges and/or mental health supports and services as facilitating their efforts to seek and access care. Prior knowledge and/or experience developed through personal or vicarious (i.e., professional employment settings or family/friend's experiences) encounters with mental health challenges

and the process of seeking and accessing care increased partners' familiarity with help-seeking and the mental health system. As a result, partners reported that they had gained important skills in detecting signs and signals of mental health concerns, dealing with related symptoms, and knowing where to seek and access appropriate services. This combination of knowledge and skills imparted partners with a sense of autonomy and increased confidence in their intuition and decisions. As a result, partners were able to exert greater influence over the timing and intensity of their contact with services, as well as the quality of services and supports.

Partners' also cited flexibility in professional and family-related roles as an important facilitator to accessing and utilizing supports and services. For some partners, consistent flexibility with work hours and schedules reassured them that they would be able to balance the demands of their work and home life with the time commitment needed to reach their desired counselling goals. Among partners with young families, the natural transition of their children becoming of school age altered partners' caregiving role, allowing for greater flexibility and regularity in attending counselling/therapy appointments. As a result, the affordances gained from flexibility increased the level of choice and control that partners believed they could exercise over the process of accessing and utilizing services and supports.

Hindering CIs. The hindering category includes incidents where participants described personal skills, abilities, competencies, experiential knowledge (personal or vicarious), and roles (either familial or professional) as preventing or impeding them in seeking and accessing mental health information, supports, and services. Incidents described under this category corresponded to three general themes: role conflict; a lack of experience and/or knowledge; and a lack of role flexibility.

Conflict between partners' professional roles in military-related mental health settings and the need to obtain support presented significant challenges to seeking and accessing services. Some partners in this situation experienced an inherent contradiction between their professional identity, in which they felt pressure to serve as a model for optimal well-being and effective stress management, and the recognition that they were in distress and needed support themselves. In the following excerpt, Participant 14 explained the how this conflict eventually led to her resignation:

You know, it's all around me, like this is where people...this is where soldiers come to get help. So it's kind of weird because you're working in a place helping others, and yet you feel embarrassed and you know, that you can't...you just won't do it yourself... Eventually the outcome was voluntarily releasing, you know...I just couldn't do it anymore.

Other partners who held professional roles within the military felt the need to conceal or censor their vulnerability, suffering, and/or hardships to ensure privacy and confidentiality, maintain clear professional boundaries, or avoid differential treatment by colleagues. Consequently, partners delayed seeking and accessing needed supports and services, and their distress and/or concerns remained unaddressed.

A lack of experience and/or knowledge regarding PTSD and seeking psychological help resulted in uncertainty, a sense of being overwhelmed, and compromised control over one's situation, thereby preventing or delaying the help-seeking process. The absence of prior knowledge and/or experience made partners feel less equipped to detect growing mental health concerns, deal with related symptoms, and know where to seek and access appropriate services. As a result, partners' attempts to seek and access services were prevented or delayed, as more time and energy was devoted to making sense of the situation and planning their next course of action.

Partners cited a lack of flexibility in familial and/or professional roles as hindering access to supports and services. For partners who assumed primary childrearing roles, a lack of flexibility emanated from limited assistance with or no access to childcare. Partners who worked outside of the home were challenged by professional work hours that were either fixed or coincided with mental health service hours of operation. For some partners, the ability to access counselling/therapy was dependent upon the veterans' situation and/or daily state. In the following quote, Participant 2 described how her role as a caregiver to her husband presented unique challenges to being able to access counselling/therapy appointments:

As stupid as it may sound, you live with someone who might take the car because he decides that day doesn't work for him. That is a situation. The fact that you must be able to cancel an appointment without being punished. Okay, so this is also something else because it happens that you have a bad day. And strategically, it's not a good idea for him to see you leave and see a psychologist because you always work in a situation where you try to balance the peace in your home. And so your availability is based on your spouse...And I understand that a psychologist is a professional and this is his money and his paycheque...but in that equation, they must realize that they deal with people who are living uncertainties every day and every minute. So that is a challenge.

Limited affordances resulting from inflexibility or unpredictability in familial and/or professional roles diminished the level of choice, influence, and control that partners could exert over the process of selecting providers, choosing services, and accessing support in a timely fashion. The inability to initiate contact and engage with services and supports when it was most vital, and the necessity to schedule access around familial or professional roles, decreased partners' sense of autonomy and self-determination. As a result, the timing and intensity of accessing services was often complicated, postponed, or halted altogether.

Category 3: Veteran's State of Readiness

Table 7 provides a breakdown of the findings pertaining to the category “Veteran’s State of Readiness” across the core areas of seeking, accessing, and utilizing. This category had a total of 26 incidents, including 16 helping CIs, 10 hindering CIs, and no WL items.

Table 7

Veteran’s State of Readiness Critical Incidents and Wish List Items

	Helping Critical Incidents (N=16)			Hindering Critical Incidents (N=10)			Wish List Items (N=0)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Seeking	6	38	7	4	25	6	0	0	0
Accessing	4	25	5	0	0	0	0	0	0
Utilizing	4	25	4	4	25	4	0	0	0

Helping CIs. The helping category includes incidents where participants described the veteran’s awareness, openness, and/or actions regarding PTSD, its impact, and the need for services as being helpful to them in seeking, accessing, and utilizing mental health information, supports, and services. These incidents shared similarity in that partners’ described how mental health service engagement and its encompassing processes were inextricably tied to their veteran husband or partner. Incidents in this category pertained to two major themes: the veterans’ supportiveness, and the veterans’ openness and content/quality of communication.

Veterans’ supportiveness of partners’ need or desire to obtain support mobilized partners in seeking, accessing, and utilizing services. Some partners reflected on the encouragement they received from the veteran to make and attend appointments with counsellors/therapists. Partners appreciated the supportiveness of veterans in these cases and experienced heightened motivation to access services. In the following excerpt, Participant 14 recounted how her husband encouraged her to continue attending therapy, instilling in her a greater sense of responsibility to her well-being:

I think in a way me seeking help was like helping [my husband], too. Because he was also seeking help, you know, through different avenues...but it was good because we were doing it together, almost as a team...He would always make sure...especially there were some days that...you're like "Oh my god, I don't know if I can go today" and you're just having a down day or something like that, but he was definitely that extra push, you know, to say "you need this"...There were days where I just felt tired, right? You know, where we were bringing something up that was just heavy. And I was just tired, I was just like "I don't think I can do this, I just want to stay in bed". And he'd be like "no, go to bed if you're tired afterwards, after you come back". But he would just kind of...he would give me the push I needed.

Veteran's supportiveness of their partners' need or desire to seek, access, and continue using counselling/therapy services served to reaffirm the value and benefits of service engagement, but also generated a sense of mutual accountability to one another's goals and managing PTSD together.

Veterans' awareness, openness, and communication surrounding PTSD and its impact on the family also contributed positively toward partners' efforts to seek and access mental health services and supports. A high level of openness, awareness, and communication from the veteran resulted in greater synchrony among the couple with respect to needs and goals. For some partners, the veteran's recognition of PTSD and/or its impact on the family was a sufficient stimulus alone to motivate access. Participant 11 described the increased empathy she gained because of her husbands' tendency to be open with her about his trauma and the experience of PTSD:

He was really open about everything...I've gotten him to talk about all of the events that happened overseas, like everything that is triggering. So I think it's different. When he would come home, when he seemed sort of off or whatever, I could say "what's going on" and he could say "you know, I had a bad day, I'm thinking of the day that [friend] got blown up"...Like he could give me really specific "this is what's happening to me today" and I could be like "Ok, ya that's a pretty shitty day and it's understandable why you want to go to the basement and watch a movie by yourself. Like, I'm ok with that".

When veterans imparted more information about their experiences and feelings, partners gained greater understanding about PTSD, how it affected the veteran, and the actions partners

needed to take to address their own concerns and needs. Veterans' increased openness provided partners with the opportunity to communicate their needs, feelings, and the impact of PTSD on their lives, resulting in partners receiving increased empathy and support from the veteran to seek help. For some partners, the veteran's awareness and openness around PTSD translated to an increased willingness to include the partner in his regular counselling and/or therapy, and asking his therapist to tailor the session to address the couples' needs. As such, the veterans' awareness and openness provided an immediate entryway for partners to access services. Once contact with a support or service was established, the veteran's recognition that counselling/therapy was needed beyond and in between crises reinforced the importance of regular engagement with services and increased the couples' motivation to prevent future crises from occurring.

Hindering CIs. The hindering category includes incidents where participants described the veteran's level of awareness/openness/understanding, and/or actions regarding PTSD, its impact, and the need for services as preventing or impeding their efforts in seeking and utilizing mental health information, supports, and services. Incidents in this category included veterans': openness, awareness, and content/quality of communication; lack of supportiveness; apprehension and fear; and instability in care.

Veterans' awareness, openness, and communication surrounding PTSD and its impact on the family also contributed negatively toward partners' efforts to seek and utilize mental health services and supports. A low level of openness and awareness from the veteran resulted in less agreement among the couple with respect to needs and goals. Low openness, awareness, and communication resulted from a denial of PTSD symptoms, reluctance to share experiences with or engage in couples counselling with the partner, and uncertainty about the partners' role or

permissible level of involvement in treatment. In these cases, partners' felt that they were unable to seek or continue engaging in supports and services unless the veteran expressed a willingness to take action. As a result, partners' efforts to seek and utilize supports and services were discouraged and redirected.

Partners cited that the veterans' lack of supportiveness interfered with their efforts to seek mental health information, supports, and services. Some partners cited a lack of encouragement and understanding from the veteran, whereas other described the veteran being exclusively focused on his own symptoms. In some cases, lack of supportiveness came in the form of veterans' dismissing or belittling partners' concerns and/or attempts to discuss their need for services and support. As a result, partners' felt that their needs took second priority, and they began to question the legitimacy of their pain and suffering. In the following quote, Participant 7 described how the absence of support took an emotional toll on her:

He hasn't come to that realization that his...you know, anybody in a group situation, one person is...the rest of the group is not well, because of that one person...And he's like "well, I'm not understanding why you would need that, you're fine with all this" and I'm like "no, I'm not fine with all this. I am struggling to keep my emotions in check when you are yelling and screaming, or you are, you know...". It was very frustrating, I think it added to my level of frustration with him. And the situation, where he...again, I felt very belittled...

In cases where partners felt that the veteran was reluctant to hear their concerns, partners experienced feelings of helplessness, anger, frustration, and depreciation. In other cases, when partners' needs and concerns were heard but invalidated by veterans' responses, partners' suffering was experienced in isolation and efforts to seek help were disqualified, prevented, or delayed.

Veterans' level of apprehension and fear regarding mental health service engagement presented unique barriers to utilizing mental health services. Partners' cited that veterans feared

judgment by mental health care providers and experienced anxiety about the partner attending their own individual counselling/therapy appointments. In the following quote, Participant 2 described how the veteran's apprehension, worries, and fears made it more difficult to continue therapy:

It's exhausting. And you know, that when you come back [from therapy], you will have to answer questions. What did you talk about? What did you say? What did she say? Because for that person, the wounded one, the fact you are seeing a psychologist might also be a trigger and challenge for him. Afraid of what you will say. Afraid that you will be convinced that you are better to leave him... There are changes that are happening because of those meetings. You make new decisions. You have a new approach. And you invite this into your own home. It all depends on the resistance of the person you live with.

The veteran's anxiety pertained to fear of the marriage/partnership dissolving if the partner engaged in individual therapy. As a result, partners reported that they needed to calm and reassure the veteran following their participation in counselling/therapy sessions that their marriage/partnership was not at risk of dissolution. This pattern of fear and reassurance continued for the duration of the partners' counselling/therapy, which only compounded the already difficult process of engaging in services.

Another unique barrier to utilization pertained to the stability of the veterans' treatment and care. In a minority of cases where the veterans' condition or care became unstable, the partners' full attention often shifted back toward the veteran and his well-being. Furthermore, when the veteran's condition became unstable, some partners questioned whether individual therapy or counselling would have any benefit while their family unit was under duress. As a result, some partners experienced temporary interruptions in their regular therapy/counselling.

Category 4: Support from Peers/Family

Table 8 shows the distribution of CIs and WL items pertaining to the category “Support from Peers/Family” across all three core areas. This category had a total of 35 incidents, including 13 helping CIs, 12 hindering CIs, and 10 WL items.

Table 8

Support from Peers/Family Critical Incidents and Wish List Items

	Helping Critical Incidents (N=13)			Hindering Critical Incidents (N=12)			Wish List Items (N=10)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Seeking	4	25	6	5	32	7	5	32	5
Accessing	4	25	7	4	25	5	0	0	0
Utilizing	0	0	0	0	0	0	4	25	5

Helping CIs. The helping category includes incidents where peers (personal or via established groups) and family members cared, helped, empathized, listened, validated, encouraged, and provided information to participants, all of which facilitated seeking and accessing mental health information, supports, and services. Incidents in this category corresponded to two central themes: family members’ recognition of partners’ need for support; and support from knowledgeable and relatable peers with a shared identity.

With respect to seeking and accessing, family or relatives were cited as among the first people to recognize that the partner needed help and support. During the seeking phase, the support received from family translated to feeling understood and less alone in their hardships. The following quote from Participant 11 illustrated how her family’s supportiveness validated the ways in which PTSD had affected her life and motivated her to seek help:

A lot of the focus was on my husband...You know, he was receiving a lot of support, and it was my family who was like “You need to take care of yourself too, and access supports.” Basically, don’t downplay my own experience of the whole situation and events...like my mom would often say “You don’t smile as often as you used to, what’s going on?”...And they would sort of gently point those out to me. Like “Hey, this is

a change we noticed, and we're worried about you"...I guess it gave me more motivation to actually seek support...

During the accessing phase, family members' expressed concerns about partners' well-being often led to discussion around avenues for obtaining help and prompted partners to commit to accessing a service or support. Therefore, at both junctures, family members' encouragement provided a stimulus for partners' to search for information and access specific resources. Family was also an important source of validation to partners, affirming partners' concerns and reassuring partners that they too deserved professional support.

Peers also played a critical role in facilitating the process of partners seeking and accessing care. Peers who were knowledgeable, experienced, and espoused a shared identity (i.e., a partner of a veteran with PTSD), were important in the exchange of information, resources, and in building community capacity among partners, all of which may have otherwise been unknown or difficult to find. Participant 14 described the helpfulness of knowledgeable and relatable peer support and how it pointed her in the right direction to access services while also maintaining her privacy:

I guess it's just that support you get from people who you can just really easily relate to...it was definitely somebody pointing me in the direction of "did you know that you have this option?" You know? And I was like "Geeze, I didn't know about this at all!". So that was the biggest thing...trying to find a way to be able to get support while also trying to protect my privacy. And then it was one of my friends, like a medic, that just mentioned "hey, what if you just go through it this way and just kind of go through MFRC, because they are also for military members too, and that way you can still do what you got to do but also seek help and feel that you have privacy".

Support from knowledgeable and relatable peers with a shared identity also played a critical role in the explication and dissemination of context-sensitive knowledge around accessing care, which enhanced partners' ability to navigate mental health and military-related systems. This support came in the form of new or atypical ways of handling setbacks in the process of accessing services, as well as the provision of insider, tacit knowledge about how to

select, approach, and secure supports and services through the military and broader mental health systems. Through peers, partners also became familiar with the specific parlance needed to infiltrate the VAC system and gain access to vital services. The process of knowledge sharing that occurred between partners led to a sense of community-owned and generated wisdom, but also resulted in a sense of empowerment and greater comfort with accessing services.

Hindering CIs. The hindering category includes incidents where participants described the absence of peer (personal or via established groups) and/or family support as preventing or impeding their efforts in seeking and accessing mental health information, supports, and services. Incidents in this category included the absence or loss of social support, and the absence of knowledgeable peers with a shared identity.

The absence of social support experienced by partners made it more difficult to seek help for several reasons. Some partners experienced an abrupt loss of social networks following the veterans' release from the military and subsequent relocation. Other partners experienced a loss of friendships through the gradual process of social distancing. In the following excerpt, Participant 2 described the process of distancing herself from social contacts and the isolating effect of PTSD:

You realize that you used to have a social life. You realize that at one point in your life you were able to go out with your friends without justifying, without feeling guilty. In my case, I gave it all up. All. And it's even a problem for me, I can't even call my friend on new year's day because I am ashamed because I know I am letting her down. And if only people know how difficult it is for me just to have a normal relationship with the people who love me...

The gradual process of distancing restricted partners' opportunities to exchange perspectives, experience emotional connectedness, and receive external validation and encouragement. As such, the ensuing isolation made it increasingly difficult to seek or access services and supports.

Partners also cited that the absence of peers who were knowledgeable, experienced, and espoused a shared identity hindered their efforts to seek and access mental health information, supports, and services. During the seeking and accessing phase, the absence of this particular type of peer support represented a loss of context-specific information, insider knowledge, and shared resources, thereby reducing the quantity of visible avenues for information and support. Accordingly, partners experienced increased stress, seclusion, and/or a lack of direction, all of which exerted a hindering impact on the seeking process. Participant 6 described the challenges of not having a relatable and experienced peer to attenuate her self-doubts and discomfort with accessing services:

I guess just not having somebody to support you through that step...Not even necessarily make the call for you, but be there as a support, so that ok, they tell you, here's a number that you can call, and then, you know, maybe call me back when you're done and see how it went, or, you know, just somebody that could support you through that too, because, I mean, I had so many doubts every time I called to, or wanted to call to make an appointment. What if I don't like this person? What if our styles don't agree, what if...I don't actually need support, what if I'm just being a jerk? So, there was a lot of self-doubt, because it's not a comfortable thing.

With little or no access to a single individual or group of like-minded partners to offer reassurance and guidance, partners experienced discomfort, apprehension, and uncertainty about the processes of locating, selecting, engaging in, and securing psychological help, all of which slowed or inhibited the action of initiating contact and following through with services or supports.

WL items. The WL category includes incidents where participants wished they had the support of peers (personal or via established groups) and/or family members, or that they had more of it, in order to facilitate their efforts in seeking and utilizing mental health information, services, and supports. WL items cited in this category included the need for peer support and the desire for family members' to live closer.

Partners cited a desire for knowledgeable peer support familiar with the intricacies of the mental health and military-related systems during seeking and utilizing phases. Partners anticipated that this form of peer support would provide context-specific information and resources that were otherwise difficult to uncover, while also providing a critical source of emotional and psychological support. Although partners stated that the support gained from individual counselling/therapy had its place, they also expressed the need to connect and share their challenges, experiences, and strategies with like-minded partners/families. In the following quote, Participant 6 discussed the need for an informal supportive community as she and her family confronted the coinciding processes of dealing with the impact of PTSD while also adjusting to the transition from military to civilian life:

I did try some different support groups at different times, but I think...they were too intense at times for already being intense at home, and when you got into a group situation, they seemed to just...everybody's experiences amplified everyone else's. But I think, it would have been nice or would be nice to have a community of...of spouses or family members who are dealing with it...because it's tough, its overwhelming. And I think it would have, or it would be just...supportive to have other people going through the same thing, but in a lighter environment...we've been out of the military world for quite some time now, but my roots are still military and my husband's heart is still military...we still find it odd adjusting to the civilian world sometimes, so...you know, just to find that connection would be comforting. It's still a hard transition. I mean, there's not a day goes by where my husband wouldn't rather still be in the military...then sitting at home with his PTSD. So, we're still transitioning to the civilian world even 12 years later.

Some partners met challenges with gaining ongoing or additional approvals for counselling/therapy from VAC. In these cases, partners cited the need for peer support familiar with the intricacies and vernacular of VAC. Access to knowledgeable, experienced peers would have provided partners with insider knowledge, thereby defusing their frustration and expediting approvals. If these opportunities existed, partners expressed that they would feel less isolated and better prepared to deal with the ongoing challenges associated with PTSD and service utilization.

Specific to the seeking phase, partners expressed the desire and/or need for family members to be geographically closer. Partners anticipated that the presence of family support would provide several important benefits to their situation. In the following excerpt, Participant 14 anticipated that family support would have provided reassurance and comfort, making it easier for her to develop compassion for herself and her situation:

So just knowing that, you know, somebody is not weak when they ask for help. Knowing that. And knowing that, you know what, it is very difficult to raise a family, to be able to continue on in your own job, while your husband is, you know, in pain and suffering, you know, like that is very difficult and a very valid reason to seek help.

In all cases, partners believed that family support would have translated to gaining some relief, either physically or psychologically, from the multiple and daily demands faced by partners. Partners also anticipated that family supportiveness would have made them feel as though broader society recognized the hardships of partners in this situation. As such, support from family would have made partners feel worthy of seeking help and provided sustained assurance throughout the process.

Category 5: Media and Communication Technology

Table 9 provides a breakdown of the findings pertaining to the category “Media and Communication Technology” across the two core areas of seeking and accessing. This category had a total of 25 incidents, including 15 helping CIs, 5 hindering CIs, and 5 WL items.

Table 9

Media and Communication Technology Critical Incidents and Wish List Items

	Helping Critical Incidents (N=15)			Hindering Critical Incidents (N=5)			Wish List Items (N=5)		
	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%	<i>n</i>	
Seeking	8	50	11	4	25	5	0	0	
Accessing	4	25	4	0	0	0	5	32	

Helping CIs. The helping category includes incidents where participants described the use of print media, internet, social media, cellular technology, mobile applications, and information hotlines as being helpful to them in seeking and accessing mental health information, supports, and services. Media and communication technology provided partners with convenient, flexible, accessible, immediate, and unlimited entryways to seeking and initiating contact with supports and services. Incidents corresponded to two main themes: the privacy, security, and ease of internet technology; and the availability of 24-hour support lines.

The internet played a valuable role in connecting partners with needed information and reassuring partners that resources existed during the seeking and accessing phase. The internet was described as providing partners with increased privacy, security, and ease in searching and initiating contact with services and programs, especially in cases where the diagnosis of PTSD had not yet been given or during peak periods of tension for the couple. Furthermore, several partners identified the use of cellular phones and/or internet as helpful for scheduling appointments in that these technologies eliminated the frustrations associated with mutual or sequential unavailability of telephone communication. Social networking applications (i.e., Facebook groups) offered an advanced level of immediacy, expedience, and familiarity to partners, allowing them to overcome challenges such as limited time, large geographical distances, and apprehension over approaching agencies in person. Facebook groups in particular served as a freely accessible and immediate form of emotional support for many partners. In the following excerpt, Participant 15 described the important gap filled by Facebook groups in terms of validating her perspective and connecting her with a form of support she may not have otherwise had:

I remember feeling so lost...And so I went on to this PTSD Awareness Facebook page...So I was reading all of these comments that other spouses had made, and some

of them were just a step behind me and some of them were a step ahead of me, but there was a common ground that we were all going through something similar...And that's what gave me the reassurance that, okay, it's not just me...And it gave me the courage to reach out to a spouse. I sent her a text and told her I was feeling so lost right now...She literally got in her car and came over. And it was the first time that I opened up to somebody who has been through what I was going through.

Facebook groups provided virtual communities to geographically dispersed partners, where users were able to meet, collaborate, create, and share knowledge around accessing supports and services. This platform also helped partners' access services and programs at their own desired pace, while still maintaining a degree of privacy.

The availability of 24-hour support lines was also identified as a helping factor during the seeking and accessing phase. Free and unlimited access to support lines provided reassurance to partners that when crises occurred, a reliable and accountable resource was available to them. Support lines were important during the seeking phase as they provided partners with additional information regarding their situation and assisted in directing partners in their next course of action. During the accessing phase, 24-hour help lines provided partners with a vital source of crisis support, facilitating and enhancing access and connecting them to longer-term resources.

Hindering CIs. The hindering category includes incidents where participants described the use of print media, internet, social media, cellular technology, mobile applications, and information hotlines as preventing or impeding their efforts in seeking mental health information, supports, and services. Incidents in this category included limited or low access to information, and gaps in resources and information specific to STS.

Low access to information due to limited social media use was identified as a barrier to seeking information, supports, and services. The following quote from Participant 13 illustrated the challenges faced in seeking professional resources amidst a larger landscape that increasingly relies on the use of social media for communicating information:

And I found it very, very challenging to find anything that wasn't...I found a lot of things like Facebook pages, I found, you know, these blog sessions and things that like, but that wasn't what I was looking for...And so, that was...you know, I'm not the type of person, and I never have been the type of person to be one of those that is active on social media all the time and things like that. I just don't because that's not who I am. And so I didn't find it useful.

The large quantity of context-relevant information shared via Facebook pages inadvertently excluded partners who were not active social media users from gaining access to important information as well as engaging in a potentially beneficial community of support. As a result, partners believed that they may have missed information that would have made the seeking phase easier and less-time consuming.

In cases where information pertaining specifically to STS was limited or entirely absent online or in print form, partners experienced increased frustration and discouragement with the level of support targeted toward their situation. This often meant that partners expended additional effort and time to locate information without improvements in or relief from their concerns and hardships.

WL items. The WL category includes incidents where participants wished for more widespread integration and application of internet, communication technology, and support hotlines in the mental health field to increase access to services. All incidents in this category pertained to the central theme of making supports and services more accommodating, flexible, accessible, and immediate through the integration and adaptation of media and communication technology. These incidents were cited as realistic means to acknowledging the unique circumstances, hardships, and stressors facing partners and to facilitate access. Partners' identified the need for: support groups to make better use of websites for communicating about schedules and programming; psychoeducational support via webinar format; military family support lines accessible to all geographical locales; and internet-based counselling. Partners

anticipated that all of these changes would improve access to care and reduce the level of psychological and physical burden experienced by partners. Participant 2 explained her desire for counsellors or therapists to provide Skype counselling:

So, right now, there's a system that provides the help but, ok, it could be improved if only I could see my psychologist through Skype. Oh my god. How easy it is. I don't have to leave. I don't have to plan. I don't have to reassure [my husband]. I don't have to make sure there's gas in the car. I just find a spot in my house where I can talk. Because we become so exhausted, so drained...we don't want to see people. We don't feel like getting dressed, putting on makeup, drive...waiting in the waiting room....faking...So this is very exhausting. Help must be provided through Skype, especially in those remote areas... I believe that massively being able to have a choice to have a Skype appointment...okay so maybe one week it would be easier to Skype but the week after it would be nice to take the car and to drive to you...and so there is always a matter of choice and respect of the situation.

By integrating media and communication technology, partners anticipated that initiating contact and fully engaging in supports and services would be easier, quicker, and more appealing. Furthermore, effective use of media and communication technology would eradicate the barriers facing geographically dispersed partners whom tend to have less supports and services at their disposal.

Category 6: Support from First-Contact Care

Table 10 shows the distribution of CIs and WL items pertaining to the category “Support from First-Contact Care” across the two core areas of seeking and accessing. This category had a total of 26 incidents, including 13 helping CIs, 13 hindering CIs, and no WL items.

Table 10

Support from First-Contact Care Critical Incidents and Wish List Items

	Helping Critical Incidents (N=13)			Hindering Critical Incidents (N=13)			Wish List Items (N=0)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%	<i>n</i>	
Seeking	6	38	8	6	38	7	0	0	
Accessing	5	32	5	4	25	6	0	0	

Helping CIs. The helping category includes incidents where participants cited their first contact with general practitioners, emergency departments, mental health specialists, crisis line workers, and community agencies as being helpful to them in seeking and accessing mental health information, supports, and services. Responsive, timely, and proactive support from first-contact care played a critical role in connecting partners with essential information and resources and relieving some of the administrative burden associated with seeking and accessing care. Incidents in this category included the responsiveness of first-contact care professionals, and the willingness of family doctors to provide referrals.

Partners' cited first-contact care professionals' responsiveness as an important facilitator to both seeking and accessing mental health information, services, and supports, particularly during the pre-referral stage of mental health service engagement. During the seeking phase, partners experienced relief and validation when first-contact professionals responded to their concerns with sensitivity, respect, understanding, and empathy. First-contact care professionals who were more attuned to partners' well-being were described as being more proactive about providing information that may be helpful in future situations or circumstances. In turn, partners' were more prepared to act quickly and efficiently when the time came to seek supports and services. Participant 5 described her first contact with an OSI coordinator, and how it better prepared her for the possibility that she may need to seek help in the future:

She spoke to us about...the stages of deployment, but also how it looks, and how the soldiers go through different stages of accepting their operational stress injury and Posttraumatic Stress Disorder. So they were able to give us the information, she sat there for a good hour and a half explaining her services to us. We were able to ask her questions and find out more information about it, and what it looked like, and stuff like that. It was the ability to just know that there was somebody backing you up, to help you get it, so you don't have to do all the work for yourself.

During the accessing phase, the expression of care and understanding imparted by first-contact care professionals contributed to partners' sense of comfort discussing their mental well-

being and the range of mental health services and supports available to them. Other partners received reassuring and validating comments from the veteran's mental health counsellors, therapists, or psychiatrists, which also motivated and prompted partners to obtain a referral to engage in their own personal counselling/therapy.

Partners' also cited family doctors' willingness to make referrals to ongoing mental health supports and services as an important facilitator during the phases of seeking and accessing. During the seeking phase, partners felt that their concerns were taken seriously when referrals and recommendations for ongoing mental health care were made in a timely manner. During the accessing phase, family physicians played a critical role in connecting partners with ongoing mental health services and supports. The following quote from Participant 13 illustrates how having a responsive, informed doctor expedites the process of accessing services:

My family doctor is very aware, and I think that's something really important, to bring your family doctor into these situations. And she's been fantastic and so she understands...you know, sometimes when I'm feeling a little bit off, sometimes I just go have a chat with her...And you know I can get very specific with her to say "This is what I'm going through right now, do you know anybody that kind of deals with that area?"...and she was very helpful in providing me the names of a couple of people that were very helpful.

The willingness of family doctors to make referrals for ongoing mental health care legitimized partners' concerns and challenges. Furthermore, family doctors were credited with providing partners information and a direct entryway into supports and services that they may not be able to access otherwise.

Hindering CIs. The hindering category includes incidents where participants cited their first contact with general practitioners, emergency departments, mental health specialists, crisis line workers, and community agencies as preventing or impeding their efforts to seek and access

mental health information, supports, and services. Incidents in this category included physicians' lack of responsiveness, and issues pertaining to receiving appropriate and relevant referrals.

Partners' cited physicians' uncaring, dismissive, or uninformed responses as a hindering factor in seeking and accessing mental health information, supports, and services. During the seeking and accessing phase, partners' described the harmful effect of undermining, irrelevant, or unproductive responses from physicians. Participant 9 recalled a time when she presented to the emergency unit at her local hospital expressing suicidal ideation and the invalidating response she received from an on-call doctor:

And the doctor who...the first doctor I met was a young doctor. And he told me, in the ER, in the observation room because of course, I told them I was suicidal, they put me in the observation room, the first doctor who saw me said "every marriage goes through a hard time, and I should..." in essence, he said I should suck it up. And I said "you should probably not be in this room with me right now", and he was quite fine with that. Being the middle of the night, the psychiatrist on staff didn't get in until 7 or 8. So he understood, I had told him, and he said "I know what we can do to help you".

Inappropriate or insensitive responses from physicians had the effect of delegitimizing partners' concerns, hardships, and distress. As a result, partners' felt belittled, diminished, abandoned, and ignored, making it more difficult for partners to believe they were deserving of support and access to services. Consequently, the challenging process of seeking and accessing was exacerbated by first-contact care unresponsiveness.

Partners' also reported that the process of seeking and accessing mental health information, supports, and services was challenged by family doctors who were either unwilling to provide or unaware of the need for a referral to ongoing mental health services and supports. Because referrals are required to obtain eligible health benefits and insurance coverage, family doctors remain an important gateway to partners' obtaining professional psychological services. Furthermore, physicians were the only entry point into ongoing, insurer-covered mental health

care for some partners. Thus, when physicians did not provide a referral, partners were halted in their process of accessing the vital care they needed. The following excerpt from Participant 7 illustrated the mechanism by which a first-contact care professional's unawareness of the need to provide a referral to mental health services hindered her ability to access care:

I did see my general physician about this probably about...6 years ago. She just kinda said "well, do better self care". That was her response. Which was, you know, exercise, yoga, meditation, that kind of stuff. But she said, you know "give it 6 months, come back and see me". I was so frustrated with her response to me that I never went back for that situation. I felt that [my mental health] wasn't important, to tell you the truth. When somebody says "oh just exercise more, try to meditate, try this then you'll be fine".

Inappropriate or ineffective referrals also made seeking and accessing care more difficult. Partners' frustration and hopelessness around addressing their urgent concerns escalated in cases where referrals were made to services with lengthy waitlists but no interim support was recommended or identified. Furthermore, partners' distress and frustration increased in cases where referrals were secured, but the consulting practitioner did not have the appropriate training to address partners' concerns. These incidents either deterred, delayed, or impeded partners' efforts to access critical sources of support.

Category 7: Health Care System Management

Table 11 provides a breakdown of the findings pertaining to the category "Health Care System Management" across all three core areas of seeking, accessing, and utilizing. This category had a total of 87 incidents, including 20 helping CIs, 41 hindering CIs, and 26 WL items.

Table 11
Health Care System Management Critical Incidents and Wish List Items

	Helping Critical Incidents (N=20)			Hindering Critical Incidents (N=41)			Wish List Items (N=26)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Seeking	4	25	7	9	56	13	5	32	6
Accessing	7	44	9	10	63	18	9	56	13
Utilizing	4	25	4	8	50	10	6	38	7

Helping CIs. The helping category includes incidents where participants described the administration, case management, and coordination of benefits, processes, and pathways to care (private, public, and/or military) as being helpful to them in searching for mental health information, supports, and services. Incidents in this category pertained to the benefits of quality and continuity in VAC case management practices.

Partners indicated that caring, reliable, efficient, and proactive VAC case management facilitated their efforts in seeking, accessing, and utilizing mental health information, supports, and services. During the seeking phase, partners' efforts were facilitated by VAC caseworkers who expressed concern for partners' situations, were knowledgeable about navigating the complexities of military and VAC systems, and were forthcoming about information specific to partners' situations. In the following quote, Participant 9 described how having an informed and accountable caseworker reduced her stress and expedited the process of her finding the most relevant, appropriate resources:

The case worker that we have now at Veteran's Affairs really grasped his responsibilities ...I know that I can always say to him "hey, this is what's going on, what are my options" and he has a very good grasp of what the options are and what might benefit. Sometimes I don't know what question to ask, or what I'm looking for, I just know I'm looking for something, and he's able to look in his tool box and say "Ah, I think this might be of benefit, bet you didn't know that one" and I'm like "Oh, I didn't even think of that, I'm glad I asked". So, what helps for us is having a knowledgeable person to work with us to

navigate a very massive complex system. He knows what's available and he knows the language to use in order to seek it out.

During the accessing phase, caseworkers were effective in establishing supportive relationships with partners by conveying care and concern, by using their knowledge of the system to connect partners with care, and by remaining accountable to their word and the expectations of their professional role. In some cases, the timeliness by which caseworkers gained approvals for coverage and direct billing were critical to partners' accessing care. During the utilizing phase, a relatively seamless and prompt counselling/therapy approval process through VAC meant that partners experienced timely continuation of services, resulting in limited or no setbacks in working towards their mental health goals. Effective case management practices demonstrated by caseworkers reduced the psychological and administrative demands placed on partners. As a result, partners were able to devote more energy and time to their own needs and concerns, and felt better prepared to seek and access information, supports, and services.

Hindering CIs. The hindering category includes incidents where the administration, case management, and coordination of benefits, processes, and pathways to care (private, public, and/or military) prevented or impeded participants in seeking, accessing, and utilizing mental health information, supports, and services. Examples include the increased complexity and reduced navigability of intersecting military-related and mental health systems (private or public); and ineffective, inefficient, and/or unresponsive case management (VAC or public system); and loss or inconsistent provision of supports and services.

Partners indicated that their efforts to seek, access, and utilize mental health information, supports, and services were hindered by the complexity and limited navigability of an overburdened, intersecting military- and mental health-related system. Such complexity and

reduced navigability often resulted in partners' being passed back and forth between agencies or services without answers or assistance. In the following excerpt, Participant 11 recalled the frustration associated with being passed back and forth between services and the additional time it takes to identify appropriate service and supports to meet her and her family's needs:

Once we had gotten to that stage of like "Ok, I do need help" it was like...I found it initially kind of hard to navigate the government websites and figuring out who to contact and based on where we live, where we'd go, and that kind of stuff. I had to call around a lot. I had to call different offices and sort of figure out where he belonged in the Veteran's Affairs system. So, I could see that being pretty deterring for other people...So initially, I thought he had to go to [the Operational Stress Injury clinic] , because that made the most sense. But then talking to them, they were like "Well no, it sounds like he should actually be with Veteran's Affairs, and go on the rehabilitation program" and things like that. So it was a lot of phoning around to the family resource center, these OSI clinics, to actually get to the point where "No, you need to register with Veteran's Affairs".

In some cases where approvals were obtained or the use of private benefits were an option for partners, access was further delayed by lengthy waitlists. In cases where no interim support was available while waiting for approvals or intake with providers, partners' distress continued to build and concerns escalated. When referrals and/or recommendations to access services through community agencies lacked coordination or relevance to partners, making contact with a mental health provider was further delayed. Therefore, the complexity and process inefficiencies of an overburdened system slowed or inhibited partners' progress in seeking, accessing, and utilizing, as important questions were often unanswered and transitions from one agency or service to the next were often fragmented or misdirected.

Partners also cited ineffective and unresponsive VAC case management practices as a hindering factor in seeking, accessing, and utilizing phases. Ineffective case management practices, such as underperformance, misinformation, and failures to return calls or follow through on administrative responsibilities, as well as high turnover among case managers,

precluded timely access to appropriate information, supports, and services. Specifically during the accessing phase, excessive delays in, denials of, or complications with obtaining counselling/therapy authorization postponed access to services because engaging with a provider depended on VAC approval. Participant 16 described the complex and lengthy procedure of obtaining approval from VAC to access services, as well as the inherent barriers that compound an already challenging process:

My husband is the first point of contact...Then its his access to his case manager, which she's not his only case manager, and she's got holidays, she's got conferences, she's got work hours... so once you finally get in contact with the person, and you have to put in a written approval or a reason why you're accessing care and asking for it be paid for by DVA, it then has to be proved to be a direct result of my husbands approved military disability awarded injury, which is his PTSD...so once you get that process in place, that takes time...And then when that comes back you finally have approval in place, then you wait for her to give you a list of approved providers, and we waited I think the entire length of time from the time I first made contact, I first needed help, to the time I actually got a list, it was six and a half months. And that list did not result in care. Every single person on that list was not successful. So, if you look at the total time from when I needed care to when I finally got myself into services...it took me nine months.

In cases where a limited number of counselling sessions were approved by VAC, partners' questioned whether their concerns would be resolved in such a brief amount of time and casted doubt about the value of accessing services. The needs and preferences of partners went unmet for longer periods of time because of ineffective and unresponsive case management practices during the seeking and accessing phase, leading to frustration, distrust, and dissatisfaction among partners. These incidents exacerbated stress levels among partners as the need to follow up, backtrack, and pursue alternatives demanded even greater attention than what had already been devoted to coping with and managing the effects of PTSD on their family. During the utilizing phase, partners who cited complications, delays, or confusions with securing additional approvals for counselling/therapy under VACs' policies endured interruptions in

ongoing service utilization. As a result, partners described feeling as though the progress they had made up until present time was threatened, halted, or negated.

Partners also indicated that the loss and/or inconsistent provision of supports and services hindered access and utilization. During the accessing phase, the abrupt cancellation of military benefits following military release, coupled with subsequent delays in registration with VAC benefits, left partners without any form of coverage for professional services. During the utilization phase, partners who experienced an unexpected discontinuation in services reported that often no justification or explanation was provided and no alternative or interim supports were recommended. Participant 9 discussed how an abrupt discontinuation of her local spousal support group not only eliminated her ability to continue engaging in services but also signaled a sudden loss of invaluable support:

[The spousal group] ran its term, so it would have took hiatus over the summer then started up again in like, September. And it just didn't start up again...So that was difficult, and that lack of communication to say "Hey, we're not starting the group because of funding or time". But just to hear nothing, to hear crickets...was...not beneficial...You build a connection with 10...12 other humans who share the same burdens...you've heard everybody's worst moment. And shared it. And then now that's gone, and you're like "I don't know if I can even share my worst moment and not be judged".

The abrupt termination of services due to funding or military to civilian transition left partners without a reliable, regular source of support. Furthermore, partners who experienced a relocation prompted by the veteran's release from the military indicated that there were inconsistencies in service provision between regions and provinces. For these partners, supports and services that were accessible, reliable, and befitting of their needs in the previous posting were nonexistent in their new locale, representing an imposed loss of support and stability.

WL items. The WL category includes incidents where participants wished for improved administration, case management, and coordination of benefits, processes, and pathways

(private, public, and/or military). WL items in this category included the need for better case management practices and the desire for better integration, coordination, and funding of military and mental health-related systems.

The need for improved case management practices was expressed across all three stages of seeking, accessing, and utilizing. Partners wished for a caseworker designated solely to partners, increased case manager decision-making power, and long-term provision of case management services. The desire for a VAC caseworker or system navigator designated specifically to partners and/or family members would facilitate efficiency, effectiveness, and collaboration among mental health professionals and services, creating a smoother process for seeking and accessing mental health providers. Furthermore, the ability of VAC caseworkers to bypass hierarchies and expedite approval processes would ensure timely access to services for partners and families in severe situations or crisis and ensure that partners' needs are met. Many partners also expressed the need for a case manager after the time in which the veteran is considered fully rehabilitated. Participant 11 indicated that the case management system needs to reflect the lifelong reality of service-related PTSD:

In the future if he's not on rehab, you don't have a case manager after that. Just like an ongoing check-in to make sure things hadn't...because obviously once he is off rehabilitation, they will consider him rehabilitated. But, you know, PTSD is probably a life-long thing that he's going to deal with. So perhaps having a case manager that continues to check-in even once a year? You know, just to make sure that things are still ok?...But just someone to...to sort of keep an eye on us...if VA completely drops his case, to have to go through that process again...I mean it was a pretty big process to go through, and it took a long time. From the time that we started requesting services to the time we actually got services was a long time.

Access to a case manager at this juncture would prevent or reduce delays in addressing future or recurring concerns related to PTSD and its impact on the family. Partners also anticipated that faster and more efficient approval processes in general would substantially reduce or altogether eliminate delays or interruptions in the utilizing phase. As such, the progress

gained by partners in counselling/therapy up to this time would be unaffected and future sessions would be used to advance one's goals rather than be used to restore previously attained levels of progress.

The need for better coordination, integration, and funding of intersecting military- and mental-health related systems was also indicated at all three stages of seeking, accessing, and utilizing. Improved health care system management was thought to be possible only through the coordination and integration of all relevant stakeholders involved in the family's care. Partners projected that improved coordination of care would restore trust and satisfaction in the overall health system, and prevent family crises, suicidal behaviour, and chronic mental health concerns from developing among family members of the veteran. Partners also expressed the need for additional funding allocated specifically to sustaining and operating partner-specific services. With increased financial provisions, partners expected that funding-induced interruptions in vital sources of support would decrease, that partners would benefit from greater consistency in seeking, accessing, and utilizing services and supports across regions and provinces, and that services and supports would be subjected to more research and evaluation to improve delivery and outcomes. Partners anticipated that the establishment of best practices and the evaluation of outcomes would lead to the development of standards and benchmarks specifically designed for partners and their families. With these alterations, partners would have greater confidence in the mental health system, experience less distress and feel more valued, and be able to focus their efforts on addressing their mental health concerns rather than coping with system inefficiencies or barriers. Furthermore, these changes would make services and supports more reliable, effective, enduring, and tenable, and in turn, would facilitate seeking, accessing, and utilizing among partners.

Category 8: Service Characteristics

Table 12 shows the distribution of CIs and WL items pertaining to the category “Service Characteristics” across the two core areas of accessing and utilizing. This category had a total of 60 incidents, including 33 helping CIs, 22 hindering CIs, and 5 WL items.

Table 12

Service Characteristics Critical Incidents and Wish List Items

	Helping Critical Incidents (N=33)			Hindering Critical Incidents (N=22)			Wish List Items (N=5)		
	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents	Participants (N=16)		Inci-dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Accessing	7	44	12	10	63	13	4	25	5
Utilizing	8	50	21	5	32	9	0	0	0

Helping CIs. The helping category includes incidents where participants described key features and qualities of service delivery, including scheduling, flexibility, program promotion, location and atmosphere, and privacy and confidentiality, as helping them to access and utilize mental health supports and services. Service characteristics played an instrumental role in facilitating access to care by appealing to or meeting partners’ unique needs, challenges, and/or circumstances. Incidents in this category included: partners’ having a greater autonomy and decision-making power; relatable and safe service climates; flexibility and convenience of service provision; and the option of engaging in equine therapeutic modalities.

Partners’ cited that having an array of choices in terms of topic and format facilitated accessing and utilizing mental health supports and services. During the accessing phase, services that covered diverse topics, from caregiver burden to suicide intervention, allowed partners to select resources, workshops, and supports that met their individual needs, goals, and preferences. During the utilizing phase, the option to choose among a variety of counselling formats, such as individual, couple, group, or family, provided partners with a sense of ownership over their

personal healing and development. Furthermore, the freedom to make choices conveyed to partners that services and program developers sought to satisfy their individual needs and preferences.

Positive, relatable, and confidential service atmospheres were also cited as a facilitator to access and utilization. During the accessing phase, service providers that intentionally used civilian-like language in service promotion conveyed to partners that they aspired to connect with non-serving family members. Participant 3 described how her local MFRC's use of more accessible, civilian language made their services more relatable, thereby making it easier for her to initiate contact:

They started a Facebook page, they hired a civilian to run the Facebook page, and suddenly I started paying attention to what they were saying. Because they were talking to me – in my language! Not military language that I don't understand. I mean, you understand it, but it doesn't seem like it's for you. It seems like it's for military members... So, it's the way they're saying it, really. Because you could take the exact words that they are saying... and a military-issued version of that... wouldn't appeal to me in the least. I'd be like "ughhh"... And I definitely don't dislike the military at all, don't get me wrong. But I definitely relate better to the civilian language.

Services were perceived as safe when partners were assured of confidentiality in accessing counselling or therapy services. Services that were delivered within a larger community wellness centre or independent of base proper assured partners that their reasons for accessing the physical building would not be known by others in the military community, thereby increasing confidentiality and reducing the apprehension associated with making contact. During the utilizing phase, partners also expressed the importance of a welcoming, warm service climate. In cases where reception and waiting room areas conveyed values of reassurance, optimism, and interconnectedness, partners felt more comfortable and appreciated, and their desire to return to these services increased.

Flexibility and/or convenience of service provision also facilitated partners' access and utilization. During the accessing phase, the provision of extended evenings and/or weekend service hours offered necessary flexibility to those with full-time employment or dependent children at home. Services located within close proximity to partners' residences were perceived as more convenient and practical because of reduced travel time. During the utilization phase, flexibility with respect to the timing, quantity, and frequency of counselling sessions allowed partners to tailor their ongoing engagement with mental health services and supports according to their individual needs, circumstances, and preferences. Among partners whom experienced geographical barriers to ongoing service engagement, the provision of mobile counselling sessions made it possible for partners to engage in regular and reliable counselling/therapy.

The opportunity to engage with equine therapy, an alternative or complementary form of support, facilitated partners' mental health service utilization. Participant 14 explained how connecting with horses in a non-threatening environment allowed her to become vulnerable and experience difficult emotions:

I would say with those horses, you have no other option but to be present in that moment. A horse...like they are never behind in the past, they are never in the future, they're kind of right in the moment...[There was] a horse named Dakota, who is blind in one eye, right? So right away, with him, he was definitely a horse that resonated with me because I felt that, although I could see his injury, you know, I couldn't really see my own? Like people can't really see what I'm feeling, but I felt like I could understand him because it would take him a little bit of time to trust you, because he's only seeing in one eye...I looked at him and just the way he would approach, and then he would get soft with me, and put his head on my shoulder, and just allow himself to be vulnerable...it allowed me to share...and to talk about some things...I will always turn my face away, or I will walk away before I let anybody ever see me cry. But there it just...it just happens. And you just pet that horse, and you love that horse, and you're bawling. I think it gave us the opportunity to be a couple...the both of us worked together as a team and kind of came back together as how we started...so it was like relearning that again.

Equine therapy provided an environment whereby partners and veterans could process difficult emotions individually and together, and learn new ways of communicating their feelings

and challenges with one another and with others participating in equine therapy. This element of equine therapy was particularly appealing, as many partners reported changes in their marital relationships related to the impact of PTSD on communication and emotional expression. Furthermore, partners expressed that the progress made through equine therapy either prepared them for or helped them to engage in more traditional forms of individual and couples counselling/therapy.

Hindering CIs. The hindering category includes incidents where participants described key features and qualities of service delivery, including scheduling, flexibility, program promotion, location and atmosphere, privacy and confidentiality, and fee structures, as preventing or impeding their efforts to access and utilize mental health supports or services. Partners offered several important reflections about specific service characteristics that obstructed access to and ongoing utilization of services and supports. Incidents in this category pertained exclusively to issues regarding flexibility and convenience of service provision.

A lack of or limited service flexibility and/or convenience pertaining to mental health providers, service fees, and geographical location hindered partners' access and utilization. During the accessing phase, some partners experienced limited or no flexibility in their assigned provider or fee-for-service structures. In cases where the cost of services exceeded family financial resources, partners' were unable to access care until a more affordable or subsidized alternative was found. Furthermore, substantial geographical distance between partners' residences and service locations was considered impractical or unfeasible given the added costs associated with time away from work and/or childcare. In other cases, services were available in partners' immediate locale but could not accommodate the demand for evening or weekend appointments. Additionally, some services that were both affordable and targeted for military

partners and their families were not equipped or designed to address longer-term, more complex issues or concerns related to the impact of PTSD. During the utilization phase, limited flexibility in service timing, quantity, and cancellation policies were particularly profound. In the following quote, Participant 2 discussed how one hour of counselling per week was not sufficient to address the extent of her concerns:

Once you sit down and get to what is really happening, you don't have enough time... You know a lot can happen in a week. I am dealing with my own wounds and somebody else's wounds, and an entire family. So let's be generous – an hour and 15 minutes. Um...it's impossible to even address...let's say that you've been through one situation in your week...once you have discussed it yes, but you haven't discussed the 6 other days, the children, your guilt towards your own children, the fact that you were invited to your friends house...there are so many aspects that are impacted, the social life, the family life, the way you see yourself, the way you react, the way you see your husband, the way you deal with what your husband brings you...how can an hour a week be enough? And you could say, what about 2 hours every 2 weeks? Well, we end up at the same place.

Limited flexibility and convenience diminished partners' confidence in the long-term benefits of counselling/therapy, increased partners' role-related stress, and conveyed to partners that their individual needs and preferences were not the main priority in service design. Some partners felt that services that imposed penalties for missed appointments or late cancellations failed to acknowledge, understand, and empathize with the daily reality, uncertainties, and unpredictability endured by partners. While partners recognized the rationale behind such penalties, these services became less realistic and more stressful for partners to continue using, especially during periods of heightened tension and unpredictability.

WL items. The WL category includes incidents where participants expressed the need for specific qualities or features to be integrated into service delivery in order to facilitate future access to mental health supports and services. The suggestions provided by partners focused particularly on making services and supports more flexible, accommodating, and relevant.

Examples include the need for the mental health community to value and offer alternatives to talk therapy/counselling; the option for consumers to choose male or female therapists/counsellors; military-related mental health services to be more civilian-like; and mental health professionals to provide more evening and weekend appointments. Participant 2 discussed the value of recognizing alternatives to talk therapy:

Psychological help is not the only help in regard of mental health. It would be nice to have a variety of mental health resources – art therapy, for instance. Yoga. As much as I understand that you don't deal with your emotions, at some point, before you are ready to accept that help, I should be able to be aware of the fact that a psychologist is an excellent resource for instance but it's not the only place where I can [experience] mental benefits. So, there is a stigma sort of that therapy is the only way...To have a variety of services – not only psychological. Art therapy, equine therapy. It has to be....my wish is that it is adaptable and that I have a choice that is relevant to who I am and where I am at in the process. One solution does not fit all.

Partners expressed the need for the mental health community to embrace a diversity of approaches to mental health, well-being, and personal functioning beyond talk therapy.

Furthermore, partners stated their desire for service providers and community agencies to use civilian-like language to promote and deliver their services. Partners also indicated the need for flexibility with respect to selecting mental health providers and scheduling appointments. By offering more tailored, flexible, and balanced services, partners individual needs, preferences, and circumstances would be recognized and honoured. Furthermore, partners anticipated that they would be more confident in their decisions to initiate contact with and invest their time in specific services and/or mental health providers.

Category 9: Institutional Accountability and Transparency

Table 13 provides a breakdown of the findings pertaining to the category “Institutional Accountability and Transparency” across the two core areas of seeking and accessing. This

category had a total of 36 incidents, including no helping CIs, 20 hindering CIs, and 16 WL items.

Table 13

Institutional Accountability and Transparency Critical Incidents and Wish List Items

	Helping Critical Incidents (N=0)			Hindering Critical Incidents (N=20)			Wish List Items (N=16)		
	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%	<i>n</i>	
Seeking	0	0	0	10	63	13	12	75	16
Accessing	0	0	0	5	32	7	0	0	0

Hindering CIs. The hindering category includes incidents where participants described the failure of military-related institutions' (and leadership within it) to prioritize the welfare of and provide critical information to military families as preventing or impeding their efforts in seeking and accessing mental health information, supports, and services. Compromised institutional accountability and transparency pertained to two types of incidents: those related to information provision, and those related to institutional actions/inactions.

Partners indicated that military-related institutions' failed to present information that was relevant, accessible, timely, and accurate, and as result, stages of seeking and accessing were hindered. During the seeking phase, partners' efforts were thwarted by military-related institutions' withholding or not disclosing relevant information, and failure to provide complete, updated, clear, and/or accurate information regarding mental health supports and providers. Participant 9 likened the challenges associated with trying to elicit information from VAC on benefits, resources, and supports to that of playing a mind-game:

VA seems to have a policy of only giving people things they ask for...But they won't tell you "Hey, you know what you could access? We have this whole program on X"...But unless you knew to ask for X, and in the right way to ask, it's like a game...It's emotionally and intellectually draining...So you've got someone who's probably already suffering some caregiver fatigue, they're emotionally drained, they're

probably not taking care of themselves to the best of their ability... They probably don't know all the things. And then you're going to throw another road block at them? It's exhausting. How do you fight the government when the government is not accountable! I truly feel they hope you go away. I think it's easier for them if you go away. And I think they justify it to themselves, they say "Oh the people who go away don't really need it. The people who really need it will eventually find a way to access the services."

Incomplete or withheld access to entitled or relevant information contributed to feelings of distrust, disillusionment, and betrayal among partners. Aside from the psychological and emotional impact of issues with institutional accountability and transparency, partners were either delayed or inhibited from connecting with resources and supports that would have been beneficial to them if provided.

With respect to institutional actions/inactions, partners cited the failure of military-related institutions to fulfill their role of supporting, caring, and providing critical resources to partners and their families as hindering the stages of seeking and accessing. Examples included failure to follow through with providing mental health information, supports, and benefits to which members and families were entitled; delay of support/services until crisis situations developed; and excessive adherence to rules and formalities. For some partners, issues related to accountability were perceived as both unintentional and an unfortunate outcome of an overburdened system. For other partners, these incidents were perceived as intentional and were often attributed to the bureaucratic, political, and economic pressures governing the military and VAC. Inadequate or failed responses to partners' requests and inquiries contributed to the perception that the institution was abandoning their family, indifferent toward their concerns, or eschewing their responsibility for the systemic impact of service-related PTSD. Instances of compromised institutional accountability led partners to question the true mandate and priorities of military-related institutions and, more broadly, the Canadian government. Participant 9

discussed her attempts to obtain assistance from VAC, while her husband entered a 60-day inpatient treatment and she worked full-time in addition to being sole caregiver to her two children:

I phoned them...because I was exhausted, I was totally frazzled, I wasn't coping well, in addition to being like the only parent, and having a full-time job, I'm like "I need help. Like I don't know what to do, I need..."...They have those caregiver relief programs. I was a caregiver, and I needed relief, but I don't qualify because the people I needed relief from were 5 and 8. And when I needed help, they were like "well you can go to legion". So I went to the legion, and they're like "We don't know what to do with you... everybody we help is like old, and they need some money to help them pay their hydro bill"...I'm tired and I'm frazzled and I'm...depressed, and I'm anxious, and I'm just done. It's so demoralizing and demeaning. It's just like kicking a puppy when it's down. It's so detrimental to mental health. I don't want a handout, I want a hand.

Partners expressed the general perception that military-related institutions, particularly VAC, often suggested services and supports to partners that were either irrelevant to or belittling of their reality. In some cases where approved and/or universally guaranteed supports and services failed to materialize, partners' sense of trust and reliance on government-sanctioned programs and services was diminished. Additionally, some partners recounted the experience of services and programs responding or materializing only when life-threatening situations emerged, resulting in partners feeling angry and resentful. In other cases, the tendency for military-related institutions to maintain excessive adherence to rules, hierarchies, and formalities without consideration for the urgency or severity of the partners' situations only exacerbated their distress and sense of abandonment.

WL items. The WL category includes incidents where participants wished that military-related institutions' (and leadership within it) gave, or would give, greater priority to the welfare of military families and the provision of information. WL items described under this category were pertinent only to the seeking phase of mental health service engagement.

Partners expressed the desire for improved institutional accountability and transparency directly related to the provision of information. Examples include the desire for VAC to make critical information more readily available and visible, and the need for military-related institutions to provide more complete, updated, clear, and/or accurate information regarding mental health supports and providers. The following excerpt from Participant 11 highlighted the projected helpfulness of increased transparency for seeking information, supports, and services:

[It would be helpful] for Veteran’s Affairs to be more transparent about the support that they could provide. Because there were so many things that they do provide that I had no idea, and you cannot find on the website or anywhere. So, people might be looking for a specific support or service, but because it’s not listed, they might not even reach out to VA...It would have helped me to know where to go...it would have made it easier for me to convince my husband to go, to say “hey look, they offer these services, so obviously there’s other people like you who have had this support and need this support”.

Partners expressed the need for complete and comprehensive disclosure of all relevant information through accessible means, thereby connecting families with the most effective, tailored, and relevant supports for their situation. Partners also expressed the desire for the institution to be more forthcoming and voluntary in providing essential information to partners, thereby reducing or eliminating the frustration, stress, and time-consuming nature of making multiple inquiries or requests without adequate answers. With these changes in place, partners believed that their concerns would feel acknowledged and that their welfare would be a priority. Additionally, the institution would be perceived as rightfully assuming responsibility for the systemic impact of service-related trauma, and honouring their pledge to support and care for military families.

Category 10: Cultural and Organizational Influences

Table 14 shows the distribution of CIs and WL items pertaining to the category “Cultural and Organizational Influences” across all three core areas of seeking, accessing, and utilizing.

This category had a total of 40 incidents, including no helping CIs, 35 hindering CIs, and 5 WL items.

Table 14

Cultural and Organizational Influences Critical Incidents and Wish List Items

	Helping Critical Incidents (N=0)			Hindering Critical Incidents (N=35)			Wish List Items (N=5)		
	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%	<i>n</i>	
Seeking	0	0	0	12	75	24	0	0	0
Accessing	0	0	0	6	38	11	0	0	0
Utilizing	0	0	0	0	0	0	4	25	5

Hindering CIs. The hindering category includes incidents where participants described the culture, values, hierarchy, roles, expectations, and policies of military-related institutions (and its members) as preventing or impeding seeking and accessing mental health information, supports, and services. Cultural and organizational influences, although directly tied to the veteran and his or her career, served as powerful inhibitors and deterrents to partners' seeking and accessing services and supports. Incidents in this category pertained to the potential for career-related repercussions and exclusionary VAC policies.

Partners indicated that their efforts to seek and access mental health services and supports were hindered by the perceived (or real) threat of repercussions to the veterans' career. During both the seeking and accessing phase, potential repercussions to disclosing PTSD or accessing services included discharge or demotion, reprimands from chain of command, and accusations of malingering. In the following excerpt, Participant 3 discussed how the risk of reprimand prevented her from accessing information, supports, and resources:

Spouses are afraid to even help their ill or injured spouses get help because they are afraid that they will lose their job. Just like I was in the beginning. I didn't know, if I had certain questions – some things just seemed outrageous to me and I was upset – I'd be like "who do I talk to about this" and he'd be like "don't freak out, I don't want to..."

there's going to be reprimand for me... officially or not, but even if they just know that it was my spouse that said anything, it's going to be a silent issue for me at work, right."...his fear of them moves to me, I was afraid to ask in case I would get him in trouble.

Although veterans directly experienced the perceived or real threat of repercussions to military careers if their PTSD was disclosed, this fear ultimately spread to partners and prompted them to remain silent about their concerns so as not to jeopardize the veteran's career or status. Consequently, these incidents inhibited, delayed, or suppressed partners efforts to seek information, supports, and services, despite the clear need to obtain support. Similarly, the fears associated with career repercussions, and the partners' motivation to protect the veteran from PTSD-related stigma or discrimination, prevented partners from initiating contact with programs, services, and mental health providers despite awareness that formal help existed.

Partners also indicated that their efforts to seek mental health information, supports, and services were hindered by specific VAC policies that afford decision-making power solely to the veteran. Participant 13 described a situation wherein she called VAC seeking information on supports available to her and was informed that she did not yet have permission to request support:

I said "Look, I need to, you know, I would like to speak to somebody. And I don't want to speak to..." my husband was seeing somebody at the time and I said "I want to speak to somebody whose not treating my husband", right? Because it's a conflict of interest and all that. And they said "well, you have to get your husband's permission. We have to get your husband's permission for you to seek help through us"...I was furious. To me this was again, this was a part of the...there has to be a Chain of Command and control. But through the department of Veteran's Affairs, it seems apparent that even though you're the spouse of a veteran, that you are not permitted to access those services without explicit permission from your spouse.

Partners described this VAC policy as exclusionary in that it prevented them from initiating contact, requesting and receiving support, or making decisions about their care unless the veteran member granted partners' permission to do so. As such, this policy dictated the

means by which partners could seek approval for counselling/therapy and obtain coverage, and in some cases, delayed or completely halted their efforts to connect with critical sources of support. This policy and its associated outcomes were interpreted as the expression of deeply embedded values of power hierarchies, order, roles, and expectations about the subordinate status of military partners. Consequently, partners felt as though their rights and needs were either minimized or completely disregarded.

WL items. The WL category includes incidents where participants expressed the need or wish for specific values, practices, and policies to be adopted by military-related institutions (and its members) in order to facilitate mental health service utilization. Partners identified the need for military-related organizations to engage in specific actions and decisions that would, in turn, make their values consistent with their promise to care for military families. WL items included the need for alternatives to talk therapy and the need for changes to VAC policies.

Partners believed that military-related organizations need to adopt a culture in which alternatives to talk therapy are valued and recognized as effective and, in some cases, more culturally relevant and compatible options for veterans' and their partners. For example, Participant 8 expressed the need for military-related institutions to recognize equine therapy as a valid modality for treating PTSD and its effects on the family:

Equine therapy is not a recognized therapy that the VAC has in their grid, right? But, you know, the world is evolving. And the world of PTSD is evolving, right? So, sometimes you've got to look outside the box, its not all about talk therapy...we tried the conventional couples counselling, and it didn't work for us, right?...So I just think that it would be helpful to the families, because again its going back to basics...equine therapy for families, to me, would almost be a much better process then to do it prior to or before the talk therapy, and then do the talk therapy. Because then, you know, you're opening up those lines of communication to lead into...you need to lay a foundation, and if you don't lay a good foundation, you can do all the therapy you want, but you're doing them in silos, right? The kids are in therapy, the wife's in therapy, the veterans in therapy. When does that all come together? It never comes together...Whereas when you, you know, when you have something that's more communication based...[now] he'll look at me and

be like “I scared away the horses” and I’m like “yep” and he’s like “and the horses aren’t ready to come back” and I’m like “nope”. Which just means that his behaviour has impacted the kids and I, and we need time to work through it.

If alternatives to talk therapy were sanctioned by DND and VAC, partners anticipated that military families would have the choice of engaging in services that were compatible with their unique needs and preferences, thereby increasing retention and improving treatment outcomes. Other partners suggested that alternatives to talk therapy, such as equine assisted modalities, can help veterans and their partners gain greater comfort with communication, vulnerability, and distress, and could provide a viable segue into talk therapy.

Partners also identified the need for an official policy whereby veterans’ permission is not required in order for partners to make decisions about their mental health care and the well-being of their family. A policy that affords greater decision-making power to partners over their well-being would provide a direct pathway between partners, VAC, and mental health service providers. Furthermore, a policy as such would recognize and uphold the fundamental rights and autonomy of partners. Additionally, in situations where the veteran is unable or reluctant to provide permission, a policy such as that noted above would allow partners to engage and continue engaging in critical services.

Category 11: Family-Centred Care

Table 15 provides a breakdown of the findings pertaining to the category “Family-Centred Care” across the core areas of seeking, accessing, and utilizing. This category had a total of 52 incidents, including no helping CIs, 25 hindering CIs, and 27 WL items.

Table 15
Family-Centred Care Critical Incidents and Wish List Items

	Helping Critical Incidents (N=0)			Hindering Critical Incidents (N=25)			Wish List Items (N=27)		
	Participants (N=16)		Incidents	Participants (N=16)		Incidents	Participants (N=16)		Incidents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%	<i>n</i>	
Seeking	0	0	0	6	38	13	10	63	14
Accessing	0	0	0	5	32	8	5	32	5
Utilizing	0	0	0	4	25	4	4	25	8

Hindering CIs. The hindering category includes incidents where participants described a lack of acknowledgement, inclusion, understanding, and support from the broader mental health system (private, public, and military-related) as preventing or impeding their efforts to seek, access, and utilize mental health information, supports, and services. Incidents within this category can be broken down into two themes: disregard for and dismissal of partners' needs and concerns, and a system-wide lack of preparedness in responding to families affected by service-related PTSD.

Partners described the tendency for the broader mental health-related system to dismiss and disregard their needs and concerns as interfering with their mental health service engagement at all three junctures of seeking, accessing, and utilization. During the seeking and accessing phase, the discrepancy between the information, supports, and services that existed and the reality of partners' lives bore the message that the critical role partners assume, and its corresponding hardships, were viewed as secondary to the veterans' recovery or were altogether invisible to society. Participant 2 recounted the sense of abandonment and uncertainty she lived with because the needs, daily challenges, and critical role of partners failed to be recognized by the larger systems of care:

Just, how do I address three, four nightmares a night when I have to go to work the next morning? How do I wake him up, how do I reassure him, how do I convince him to talk

about it to a psychologist? My dignity was taken away and it's not because of my husband. My husband was a victim. He was sent to war, he did his job, he was abandoned himself by the system, by the military, and then by Veterans Affairs... So you abandon my husband, you abandon his family. So that means that you close your eyes on all the collateral damage... And to begin with, is to recognize the fact that I exist. So, if I live with a husband who will have to medicate himself through pills, for instance, or through medical marijuana ... if I am not educated on what these pills are, what should I expect?

While supports and services were identified often, partners eventually discovered that these programs existed without regard for their perspective. Partners found themselves in a precarious position where supports and services were promoted as targeting them in theory, but in practice did not meet their unique needs. Consequently, partners' attempts to seek and access information, supports, and services were halted and/or redirected to other possibilities, further delaying utilization. During the utilization phase, partners' cited the tendency for the system, and individual mental health providers, to focus predominantly on the concerns and trauma experienced by the veteran to the exclusion of partners' concerns or needs. Furthermore, the use of military and/or domain-specific language (i.e., psychological jargon) was largely unknown and incomprehensible to partners, making it difficult for partners to establish a relationship and benefit from their engagement with such services and programs. Partners interpreted this as an indication that their well-being, perspective, and reality is of secondary importance to the veteran.

Limited understanding and application of family-centred models of care among mental health system stakeholders also presented challenges to seeking, accessing, and utilizing mental health services and supports. Partners cited the relative absence of family-centered frameworks, approaches, and specialized training for family members across military- and mental-health related systems. During the seeking and accessing phase, partners' indicated that the broader mental health system demonstrated their lack of comprehension and preparedness in responding

to the concerns of modern families affected by PTSD in that trauma-informed family models of care were either difficult to find or completely lacking. This meant that partners often did not find or initiate contact with a service that met their needs and goals as a family. Participant 16 described how the relative absence of family models of care within the military-related system inherently excludes the needs and concerns of families, thereby making it difficult for partners and their families to continue using existing services:

That family model of care should have been there the minute my husband started the military 27 years ago. Because the culture for 27 years was, “he is now owned by us, you are simply there to support him, we don’t care what we ask of him and now its going to effect you,” that’s not very family-centered. “We’re going to move you, we’re going to move him here, we’re going to ask him to go here, we’re going to change him, we’re going to do this and that”...that has never been a family-centered model of care...it is completely unrealistic, it is financially not stable, sustainable, even what we’re getting from the government, and I think it’s time we started listening to the family models.

During the utilization phase, partners expressed the challenges of being referred to or provided services and supports that were outdated and failed to meet the needs of contemporary military families affected by PTSD. In these instances, partners were referred by VAC to services or supports that were initially described as relevant to their family’s situation. Upon making contact or engaging with these services, however, partners discovered that they were more appropriate and perhaps originally designed for families of veterans with physical injuries. Partners interpreted these experiences to mean that services do not yet reflect the most up-to-date knowledge on military families and PTSD. Consequently, partners’ efforts to continue engaging in services were thwarted by incompatibilities between existing services and their present needs.

WL items. The WL category includes incidents where participants wished that the broader mental health system (private, public, and military-related) would acknowledge, consider, and involve partners in the planning and dissemination of information, education, services, and supports. The suggestions made by partners in this category applied to all phases of

seeking, accessing, and utilizing. WL items fell under two themes: the need for the broader military- and mental health-related system to acknowledge and address partners' needs; and the need for increased support specifically targeting PTSD-affected families.

Partners expressed the need for a pivotal shift toward more tailored, specialized information, guidance, and services for partners of veterans with PTSD. During the seeking phase, this shift would involve partners receiving full recognition as essential members of the veteran's healthcare team, acknowledgement of partners own unique stressors and early detection of secondary PTSD, and service design reflecting an understanding and integration of partners' perspectives. The implementation of these changes would not only communicate to partners that the broader system of care acknowledges their needs and lived experience, but it would also proactively equip partners with the knowledge, skills, and tools needed to manage the effects of PTSD on the entire family. During the accessing phase, other partners cited that their needs and concerns should be considered when planning and delivering the veteran's care. This form of acknowledgement would serve to recognize partners as a constant in the veteran's life, as well as the veteran's principal source of care, support, and stability. Furthermore, the involvement of partners in the veteran's care would provide a gateway for partners to learn about and access supports and services relevant to their needs and concerns. During the utilization phase, partners expressed the desire for comprehensive and timely training on effective tools for managing service-related PTSD. Participant 6 expressed the need for preventative education and training pertaining to caregiving and avoiding burnout:

At the time, you're so concerned with not stressing out your partner or your family member anymore, that you just start to take it on all by yourself, and do everything yourself, and then...I found in the end that's what I was doing. So, I was just not bothering him with anything, and then it was all on me. So, I think it would have been good to have some information on how to...how to be somebody's caretaker who has those issues.

Partners identified that this training should be ongoing, individually-paced, and cover multiple topics. With such training, partners felt that they would be more equipped to deal with the challenges of supporting and caring for a loved one with PTSD, but also understand the signs and symptoms of burnout and psychological distress.

Partners also identified the need and desire for greater recognition, promotion, and implementation of family-centered care across the mental health systems, and anticipated such changes would facilitate access and utilization. With respect to access, subsidized childcare while attending appointments was identified as having the potential to remove barriers for families with preschool-aged children. Participant 5 discussed the essential need for flexible, accessible childcare in order to engage with services at times when it most needed:

The ability to get childcare [would have been helpful]. When you have children, you can't take your children with you to therapy sessions...Before my husband's diagnosis, we had to book our therapy sessions around my schedule and his schedule, so that I was able to go when he went off from work...You never went when it was convenient for you, but when it was convenient for the childcare. So, sometimes you didn't deal with the situation when you should have been dealing with the situation...you dealt with the situation when it was convenient.

A minority of partners expressed the wish for family resource workers to be placed in military-related mental health units and/or agencies, such as the Joint Personnel Support Unit. In doing so, partners and families would have immediate access to support and referral pathways. The implementation of these suggestions would enhance partners' access, as formal supports and services would not only reflect the need to support families affected by PTSD but also recognize the expertise and skills families bring to the veteran's system of care. As such, partners' would experience increased confidence that services understand and aspire to alleviate the systemic impact of PTSD for all family members. During the utilization phase, partners anticipated that increased evidence demonstrating the effectiveness of family-centered care would lead to

improved training and guidelines within the mental health system at large. Participant 1 called for more family-based care models and research as way to ground mental health interventions and programming in evidence:

I think that a lot of work with families or couples is warranted and, I mean, obviously they need to figure out what kind of evidence-based practices are most helpful with couples. They need to treat the individual with PTSD alone but also incorporate the families in...and I definitely look at it as a more holistic modality rather than just treating someone in isolation and not recognizing the importance that a family has because...we are together as a family unit and we have to function as a family unit...you look at a systems approach... they need that research to figure out what the evidence is showing and follow through with the evidence...because I think that although there is some research out there...and I don't know if it's Canada or what...but we're not implementing that to best meet the family....so even if [my partner's] improving I'm still broken in a sense...so that doesn't make sense to fix one person when the family as a whole is so important.

Partners anticipated that executing these suggestions would make services more effective, thereby increasing ongoing engagement with existing services and supports. Partners also expressed the need for all family members to be involved in decision-making surrounding the veteran's clinical care, signifying a shift toward viewing the relationship between family members and the health care system as a collaborative partnership. Consequently, the family's role in supporting and caring for the veteran, as well the need for all family members' well-being to be considered, would be given greater precedence and lead to improved engagement with services.

Category 12: Provider Expertise/Competencies

Table 16 shows the distribution of CIs and WL items pertaining to the category "Provider Expertise/Competencies" in the one core area of utilization. This category had a total of 16 incidents, including 5 helping CIs, 7 hindering CIs, and 4 WL items.

Table 16
Provider Expertise/Competencies Critical Incidents and Wish List Items

	Helping Critical Incidents (N=5)			Hindering Critical Incidents (N=7)			Wish List Items (N=4)		
	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents	Participants (N=16)		Inci- dents
	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>
Utilizing	4	25	5	6	38	7	4	25	4

Helping CIs. The helping category includes incidents where participants described specific sets of skills, attitudes, knowledge, experience, and education demonstrated by mental health providers as helpful to them in utilizing mental health supports or services. Partners cited two specific competencies that were credited with facilitating the utilization phase: concurrent expertise in military culture, service-related PTSD, and civilian life; and expertise in how family systems were impacted by service-related PTSD.

Partners indicated that concurrent expertise in military culture, civilian life, and service-related PTSD was critical to providing effective and culturally-relevant services to partners. Partners highlighted that service-related PTSD characterized a unique presentation because of its inherent association with military culture. Providers who had a comprehensive understanding of military and civilian life understood and validated the challenges and experiences of military partners who straddle both worlds. Participant 6 described a situation where her civilian counsellor took it upon herself to become more educated in military culture and PTSD, which not only served to make counselling more effective but also conveyed a deep sense of caring and support:

Well, I felt over our sessions that her growing knowledge of the military and all that...and her compassion for it. I felt that it really...we were able to connect on that level too because I feel very passionate about the military, obviously, growing up in it, and joining it, and then marrying somebody in it. The military was who I was. So, by her taking all that interest in it, it made me feel like she was taking an interest in who I was too...sometimes, with the PTSD, and all of the years we spent fighting for VA...I felt

quite often overlooked on my own. So, having somebody who not only was there to support me but was also taking an interest in my concerns and my mental health and trying to find a level on which she can connect to me, I found that such a great support, because it meant that somebody was looking out for me...like I'd been looking out for my husband. I really feel that she was one of the reasons that I was able to continue on at a steadier path.

In cases where providers possessed these competencies, partners did not feel the need to explain their way of life, the nature of the veteran's injury, and how the two intersect to generate stress, conflict, and challenges. Consequently, partners experienced a steady progression toward identifying the concerns that brought them to seek mental health services, and were able to use the time they had to address critical issues rather than educate their provider.

Partners also indicated that providers who demonstrated competencies and expertise in family therapy, family-oriented interventions, and the impact of PTSD on family dynamics represented a critical turning point for their decision to continue engaging in services. In these instances, the attention given to how family dynamics had changed in response to PTSD validated partners' experiences and observations. Furthermore, family therapists/counsellors were able to facilitate greater understanding of interpersonal interactions and perspectives, thereby increasing empathy and collaboration within families. Overall, the competencies of providers increased partners' confidence in the helpfulness of therapy/counselling and motivation to continue service engagement.

Hindering CIs. The hindering category includes incidents where participants described gaps in specific sets of skills, attitudes, knowledge, experience, and education demonstrated by mental health providers as preventing or impeding their efforts to utilize mental health supports or services. Incidents cited in this category included a lack of expertise in military culture, military PTSD, STS, and family-oriented interventions.

Partners indicated that limited or no expertise in these areas reduced the relevance and quality of the services provided. Partners felt misunderstood, misguided, and in some cases, incorrectly assessed, because critically important concepts and/or client experiences were unfamiliar to the provider. Participant 1 described a situation where she was attempting to address her symptoms of STS; however, a lack of expertise in STS led her therapist to make misattributions about her symptoms:

Even if [counsellors] specialize in trauma, I don't think they specialize in the secondary trauma...and the impact that it has on somebody...for example, we went to this one counsellor who ended up seeing us together and as I said, she thought that I should leave [my husband] but she also didn't understand, even though her area was trauma, she said to me "I don't understand why you're so messed up unless you were sexually abused as a child" type thing...and "maybe you've repressed that", and I was like...is there something I am forgetting? And so, I mean I know that I have not been sexually abused...I just don't think there's people who specialize enough in secondary trauma.

For some partners, little to no knowledge of these concepts translated to ineffective, irrelevant, and incompatible service provision. Even in cases where providers had expertise in trauma, limited expertise in STS compromised the effectiveness of services. Consequently, partners' terminated counselling/therapy with providers who lacked such competencies, recommenced their search for an appropriate provider, and delayed engagement with much-needed support.

WL items. The WL category includes incidents where participants expressed the need for mental health professionals to have specific skills, attitudes, knowledge, experience, and education in order to facilitate mental health service utilization. Partners indicated that a specific constellation of expertise and competencies is needed among mental health providers, including experience and skills in military culture, service-related PTSD, STS, and family systems. Like all of the participants who endorsed the need for greater provider expertise in military culture, Participant 6 emphasized the critical importance of this competency:

Everyone has their own culture, so I think that, just knowing how the people work, or how...what it is they feel and how they think about the different things, you know...its hard to explain to somebody who has never moved in their life that I...you know, moved to 8 different schools before I graduated high school. And they just look at you like “wow, that must have been so difficult” but then you gotta explain, well no, everybody moves so, everybody’s excited on the first day of school to find the new kids...So having to...explain that to them, when it’s just what it is, for me, that was just my life, versus to them going “wow that’s just...” and not everyone can grasp it, not everyone can understand it but it is...it is a different lifestyle...So, I think them having a background in that military lifestyle is extremely helpful in that respect because they’re not focused on the inconsequential events of my life, they’re focused on the parts that I really want to talk about!

Partners acknowledged that the combination of expertise may vary based on the provider and the unique needs of the client; however, the adoption of these skills would demonstrate a sensitivity toward the realities of partners and their families. Partners believed that enhanced expertise and competencies in the abovementioned areas would not only make services more relevant, effective, and appealing to partners, but also help providers avoid misattributions, misdiagnoses, and unhelpful or harmful practices. Collectively, partners anticipated that this constellation of expertise would assure partners that counselling/therapy is a worthwhile investment of their limited time, energy, and financial resources.

Category 13: Therapeutic Alliance and Change

Table 17 shows the distribution of CIs and WL items pertaining to the category “Therapeutic Alliance and Change” in the one core area of utilization. This category had a total of 36 incidents, including 22 helping CIs, 14 hindering CIs, and no WL items.

Table 17
Therapeutic Alliance and Change Critical Incidents and Wish List Items

	Helping Critical Incidents (N=22)		Hindering Critical Incidents (N=14)		Wish List Items (N=0)				
	Participants (N=16)	Inci- dents	Participants (N=16)	Inci- dents	Participants (N=16)	Inci- dents			
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>		
Utilizing	12	75	22	11	69	14	0	0	0

Helping CIs. The helping category includes incidents where participants described: the relationship between them and their mental health professional, the mental health professionals' characteristics or styles of intervention, or positive change or outcomes experienced in counselling and/or therapy as being helpful to them in utilizing mental health supports and services. Partners identified several aspects of the relationship between themselves and their counsellor/therapist that facilitated their continued engagement in services. These observations included the perception of having a strong therapeutic relationship, and experiencing progress, empowerment, or results over time.

A strong therapeutic relationship between partners and their counsellors/therapists was cited as an important facilitator to continued service engagement. Several partners cited the relatability, non-judgmental approach, reassuring nature, and warmth of their counsellor/therapist as being an important motivator in their continued attendance. In the following quote, Participant 8 shared the positive impact of having a comforting, non-judgmental counsellor whom listened attentively to her experiences, leading to collaborative goal formation:

I think that that initial thing is very scary. You know, its very kind of...what do I say? How much do I say? Where do I start, you know what I mean? And sometimes it's just being allowed to go in there and have verbal diarrhea. And the person just saying you know, "wow, ok, I hear you, and you've had a lot going on". And then just kind of disseminating it...I think it set my standards, and it set...my expectations I guess. And it helped me to identify my needs. Because at that point, I didn't really know what my needs were, I just knew that I needed to talk to somebody. So I think it kind of set some organization to it.

These qualities created an environment whereby partners experienced trust, caring, support, vulnerability, and the instillation of hope. Some partners identified the strong connection/fit between themselves and their counsellor/therapist as important in determining continued use of services. In these instances, partners felt that their own communication styles were both understood and accommodated, and that the interventions, framework, and

philosophies of the counsellor/therapist were consistent with partners' needs, preferences, and goals. Collectively, these elements helped to form a strong therapeutic bond, prompting partners to continue working with the counsellor/therapist toward their goals.

Partners indicated that perceptions of positive change and/or making progress towards mental health goals were also helpful during the utilizing phase. Partners' observations of positive gains or progress made throughout counselling/therapy led to feelings of empowerment and strengthened partners' belief in the effectiveness of counselling/therapy. One partner described the helpfulness of being trained in effective hands-on tools and/or solutions that could be used outside of the immediate therapeutic setting. The experience of learning a novel tool or technique, and applying it in situations at home, increased her confidence in her ability to overcome the challenges she faced. Overall, perceptions of positive change and/or making progress translated to partners' beliefs that counselling/therapy was a worthwhile investment of their time, thereby increasing their motivation to return to future appointments.

Hindering CIs. The hindering category includes incidents where participants described: the relationship between them and their mental health professional, the mental health professionals' characteristics or styles of intervention, or a lack of progress/change as preventing or impeding ongoing utilization of mental health services and supports. Examples include the perception of having a weak therapeutic alliance, and the experience of limited or no progress/change in counselling/therapy.

Partners identified several aspects of the therapeutic relationship between themselves and their counsellor/therapist that deterred or discouraged their continued engagement in services. Deterrents included a lack of provider genuineness; a mismatch between the providers' interpersonal style, professional framework, or goals and that of the partner; and counsellors'

prioritization of the husbands' trauma over the concerns of the partner. Partners described the discomfort that arose in instances where the interpersonal style, framework, and goals of the counsellor contradicted or were at odds with their own. The following excerpt from Participant 11 illustrated how the discrepancy between her goals and that of her provider compromised the alliance and ultimately resulted in her terminating therapy:

You know, because I made it very clear that I was...that we were in a committed relationship and this doesn't really change anything. Like the support that I needed was to sort of remain emotionally stable throughout this process, and you know, her common or often...advice was for me to leave him, and leave the relationship, and that was not something that I'd ever even brought up or even talked about because I had no desire to do that. So, you know, it was sort of hard to get past that because its like...you're not really hearing what I'm saying...it sort of came out of the blue, we had never talked about a breakdown in the relationship, not once did I ever feel like I did not want to be in a relationship with him, like it was just something that had never even crossed my mind...it was very off-putting. So then I really felt like I didn't have a connection with her, because she was suggesting something that was so not even on my radar.

In these cases, partners' motivation and desire to engage in counselling/therapy decreased, and led them to question the value of engaging in services. Among those who expressed the need to address marital and/or personal concerns within the context of couples counselling, partners felt hindered by the tendency for counsellors/therapist to prioritize the veterans' trauma over the partners'. This experience led partners to feel belittled and irrelevant, and in some cases, to believe that their hardships were not severe enough to warrant priority from mental health providers.

Partners also cited the perception of making little to no progress towards therapeutic goals as diminishing their beliefs in the effectiveness of counselling/therapy. Furthermore, limited or no progress reduced partners' hope that their situation could change for the better. The provision of ineffective tools, such as bibliotherapy that was irrelevant to the partners' situation, decreased partners' confidence in the counsellor/therapists' ability to address their challenges.

These incidents prompted partners to discontinue engagement with services and begin the search for a new mental health provider, further delaying their ability to benefit from continued use of mental health supports and services.

Results of the Credibility Checks

In accordance with the ECIT methodology outlined by Butterfield et al. (2009), nine credibility checks were applied to enhance the trustworthiness of the research results presented in this chapter. This section summarizes the results from the nine credibility checks employed in this study.

Audiotaping Interviews

All 16 interviews were audio-taped and saved on a password-protected computer. The audio files were copied onto a password protected USB drive and transferred to a third party research assistant for transcription. Once the interviews had been transcribed, I began the process of reading the interviews to reorient myself to the participants' contextual experiences and critical incidents.

Interview Fidelity

The 3rd, 6th, and 10th interview were subjected to an interview fidelity check. All three interviews were submitted to a doctoral student who had previously used ECIT methodology in her MSc research. After the first fidelity check, she confirmed that I was adhering to the interview guide and had successfully avoided the use of leading questions. Furthermore, she provided suggestions for how I could probe more effectively for supporting evidence (i.e., meaning/importance). After the second fidelity check, she confirmed that I had adhered to the interview guide, avoided leading questions, and effectively probed for supporting evidence. The third fidelity check was undertaken to ensure that I had maintained consistency in my interviewing over time.

Independent Extraction of Critical Incidents

A graduate student acquainted with the ECIT methodology, but not implicated in the current study, independently extracted critical incidents from 25% (n=4) of the interviews. The independent extractor was provided instructions for completing the task. Following the independent extraction, a 97% agreement rate was reached. This indicated that the ECIT methodology was adhered to throughout data analysis. The independent extractor and I discussed each discrepancy and reached a 100% agreement rate.

Exhaustiveness

Based on the template provided by Butterfield et al. (2009), a tracking table was employed to monitor the creation of new categories as data analysis occurred (see Appendix I). This record included the date that the CIs were extracted from their respective interviews, the date of categorization, and the specification of new categories. New categories were identified for each of the first seven interviews. After the 8th interview was analyzed, no new categories were needed to capture the CIs and WL items and thus indicated exhaustion. As such, the CIs and WL items from the remaining interviews were placed into existing categories. Although interviews were no longer needed after exhaustiveness had been reached, in keeping with the social justice perspective of honouring interested participants' wishes to share their stories and contribute to a study that both acknowledged and sought to address their hardships (Fassinger & Morrow, 2013), a total of 16 interviews were conducted.

Participation Rates

All 13 categories met the 25% participation rate standard delineated by Butterfield et al. (2009). Participation rates ranged from 25% to 75% (see Tables 5 through 17). Based on these

participation rates, the categories developed in this study demonstrate a high level of robustness (Butterfield et al., 2009).

Independent Placement of Incidents into Categories

A graduate student who was not involved with this study and unfamiliar with ECIT completed the independent placement of incidents into categories. As outlined by Butterfield et al. (2009), I randomly chose 25% of the CI and WL items within each category, which yielded 134 incidents in total. I also provided the category headings and their corresponding operational definitions. I then had the graduate student assign each incident to the category that he or she believed it best fit. Subsequently, I calculated the rate of agreement between the graduate student's placement and my own assignment of incidents into categories. This process yielded a 94% agreement between myself and the graduate student. In line with the parameters established by Andersson and Nilson (1964), an agreement rate of 80% or better is recommended for this check and indicates valid categories.

Participant Cross-Checking

Following data analysis and the completion of the first six credibility checks, participants were provided secure access to a word document via DocuSign containing a list of the CIs and WL items extracted from their interview. CI and WL items appeared under their corresponding categories and category descriptions. Participants were asked to respond to the following questions as measure of credibility and trustworthiness:

1. Are the helping/hindering critical incidents and wish list items correct?
2. Is anything missing?
3. Is there anything that needs revising?
4. Do you have any other comments?

With respect to the categories, participants were asked to answer the following questions:

5. Do the category headings make sense to you?
6. Do the category headings capture your experience and the meaning that the incident or factor had for you?
7. Are there any incidents in the categories that do not appear to fit from your perspective? If so, where do you think they belong?

As indicated in the consent procedures, participation in this credibility check, referred to as the follow-up interview, was voluntary. Participants were required to respond within two weeks from receipt of their individual interview findings, after which time the CIs, WL items, and categories were taken as an accurate representation of participants' experiences. All 16 participants agreed to participate in the follow-up interview at the time of informed consent. During the follow-up interview phase, all but four participants out of 16 provided responses. Of those 12 who did participate, their responses indicated that the CIs and WL items were correct and that the categories in which the items were placed accurately reflected their experiences. Three participants were asked to engage in a brief telephone interview to gather clarifying information about the supporting details of CIs from their interview. All three participants provided information about the importance and meaning of the incident and provided an example. I then discussed with participants which category best captured this new incident. All three incidents were incorporated into the final results.

Expert Opinions

Two experts were recruited and asked to respond to the following questions:

1. Do you find the categories to be useful?
2. Are you surprised by any of the categories?
3. Do you think there is anything missing based on your experience?

The first expert was an associate professor in family studies, with extensive research experience in issues pertinent to contemporary military partners of veterans with PTSD. After reviewing the findings, she agreed that the categories were useful and corresponded well with her experiences conducting research with military families. Without previous knowledge of the theoretical framework guiding the current research, she stated that as she reviewed the categories the four levels of Bronfenbrenner's EST readily came to mind and became a useful framework for framing the findings. She indicated that no categories appeared to be missing, although she noted that the categories themselves likely function interdependently.

The second expert recently retired from the Canadian Armed Forces and worked as a mental health aftercare facilitator for several years in the area of concurrent addictions and PTSD. After reviewing the findings, he indicated that the categories were useful and that he was not surprised by any of the categories. He stated that the breadth and detail of the categories gave a complete picture of all the possible issues that can be experienced by military partners. He was particularly appreciative of the inclusion of the categories concerning the therapeutic alliance and provider competencies, as in his experience limited cross-cultural competence often emerged as an issue with members, their families, and providers. Although he found all categories to be useful and he was not surprised by any, he indicated surprise at the absence of incidents relating to support from the veteran's chain of command. In his professional experience, often there is little direct support/interaction between families and the chain of command, but this could provide an important means to facilitating mental health service engagement.

Theoretical Agreement

Theoretical agreement involves two steps: (a) identifying and explaining the underlying suppositions of the research study, and consulting and reviewing the scholarly literature to

determine whether these suppositions are valid (Butterfield et al., 2009; Maxwell, 1992); and (b) comparing the categories with pertinent scholarly literature to see which categories support previous findings and which categories have revealed novel contributions to the field of study (Butterfield et al., 2009). The first step of this credibility check was supported by the literature review chapter, detailing previous research findings that elucidated (a) the systemic impact of service-related PTSD on partners; (b) the current landscape of mental health services and supports established for partners; and (c) the limited knowledge on the specific facilitators and barriers to mental health service engagement among partners.

The second component of this credibility check, which involves a comparison of the categories with the scholarly literature, was undertaken and indicated support for all 16 categories. A discussion of this literature, the novel contributions of the current study, and its implications for mental health services will be presented in the following chapter.

Summary of Chapter

This chapter comprised a detailed description of 16 partners and their experiences of seeking, accessing, and utilizing mental health services and supports. Two themes were identified in describing the context of partners' situation and life circumstances: (a) Multiple Roles and Demand, and (b) Change and Adjustment. Five themes were identified in depicting the context of events precipitating the need or desire to seek mental health services and supports: (a) Confusion and Uncertainty, (b) Overwhelmed, (c) Changes in Oneself, (d) Mental Health Emergency, and (e) Alterations in Family Relationships. A total of 537 helping and hindering CIs and WL items were extracted and organized into 13 categories under the seeking, accessing, and utilizing core areas. These categories included: (a) Beliefs and Attitudes; (b) Skills, Competencies, and Roles; (c) Veteran's State of Readiness; (d) Support from Peers/Family; (e) Media and Communication Technology; (f) Support from First-Contact Care; (g) Health Care

System Management; (h) Service Characteristics; (i) Institutional Accountability and Transparency; (j) Cultural and Organizational Influences; (k) Family-Centred Care; (l) Provider Expertise/Competencies; and (m) Therapeutic Alliance and Change. The chapter concluded with the results of the nine credibility checks, indicating robust and trustworthy findings.

CHAPTER FIVE: DISCUSSION

We should not be asking the question “what works?” but rather “When does something work, for whom, and in what context?”

Dr. Sally Thorne (2017, personal communication), Professor, University of British Columbia

The primary objective of this research was to explore helping and hindering CIs and WL items identified by PoPVs in the context of mental health service engagement, as well as the circumstances and precipitating events that gave way to their need or desire to seek help. The seven themes established from the contextual component of this research will be discussed and compared with relevant findings in this field. To follow, the 13 categories formed across three core research areas (i.e., seeking, accessing, and utilizing) will be discussed in relation to the existing scholarly literature. Subsequently, the implications of these findings for relevant stakeholders are discussed. The chapter concludes with an outline of the limitations of the current study and offers directions for future research.

Discussion of Contextual Results

All categories pertaining to PoPVs’ life circumstances and the factors that precipitated help-seeking are supported by existing literature. However, given that the majority of the literature in this area has focused on the development of mental health conditions and psychological distress in PoPVs, a surprising finding was the high frequency of precipitating factors identified that were not directly related to PoPVs’ mental health concerns. The following section discusses these results by each contextual component.

Context of Life Circumstances

All participants described their current circumstances in terms of the unique constellation of responsibilities, roles, and occupations they perform and manage simultaneously, a finding supported by previous studies (e.g., Outram et al., 2009). Not surprisingly, the accumulation of

demands, stress, and tasks associated with managing multiple roles was not only taxing on partners, but also led to boundary confusion for some partners. These results are consistent with previous literature on ambiguous loss in PoPVs (Dekel et al., 2005; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008). Specifically, the chronicity of PTSD and the uncertainty surrounding the veteran's status and functioning results in confusion and a lack of specifications around roles and responsibilities (Dekel et al., 2005; Faber et al., 2008). In the current study, role ambiguity represented a source of stress for PoPVs as it further contributed to their sense of uncertainty and being overwhelmed, but also created tensions in the partner-veteran relationship as familial dynamics shifted to reflect new role allocations.

Previous research has found that PoPVs assume a broad range of roles in response to the demands associated with the veterans' PTSD symptoms (Beks, 2016b; Dekel et al., 2005; Mansfield et al., 2014). Consistent with the current study, these various roles affect PoPVs in diverse ways. Some PoPVs report high levels of burden, in addition to psychological and emotional distress (Beckham et al., 1996; Calhoun et al., 2002; Dekel et al., 2005; Manguino-Mire et al., 2007). Other PoPVs, despite experiencing stress and burden associated with their roles, report feeling empowered by their ability to care for the veteran and their family (Dekel et al., 2005; Yambo et al., 2016). In yet another study, Manguino-Mire et al. (2007) found that higher levels of self-reported PoPV self-efficacy were associated with decreased burden, even after controlling for psychological distress, perceived threat, and perceived barriers to mental health treatment. In contrast, Calhoun et al. (2002) found that PoPVs self-reported levels of burden were associated with the severity of the veterans' PTSD symptoms. Thus, interventions and psychoeducational training aimed at increasing self-efficacy, while also considering the

severity of veterans' PTSD symptoms, may reduce perceived burden and distress and enhance feelings of empowerment.

Earlier research conducted by Lyons (2001) found that the emergence of PTSD symptoms in veterans resulted in significant periods of adjustment for PoPVs, including the experience of dealing with: the veterans' PTSD symptoms, substance abuse, physical and/or emotional abuse, the assumption of new roles, their own feelings, and the development of coping strategies. These findings support the current study in that PoPVs described their adaptation to the changing environment as necessary to reach temporary periods of stability and regain some element of control over the situation, which supported veterans in achieving stabilized care.

Context of Precipitating Events

The five themes found within the context of precipitating events fit with the literature on general models of help-seeking (Cauce et al., 2002; Fox, Blank, Rovynyak, & Barnett, 2001; Kessler et al., 2001; Liang, Goodman, Tummala-Narra, & Weintraub, 2005). These models focus on the internal, cognitive processes that take place as individuals seek help, and include three stages: problem recognition and definition, the decision to seek help, and the selection of sources of support (Liang et al., 2005). Further, the manner in which individuals respond to their troubling experiences depends on how they define the problem and their evaluation of its severity (Liang et al., 2005). The decision to seek help is dependent upon two conditions: (a) appraisal of the problem as undesirable; and (b) the perception that problem resolution is unlikely without help from others (Cauce et al., 2002). In the current study, PoPVs' appraisals or explanations of their situations, physical sensations, and internal experiences ultimately shaped their decisions to seek help. In turn, the label assigned to the problem influenced their intentions to seek specific sources of support (e.g., individual vs. couples counselling). Furthermore, PoPVs

indicated that the problem had affected their life beyond the point at which they could deal with it on their own. It is important to note that this help-seeking model is non-linear and dynamic, as individuals may engage in an ongoing feedback loop whereby their appraisals shift over time until a fitting definition and source of support are established (Liang et al., 2005). This recursive process is consistent with the narratives provided in the current study, as PoPVs cited more than one precipitating factor that led them to seek help, some of which occurred successively, concurrently, or transformed over time. For organizational purposes, however, each of these themes is discussed independently.

Confusion and uncertainty. The state of bewilderment and apprehension experienced by PoPVs in the current study is consistent with earlier research on PoPVs' experiences of navigating the unpredictability of living with a military veteran affected by PTSD (Beks, 2016b; Lyons & Root, 2001; Mansfield et al., 2014; McLean, 2006; Outram et al., 2009; Yambo et al., 2016). Furthermore, PoPVs' desire and need to make sense of the veterans' behaviour has been cited in previous research (Outram et al., 2009). While these collective findings provide a deeper understanding of PoPVs struggle to adapt, the findings reported here point toward PoPVs' state of confusion, uncertainty, and vigilance as a powerful motivator underlying help-seeking. Specifically, PoPVs were motivated by the desire to acquire knowledge, skills, and tools to modify the environment, which in turn, would alleviate or prevent the effects of PTSD on the veteran and their family.

Overwhelmed. Earlier studies have found that the overwhelming demands and challenges endured by PoPVs over time led to a loss of identity and sense of self, predominantly as a result of the tendency for PTSD to consume the attention, time, and energy of PoPVs (Beks, 2016b; Outram et al., 2009; Yambo et al., 2014). A number of earlier studies have referred to this

process as *overfunctioning* (Franciskovic et al., 2007; Lyons, 2001), framing such actions as a maladaptive response. However, consistent with previous authors, the current study interprets the strategies employed by PoPVs as an understandable and reasonable response to the extreme uncertainty and unpredictability that characterizes their daily life (Beks, 2016b; McLean, 2006; Waddell, Pulvirenti, & Lawn, 2015). Furthermore, the gradual progression of becoming overwhelmed and overextended occurred prior to obtaining adequate support. As such, this study takes the position that the sense of being overwhelmed resulting from living with a veteran with PTSD is not indicative of maladaptive coping. Rather, this finding suggests that formal supports and services must adapt to the unique needs of PTSD-affected families, recognize the chronicity and severity of PTSD and its impact on PoPVs, and establish contact with PoPVs before the point of becoming overwhelmed in order to facilitate earlier help-seeking.

Changes in oneself. Consistent with the current findings, previous studies have found that PoPVs may experience a range of physical health problems (Koić et al., 2007; Outram et al., 2009) and mental health difficulties (Ahmadi et al., 2011; McLean, 2006; Yambo et al., 2014), including the experience of a “nervous breakdown” due to cumulative stress (Outram et al., 2009, p. 131). However, most of this research has focused on the prevalence of physical and mental health problems rather than the health-related changes that precipitate help-seeking. One exception is a study conducted by Mansfield et al. (2014), in which chronic distress and social isolation were identified as health-related states that prompted PoPVs’ search for mental health services. As such, the current findings unveil the diversity of physical and mental health concerns with which PoPVs may present to health care providers. The varied nature of these health-related changes experienced by PoPVs likely plays an influential role in the type of health care provider sought. Given that presenting concerns are an important factor in determining

interventions, the current findings provide valuable insight for assessment and treatment planning among providers who serve as the first line of contact for PoPVs. These findings also highlight the need for mental health providers to appreciate and understand the impact of trauma on health outcomes in PoPVs.

Mental health emergency. Given the strong relationship between service-related PTSD and suicidal ideation (Calabrese et al., 2011; Guerra & Calhoun, 2011; Ramsawh et al., 2014), it is surprising that few studies have provided insight into PoPVs' experiences with veterans' suicidal behaviours (Dekel et al., 2005; Mansfield et al., 2014; Yambo et al., 2016). Nevertheless, these few studies are consistent with the current research, in that PoPVs' often found themselves intervening with the veterans' suicidal behaviours (Dekel et al., 2005; Mansfield et al., 2014; Yambo et al., 2016). Yet, it is clear from this small body of research that the unmet needs of PoPVs in this situation have remained largely unexplored. Therefore, the present study takes some preliminary steps toward filling this knowledge gap. The implications of these findings for PoPVs' SOC are two-fold. Firstly, some PoPVs may not feel prepared or equipped to intervene with veterans' suicidal attempts, which places them at risk for even greater harm to their mental health and well-being. Thus, a combination of education and training in suicide prevention/intervention specifically designed for PoPVs is warranted. Not only could such training enhance PoPVs' confidence and self-efficacy in responding to and detecting signs of distress (Ayer, Ramchand, Geyer, Burgette, & Kofner, 2016), but it may also reduce the psychological impact of mental health emergencies on PoPVs. Second, PoPVs should not be in a position where they must assume sole responsibility to respond and intervene with veterans' suicidal behaviours. Effective suicidal prevention/intervention requires a concerted effort among military institutions and the mental health system. PoPVs in this study intervened with veterans'

suicidal behaviours in the absence of formalized supports, despite attempts to connect with services leading up to and during the incident. This suggests that suicide/crisis intervention services, such as distress telephone lines, may not sufficiently meet the needs of all situations and all populations, and may not be accessible to all families in need. Furthermore, the various pathways to suicide/crisis support beyond distress lines must be widely publicized and accessible to PoPVs. Future research is needed to explore these service gaps, as well as to evaluate the accessibility, availability, and effectiveness of these services for military and veteran families.

Alterations in family relationships. Consistent with the current findings, changing patterns in family interactions are cited in previous research (Dekel & Monson, 2010; Meis et al., 2010; Sherman et al., 2008; Yambo et al., 2016). For example, Sherman et al. (2008) found that PoPVs experienced a number of barriers to effective communication, including the veterans' tendency to emotionally distance him/herself from family members, alterations in veterans' personalities, and their own limited understanding of PTSD and how it impacts the veterans' functioning. Furthermore, PoPVs identified such changes as a significant source of their frustration and distress (Mansfield et al., 2014). While this body of literature provides support for the adverse effects of PTSD symptoms on family functioning, the current study extends the implications of these findings to service design and treatment planning. Notably, changes in family functioning are an important precipitant to seeking help among PoPVs. However, the majority of government and non-governmental supports offered to Canadian PoPVs are individual services, peer-oriented, or psychoeducational in nature (Tam-Seto et al., 2016). This suggests that existing services and supports may be inconsistent with or unable to support the needs of PoPVs who are specifically seeking help for concerns surrounding family functioning.

In conclusion, the results of the contextual component correspond and intersect with the critical incident categories. However, the contextual themes were elicited within a framework of the factors that propelled PoPVs to seek mental health help, whereas the critical incident categories were derived within the framework of factors that facilitated or hindered overall mental health service engagement. The intersection of themes and categories between the two sections is not surprising as the trajectory from problem identification to ongoing mental health service use represents a recursive, dynamic, and interdependent relationship.

Discussion of Critical Incident and Wish List Results

The critical incident component of this study set out to explore the factors that facilitate or impede mental health service engagement among PoPVs within their respective SOCs. The findings suggest that the categories are consistent with the four levels of EST (Bronfenbrenner, 1969). Furthermore, the elements within PoPVs' SOCs function interdependently to shape experiences with mental health services. The following section discusses the significance and implications of each of these categories within their respective ecological level.

Microsystem Level

Beliefs and attitudes. Perhaps the most salient finding to emerge from this category was the hindering effect of self-stigmatizing attitudes and beliefs on mental health service engagement among PoPVs. The role of self-stigma has received considerable research attention, elucidating the process by which individuals internalize the stigmatizing attitudes communicated in their social environment (Schomerus & Angermeyer, 2008). More recently, a growing body of evidence suggests that self-stigmatizing attitudes among military populations serve as a powerful deterrent to mental health service engagement (Hoge et al., 2004; Sayer et al., 2009; Sharp et al., 2015). In line with current findings, previous research on American partners of active military members revealed that self-stigmatizing beliefs (i.e., seeking help is embarrassing; perceptions of

weakness or pathology) were cited as barriers to seeking mental health services (Eaton et al., 2008).

The personal worldviews and attitudes held by PoPVs in the current study also served as a barrier to their engagement in mental health services, a finding that bears similarities to previous research. In a study conducted by Sherman et al. (2008), PTSD-affected veteran couples expressed a preference for self-reliance and believed family issues should remain private. While this particular worldview was cited in the current study, PoPVs cited additional barriers that have not been discussed or reported in previous research on this population. Specifically, these barriers included: feelings of doubt about the helpfulness of counselling/therapy, beliefs that intervention is only warranted for extreme or severe problems; perceptions that mental health providers would either not understand or believe their traumatic experiences; and the anticipation of facing difficult emotions in counselling/therapy. The current study also demonstrated how specific beliefs and attitudes promoted PoPVs' mental health service engagement. These findings are echoed in previous research, in that earlier studies have found that acceptance (Waddell et al., 2015), perseverance and optimism (Teti et al., 2012), and positive or normalizing attitudes toward mental health challenges (Bignall, Jacquez, & Vaughn, 2015) play an important role in shaping individuals adaptive responses to adversity.

Collectively, the current findings contribute to existing knowledge by broadening our understanding of the range of beliefs and attitudes that may interfere with PoPVs' mental health service engagement. Furthermore, these findings fit with the Health Belief Model (HBM), which proposes that individual self-efficacy and locus of control, combined with perceptions of vulnerability, severity of the concern, and the benefits or barriers of following through with a service, influence the probability of engagement with mental health services (Choudhry, Mani,

Ming, & Khan, 2016; Rosenstock, Strecher, & Becker, 1988). Thus, the HBM underscores the importance of beliefs, perceptions, and attitudes in both understanding, modifying, and promoting health behaviours (Rosenstock et al., 1988), and has important implications for PoPVs' mental health service engagement. First, the hindering beliefs and attitudes expressed in the present study may be targeted and modified through program promotion, education, and training, and, in turn, dispel perceived barriers to mental health service engagement. Second, mental health providers working with PoPVs may routinely assess for the presence of these hindering beliefs and attitudes and apply interventions accordingly. At the same time, providers may explicitly promote facilitative beliefs and attitudes, thereby increasing the chances of continued service participation.

Skills, competencies, and roles. While no previous research has investigated skills, competencies, and roles in relation to mental health service engagement, these findings are analogous to the model of self-efficacy (Bandura, 1977). Bandura (1986) defined self-efficacy as an individual's appraisal of their abilities to organize and carry out the actions required to reach a specified level of performance. Bandura (1986) maintained that the possession of knowledge and skills was important, albeit not sufficient to perform a specific task; individuals must also possess confidence in their ability to carry out a specific task under usual, and perhaps most notably, in challenging or stressful circumstances. As such, self-efficacy influences an individual's choice of activities and level of persistence (Bandura, 1977). Bandura (1997) maintained that one of the primary and most influential sources from which individuals gather and evaluate their self-efficacy is their actual performances and past successes. In the current study, PoPVs' personal and professional experiences working in and navigating the health system, and their past successes in seeking and accessing mental health services, imparted them

with greater confidence in their ability to find and secure appropriate psychological help. Thus, many PoPVs attributed their success in engaging with mental health services to their own personal resources. These findings are important because there is considerable diversity in both personal and professional experiences prior to help-seeking, which may lead to inequities in access. Therefore, supports, services, and military-related institutions may target PoPVs' self-efficacy through pre-emptive psychoeducational resources and groups, thereby improving their confidence in and perceptions of control over the processes and tasks involved in accessing care.

The current findings also revealed that the nature of the demands (i.e., sole caregiver and absence of childcare) and the level of rigidity/flexibility associated with various roles (i.e., flexible work hours) assumed by PoPVs influenced whether or not they faced logistical impediments to mental health service engagement. These findings are supported by previous research in which American PoPVs cited competing demands, roles, and priorities as barriers to accessing care (Lyons & Root, 2001; Sherman et al., 2008). Furthermore, Eaton et al. (2008) found that the most commonly cited barriers to seeking mental health services among American partners of active military members pertained to difficulty in getting time off work and securing childcare. These findings suggest that low access to services may not indicate a lack of need, but rather the presence of structural and/or systemic barriers (Lyons & Root, 2001). As such, logistical impediments must be considered when designing supports and services, and innovative strategies must be employed to help mitigate these barriers for PoPVs.

Veteran's state of readiness. Consistent with the present findings, previous research found that veterans with PTSD expressed reluctance to involve their family members in care due to: fear of embarrassment in front their family members; concern their family members would learn strategies that would later be used to the veterans' disadvantage; and concerns about how

the partner would be affected by exposure to combat experiences (Lyons & Root, 2001; Sherman et al., 2008). In contrast, Batten et al. (2009) found that the majority of veterans in their study viewed PTSD as a source of stress and desired greater family involvement in their treatment. These findings suggest that veterans' may recognize the benefits of their family either being involved in their treatment or engaging in their own individual services, but experience varying levels of willingness based on their own beliefs about psychological services. Therefore, it is of critical importance that mental health and military-related providers address the range of concerns veterans may have that prevent family members from engaging in mental health services and apply appropriate interventions to modify these beliefs.

One of the more significant findings to emerge from this category was that veterans' disclosures of traumatic deployment-related experiences were cited as beneficial to PoPVs' mental health service engagement. However, the consensus in the clinical and research literature is that veterans' disclosures of deployment-related experiences must be approached with caution, predominantly due to the risks of PoPVs developing STS (Campbell & Renshaw, 2012; Fredman, Monson, & Adair, 2011). Clinical guidelines developed on this very topic suggest that disclosure of traumatic events should be modest and sensitive to PoPVs' distress (Fredman et al., 2011), indicating that disclosure must be considered on a case-by-case basis. Research has found that veterans' disclosure of traumatic peacekeeping experiences to their partners was negatively associated with PTSD symptomatology, especially when PoPVs offered validating and positive responses to their disclosures (Bolton, Glenn, Orsillo, Roemer, & Litz, 2003). Although the role of veterans' disclosures on PoPVs has received less empirical attention, Campbell and Renshaw (2012) found that the effects of veterans' deployment disclosures on PoPVs depends on the veterans' level of PTSD symptomatology. Specifically, PoPVs' levels of psychological distress

following deployment disclosures were positively associated with veterans' PTSD symptom severity, but only in couples where the veterans' PTSD severity rose into the clinically significant range (Campbell & Renshaw, 2012). This suggests that in couples where PTSD symptomatology is less clinically significant, disclosures of deployment-related experiences may be similar to communication about other issues experienced within the couple relationship (Campbell & Renshaw, 2012). In turn, PoPVs may better understand and empathize with the veteran that leads to improved relationship functioning and cohesion. In contrast, in couples where the veterans' PTSD symptomatology is in the clinically significant range, deployment-related disclosures may be more emotionally charged and PoPVs may be negatively affected by the disclosure. While the current study is unable to support such linkages, it does support the finding that disclosures can have a positive effect on couple functioning and builds upon this literature by suggesting that disclosure plays a facilitative role in PoPVs' mental health service engagement. Future quantitative research may investigate the relationship between veterans' disclosures and PoPVs' mental health service engagement, and determine whether couple functioning serves a moderating role.

Previous research suggests that the emotional distancing that often accompanies PTSD, or the tendency to avoid discussing past experiences may impair partner-veteran communication (Sherman et al., 2008). Impaired communication may then lead to PoPVs' misunderstanding or misattributing veterans' behaviours and functioning (Sherman et al., 2008). As a result, both individuals are restricted in gaining a mutual understanding of one another's emotional and behavioural experiences (Sherman et al., 2008). In the current study, PoPVs indicated that changes in the frequency, quality, and content of veterans' communication hindered mental health service engagement. In instances where communication was challenged, PoPVs were

unable to express their distress and concerns in a supportive climate and, in turn, their need for professional support remained unacknowledged. These findings fit with the theoretical model of dyadic coping (Bodenmann, 2005; Bodenmann & Cina, 2006), which conceptualizes the coping that occurs within a romantic relationship as a stress communication process. The main theoretical premise behind dyadic coping is that when one partner's appraisal of stress is transmitted to his or her partner, this partner recognizes and interprets the stress signal (Bodenmann, 2005). Based on the interpretation, this partner will respond with a number of different coping strategies in order to alleviate his or her partner's distress (Bodenmann, 2005). Bodenmann (2005) maintains that positive dyadic coping (i.e., working together to deal with partners' distress) reduces stress for both partners and improves relationship quality, as positive strategies promote communal trust, respect, commitment, and a feeling that the relationship is supportive. In the current study, PoPVs' descriptions of dyadic interactions were analogous to dyadic coping strategies, whereby negative coping strategies (i.e., displaying disinterest, reluctance, and/or doubt toward partners' stress signals) hindered PoPVs and positive dyadic coping strategies were identified as helpful. This finding is consistent with previous research on relational processes within PTSD-affected veteran couples, in which positive dyadic coping strategies served as a protective factor for PoPVs (Lambert, Hasbun, Engh, & Holzer, 2015). However, the current study builds upon these findings by suggesting that positive dyadic coping strategies may play an important role in PoPVs' mental health service engagement. Thus, it is important that mental health providers, community agencies, and psychoeducational resources communicate the importance of positive dyadic coping strategies to PTSD-affected military couples, not only to enhance relationship quality as they cope with PTSD together, but also to mitigate the effects of negative coping strategies on mental health service engagement.

Mesosystem Level

Support from peers/family. Consistent with the current study, previous research has found that family members may serve as a critical source of encouragement and validation, can facilitate problem recognition, and increase treatment adherence (Sayer et al., 2009). However, the most salient finding to emerge within this category was the invaluable role of peer support. This finding is analogous with earlier studies exploring the stressors and challenges of living with a veteran with PTSD (Outram et al., 2009; Sherman et al., 2008). For instance, Australian PoPVs indicated spousal support groups as a critical source of support and guidance, providing opportunity to discuss the impact of PTSD on their lives with others who understood their circumstances (Outram et al., 2009). In a study conducted by Sherman et al. (2008), PoPVs and veterans cited the isolating effect of PTSD as a barrier to mental health service engagement, and support groups were described as an important means to alleviating this isolation among PoPVs. In line with earlier research (Outram et al., 2009), the current study found that peer support offered non-judgmental acceptance, strategies for coping, and information about accessing mental health related resources. Given its role in reducing isolation, it is not surprising that PoPVs in the current study identified a lack of peer support as hindering their efforts to engage mental health services.

The findings of the current study also provide novel insight into the specific role of the informal, knowledgeable, experienced peer support provided by PoPVs. According to Mead, Hilton, and Curtis (2001), the historical pathologization of behaviour by various health professions and the subsequent alienation endured by individuals experiencing these challenges prompted the peer support phenomena. Individuals whose experiences had been discounted or pathologized came together and built communities based on this shared identity (Mead et al.,

2001). These communities served to legitimize their lived experience, enhance their autonomy, and frame their hardships within a larger social, cultural, and political context (Davidson, Bellamy, Guy, & Miller, 2012; Mead et al., 2001; Solomon, 2004). Similar motivations for and outcomes of developing peer support communities among PoPVs have been described in previous research (Outram et al., 2009). In the current study, the experience of being discounted, alienated, and abandoned created a need for PoPV-generated support and knowledge sharing that facilitated understanding, validation, and engagement. Furthermore, it is through this process that PoPVs experienced a sense of community belonging, exchanged insider knowledge, and became more equipped to challenge systems and access the supports they needed.

Media and communication technology. Among media and communication technologies, social media (i.e., Facebook groups) was frequently cited as connecting PoPVs to support that they would otherwise not have, a finding echoed in previous research on the use of internet and social media among Australian PoPVs (Ruiz & Stadtlander, 2015). Evidently, the use of internet technologies removes or lessens logistical and geographical barriers to seeking and accessing support; however, research suggests that such technologies also alleviate social isolation by empowering individuals, promoting well-being, and increasing feelings of control (Barak, Boniel-Nissim, & Suler, 2008; Naslund, Aschbrenner, Marsch, & Bartels, 2016; Ruiz & Stadtlander, 2015). Given that past studies have found PoPVs commonly experience social isolation (Dekel et al., 2005; Maloney, 1988; McLean, 2006; Woods, 2010; Yambo et al., 2016), the tendency for PoPVs in the current study to gravitate toward and actively use social media to exchange information and emotional support is not surprising. However, this phenomenon is not universal. The current findings indicated that the pervasive use of media and communication technology among communities of PoPVs acts as a hindering factor for individual PoPVs who

are not active social media users. This finding highlights the need for information and resources to be available and promoted in a variety of formats and settings in order to ensure equitable access to services and supports for all PoPVs regardless of personal media literacy levels.

It is also worth noting that PoPVs in the current study expressed the need for more reliable, widespread, and extended applications of media and communication technology to address PoPVs concerns and facilitate access to supports, including distress lines. Previous research found that crisis/distress support lines were a critical source of support for veterans and their family members who are either reluctant or unable to access in-person mental health services, or who are experiencing a life-threatening situation (Bryant, 1998; King et al., 2014). Thus, making media and communication-based supports and services more accommodating, flexible, accessible, and immediate is an important strategy for existing programs to overcome logistical barriers and acknowledge the unique circumstances facing PoPVs and their families.

Support from first-contact care. Despite the important role played by first-contact care providers in the Canadian health care system (Divinsky, 2007), relatively little is known about how their responses influence mental health service engagement. In previous research, American veterans with PTSD indicated that the facilitative effect of primary care providers during the help-seeking process occurred in two phases: (a) making the referral to a specialist mental health practitioner, and (b) providing a trusting, supportive environment, which led veterans to follow through with the referral (Sayer et al., 2009). While the literature on positive effects of first-contact support is limited, considerably more research has been conducted on the iatrogenic effects of negative responses from professionals within the helping disciplines (Divinsky, 2007; Matsakis, 1996; Parry, Crawford, & Duggan, 2016). According to Morgan (1983), *iatrogenesis* refers to any negative effect brought forth or caused by the activities of helping professionals in

the process of helping. This phenomena has been cited widely in the psychiatric and mental health care literature, and studies have shown that consumers' distress and/or symptoms are perpetuated by the language, actions, or inactions of mental health providers (Parry et al., 2016; Sartorius, 2002; Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011). Specifically, this concept has been used to explain increases in distress and feelings of abandonment among PoPVs (Matsakis, 1996; McLean, 2006). Similar to the hindering incidents reported in the current study, McLean (2006) found that dismissive or non-empathic responses from first-contact care providers deprived Canadian PoPVs of needed supports and services, or alternatively, necessitated repeated attempts to access services. Together, these findings suggest that more education and training for first-contact care providers is warranted to counteract the unintended iatrogenic effects of gaps in clinical knowledge pertaining to PoPVs' distress and experiences.

Therapeutic alliance and change. The most salient finding among facilitative factors in this category was PoPVs' experience of progress made throughout counselling/therapy and their subsequent sense of empowerment. This finding is important for two reasons. Firstly, while there is no single paradigm unifying all psychological therapies, the perception and experience of client change remains an important factor in many therapeutic settings (Duncan, Miller, Wampold, & Hubble, 2010). The central importance of therapeutic change is reflected in the growing trend of progress monitoring, which serves not only to establish the effect of therapy but also to guide future clinical practice (Duncan et al., 2010; Overington & Ionita, 2012). A considerable body of evidence indicates that tracking progress in clinical practice is associated with improved treatment outcomes and fewer cases of client deterioration (Anker, Duncan, & Sparks, 2009; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Shimokawa, Lambert, &

Smart, 2010). These findings suggest that routine outcome and/or progress monitoring may be an important tool to integrate into counselling/therapy in order for PoPVs to reflect, communicate, and consolidate whether change has occurred. Additionally, progress monitoring would give providers an opportunity to modify counselling/therapy interventions to meet the evolving needs and goals of PoPVs.

Secondly, many theoretical frameworks emphasize client empowerment as both an integral activity and outcome of the counselling process (Cattaneo & Chapman, 2010; White & Epston, 1990; Worell & Remer, 2002). In line with previous research (Baker, 2009; McLean, 2006; Outram et al., 2009; Yambo et al., 2016), the current study indicates that PoPVs may be commencing counselling/therapy feeling disempowered, discouraged, and overwhelmed by the effects of the veterans' PTSD on their life, and are also in search of solutions for the specific challenges they face. Therefore, the integration of therapeutic frameworks that emphasize client empowerment and agency may be an optimal counselling/therapy approach with PoPVs.

However, additional research is needed to better understand the precise meaning and process of empowerment experienced among PoPVs, as well as the specific therapeutic approaches used by their mental health providers.

Exosystem Level

Health care system management. Three central issues pertaining to health care system management were identified by PoPVs: (a) case management practices, (b) resource allocations to mental health supports and services, and (c) the coordination of intersecting mental health and military-related system. In the current study, case management practices appeared to vary widely with no apparent consistency between or within regions or jurisdictions. In fact, differential case management practices appeared to contribute to disparities in access to care for PoPVs in the

current study. Specifically, among the few PoPVs who reported experiencing invested, caring, and accountable case management, access to care and supports was efficient and less cumbersome. However, the majority of PoPVs expressed that the process of gaining approval for services was overly complicated and drawn out by ineffective case management, which only further contributed to their family's distress. Similar experiences have been reported among American PoPVs, in that low navigability of the VA health care system was cited as consistent barrier to continued participation in individual and couples therapy (Mansfield et al., 2014). PoPVs in the current study also felt that the role of case managers required revision and expansion to better reflect the changing composition of veteran families. Specifically, the current and incoming cohort of veterans are younger, will access benefits for a longer period of time, and are more likely to be married and have children under the age of 18 (Office of the Parliamentary Budget Officer, 2015; Park, 2008; Rouleau et al., 2013). Therefore, effective and evidence-based case management practices are critical to supporting PTSD-affected families as they age and endure longer periods of disability.

PoPVs also identified the hindering effect of limited resource allocation to mental health services and supports, as well as cuts to existing programs. The abrupt discontinuation of programs, such as partner-oriented support groups, without the provision of interim support is problematic for two reasons. First, because PTSD-affected families may be geographically dispersed or live in rural communities, they may have no alternate form of support. Second, the abrupt loss of support can leave PoPVs in a state of heightened vulnerability, especially for those who are experiencing social isolation. While previous research has not examined the direct effects of unplanned termination of support on PoPVs' distress, one study reported that American PoPVs cited cuts to mental health services, low staffing, and lengthy wait times as

barriers to continued participation in individual and couples therapy (Mansfield et al., 2014). Therefore, these findings suggest that the unique issues related to military-related mental health management, such as cuts to programs, may further compound the pre-existing stressors associated with mental health service access in the broader, public system.

PoPVs in the current study felt that the manner in which mental health systems are orchestrated overlook the chronicity of PTSD and how it affects PoPVs across the lifespan and at different developmental junctures in the individual and family life cycle. For many military and veteran families, the effects of PTSD are lifelong (Dekel et al., 2005; Mansfield et al., 2014; Yambo et al., 2016). Therefore, mental health and military-related systems must be designed in a way that effectively responds to the varying levels of need experienced over the lifespan of PTSD-affected families. The coordination of these intersecting systems needs to consider the unpredictable ebb and flow of PTSD, including the periods of instability, stress, upheaval, and crisis that may recur over the course of the veterans' life and its influence on family members' evolving needs. As emphasized in the current study, a coordinated effort between the broader mental health system and military-related institutions must ensure that support is easily re-accessible to families throughout the entire lifespan, regardless of the time that has elapsed since previous contact.

Macrosystem Level

Service characteristics. Many logistical and structural barriers related to service characteristics have been cited in previous research on military populations. For instance, prior studies have revealed that barriers to service access and utilization include services fees (Sayer et al., 2009), the need to travel long distances between home and service centers (Lyons & Root, 2001), and absence of services in rural and remote areas (Outram et al., 2009; Sherman et al.,

2008). Given the high mobility of Canadian military and veteran families (Battams, 2016), the effects of frequent relocation on PoPVs' careers and earning potential (Urban et al., 2012), and the differential access to benefits and compensation reported by PoPVs in the current study, it is not surprising that financial and geographical impediments were frequently cited as barriers to care. Currently, no research has investigated the logistical and structural facilitators to mental health service engagement among PoPVs. In the current study, mental health service engagement was facilitated by service characteristics that afforded PoPVs greater autonomy in choosing the type of service they receive, when they receive it, who delivers it, and how often. Thus, the findings of this study make some noteworthy contributions toward understanding the role of service design and delivery in facilitating PoPVs' ability to connect with needed supports.

PoPVs' perceptions of the relevance and appropriateness of programs and services in relation to their presenting concerns and/or needs also emerged as an important determinant in mental health service engagement. However, no research to date has explored perceptions of service relevance among PoPVs. In the current study, when services were relevant to PoPVs' needs and compatible with their own conceptualization of the presenting problem, PoPVs were more invested in pursuing these services and reported better outcomes. These findings indicate that the scope and breadth of services available to PoPVs must be as diverse as the range of needs and presenting concerns experienced by this population. Specifically, coordinated efforts among the military, VAC, and the mental health system to disseminate formal programs and supports for PoPVs must adopt a tailored approach to service design and implementation. It must also be recognized that a mismatch between services and PoPVs' needs is likely to lead to poor outcomes and create the illusion that services are not needed because of low access (Batten et al., 2009).

Provider expertise/competencies. Research suggests that mental health provider competencies and training play an important role in the quality, effectiveness, and relevance of mental health interventions for clients (Branson, Shafran, & Myles, 2015; Fairburn & Cooper, 2011). Furthermore, competency standards are critical to ethical therapeutic practice, not only with respect to treating specific mental health conditions (Fairburn & Cooper, 2011), but also for addressing the needs of culturally diverse clients, groups, and communities (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Previous authors have proposed that a specific set of provider competencies, skills, and expertise that integrates trauma theory and military culture is needed in order for counselling/therapy to be effective with military and/or veteran personnel with PTSD (Beks, 2016a; Butler, Linn, Meeker, McClain-Meeder, & Nochajski, 2015; Smith, 2014). However, core provider competencies for working with PoPVs have not been discussed in previous literature. Given the PoPVs' role in military families and communities, and their proximity to the psychological and physical symptoms of service-related PTSD, it is not surprising that PoPVs in the current study identified the absence/presence of provider expertise in trauma, military culture, and family systems as an important factor in their decision to continue using mental health services. Additionally, while PoPVs found knowledge of military culture helpful, they did not perceive the use of military jargon in service delivery to be beneficial or appealing. The findings from this study also revealed that PoPVs would benefit from providers who possess competencies in STS as well. Interestingly, PoPVs reported that few, if any, providers had expertise in STS, and that even those providers with expertise in trauma had a limited understanding of vicarious traumatization. This finding suggests that two issues may be at play. Firstly, providers may lack specialized training in trauma- and stressor-related conditions, as comprehensive coverage of these topics is not yet a core component of the

standard curricula of graduate educational programs in psychology (Cook & Newman, 2014; Courtois & Gold, 2009). Secondly, it is plausible that a gap exists between clinical education, knowledge, and training in STS, and clients' lived experience of this mental health condition (Cook & Newman, 2014). Thus, future research is needed to develop an evidence-based core competency model for working with PoPVs, particularly those experiencing STS. Additional training is also necessary to understand a broader range of secondary reactions to trauma and to tailor interventions in ways that honour PoPVs' diverse experiences.

Institutional accountability and transparency. PoPVs cited the failure of military-related institutions' to prioritize the welfare of military families as hindering their efforts to engage mental health services. This led many PoPVs to believe that if greater priority were given to the welfare of military families, their attempts to engage mental health services would have been more successful and straightforward. The incidents cited in this category are consistent with previous research. For instance, in an earlier study conducted by McLean (2006), Canadian PoPVs described mistreatment by military and government professionals who were designated to assist them. Responses from military and government professionals, such as insensitivity, disbelief, denial, and delay of assistance, contributed to a sense of shame, abandonment, and distrust among PoPVs and veterans (McLean, 2006). Beyond the Canadian context, Australian PoPVs have reported feelings of resentment toward the government due to the excessive and unreasonable expectations that have been placed upon them to care for veterans in the absence of tangible government support (Outram et al., 2009). Therefore, these findings provide compelling impetus to more closely examine the role of institutional behaviours in PTSD-affected military and veteran families' mental health service engagement.

The relationship between institutional failures to prioritize military families and PoPVs' subsequent feelings of distrust, disillusionment, and abandonment, as well as increased distress, is analogous with the phenomena of *institutional betrayal* (IB; Smith & Freyd, 2014). According to Smith and Freyd (2014), IB refers to the failure of a trusted and powerful institution to protect and support its members. Furthermore, institutional wrongdoings may not only exacerbate the initial trauma experienced by members, but may also represent a distinct traumatic event in its own right (Freyd & Birrell, 2013). However, in order for IB to occur, members must first trust and depend upon that institution (Smith & Freyd, 2014). Indeed, PoPVs seek care in a state of heightened vulnerability due to their reliance on military and government institutions. Therefore, it is important to discuss the role of IB in PoPVs' mental health service engagement for two reasons. First, previous research has found that instances of IB are associated with exacerbated symptoms of PTSD and suicidal ideation among military personnel whom initially experienced symptoms following exposure to traumatic events (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016; Smith & Freyd, 2013). Given that PoPVs may develop a range of mental health concerns, including STS (O'Toole et al., 2015; Yambo et al., 2014), and that they too are dependent upon military and government institutions for access to critical supports, it is likely that PoPVs' symptoms are affected by IB in much the same way as military and veteran personnel. Secondly, much of the extant literature on PoPVs' mental health has focused on individual and dyadic factors, ranging from personal coping strategies (Franciskovic et al., 2007; Lyons, 2001) to marital functioning (Lambert et al., 2015). IB broadens this discussion by highlighting the influence of PoPVs' interactions with military and government organizations, adding a new dimension to conceptualizations of PoPVs' distress and vicarious trauma.

It is worth noting that the DND and VAC have taken a number of steps to improve accountability and transparency with respect to military and veteran families. For instance, the DND and VAC have formally pledged to support military and veteran families through the unveiling of the Canadian Forces Family Covenant in 2008 (Rouleau et al., 2013) and the Veteran and Family Community Covenant in 2011 (VAC, 2013). Both social contracts aspire to bring greater awareness to the needs of military and veteran families as well as programs and services designed to support them (Rouleau et al., 2013; VAC, 2013). With the increased implementation of VAC-sanctioned programs and services directed toward veteran families since the establishment of the Covenants, it is surprising that PoPVs' challenges with and perceptions of the military and government have remained relatively consistent since McLean's (2006) original study. Collectively, these findings suggest that the tangible impact of the values codified in the Covenants has yet to be determined. Furthermore, it is plausible that an enduring discrepancy remains between the needs of PoPVs and the efforts put forth by the DND and VAC. Without an in-depth understanding of these needs, it is likely that perceptions of IB among PoPVs and PTSD-affected families will persist. Thus, the current study provides preliminary insight into the types of institutional actions that hinder PoPVs' mental health service engagement. However, future research is needed to examine the role of institutional accountability, transparency, and betrayal in the mental health outcomes of Canadian PTSD-affected military and veteran families.

Cultural and organizational influences. In line with earlier research, the current findings suggest that the implicit messages communicated via military-related values, hierarchical structures, roles, expectations, and policies have a profound impact on mental health service engagement. Firstly, research suggests that military personnel may be deterred from

mental health service engagement due to fears of career-related repercussions (Weiss & Coll, 2011). For instance, veterans with PTSD in both Canada and the U.S. have reported that a significant barrier to their help-seeking pertained to fears of negative consequences for service-related compensation or career advancement if their mental health concerns were disclosed to colleagues (Lyons & Root, 2001; Sherman et al., 2008; Weiss & Coll, 2011). The legitimacy of these concerns has been substantiated by recent research and anecdotal evidence that has revealed a range of ramifications experienced by military personnel following disclosures of PTSD, including military release, career stagnation, and a lack of workplace accommodations (Freyd & Birrell, 2013; Russell, Zinn, & Figley, 2016; Walters, 2015). Consistent with an earlier study (Eaton et al., 2008), the current research found that PoPVs refrained from seeking help because they feared harming the veterans' (then military member) career. These findings suggest that fears of career-related ramifications among PTSD-affected veterans extend to PoPVs and directly influence their mental health service engagement. Therefore, it is plausible that services located and operated independently of base or military communities may offer PoPVs an increased sense of confidentiality and privacy, thereby reducing fears about career-related ramifications and facilitating mental health service engagement.

PoPVs in the current study noted that specific aspects of military culture hindered their mental health service engagement. The mechanism by which this cultural context shapes military personnel's response to trauma and their subsequent efforts to alleviate traumatic after-effects has been discussed by several authors (Hoge, 2011; Lorber & Garcia, 2010; Weiss & Coll, 2011). The military's emphasis on traditional male gender norms of fearlessness and invulnerability is considered vital to maintaining force preparedness for military-related operations (Hoge, 2011; Lorber & Garcia, 2010; Weiss & Coll, 2011). However, beyond the

confines of CAF operations, the residual effect of these attitudes, beliefs, and customs creates a culture of silence about post-traumatic stress symptoms (Jakupcak, Osborne, Michael, Cook, & McFall, 2006; Lorber & Garcia, 2010), which in turn, acts as a powerful barrier to help-seeking among military populations (Iversen et al., 2011; Langston, Gould, & Greenberg, 2007). These fears and beliefs are not unfounded, as incidences of workplace discrimination and accusations of malingering have been reported by active and retired military personnel following disclosures of PTSD (Jones, Howard, Potts, & Hoffman, 2003; Rennick, 2005). While PoPVs in the current study did not necessarily accept the attitudes and beliefs underlying the silencing effect of military cultural norms, many felt that they could not seek help themselves unless the veteran was ready or willing to access help. This novel finding indicates that the unique military and veteran cultural context may impede engagement with mental health services for the entire family unit, resulting in family distress going unaddressed for an extended period of time. Therefore, it is critical that educational interventions are disseminated to address the constellation of beliefs, attitudes, and customs that may interfere with mental health service engagement, not only to military personnel and veterans but to family members as well.

The most significant and frequently cited hindrance within this category was the VAC policy that prevents PoPVs from initiating contact, requesting support, or making decisions about their care unless the veteran member grants permission first. This policy had a direct impact on PoPVs' attempts to secure approval for counselling/therapy and obtain coverage for such services through VAC. In 2013, VAC published "A Timely Tune-up for the Living New Veterans Charter", a report detailing the actions taken to implement recommendations from the House of Commons Standing Committee on Veterans Affairs. This report stated that VAC has taken steps to ensure that "family members of Veterans are able to access VAC rehabilitation

programs independently, and that all important information pertaining to the rehabilitation program is made available without breaching confidentiality” (VAC, 2013, p. 18). This formal document represents a shift toward recognizing the critical roles that PoPVs assume in veteran families. To date, additional information on the precise parameters and specifications of this initiative and its implementation is unavailable in the public domain. Thus, the nature, application, and impact of this recommendation remains unclear. Nevertheless, based on the findings from the current study, PoPVs would be afforded greater decision-making power over their well-being if they had direct access to case management personnel without the need for permission from the veteran member. As such, this change would provide a direct pathway between PoPVs, VAC, and mental health service providers.

Family-centred care. Given that trauma results in changes at the individual and systems levels, it is not surprising that PoPVs’ referred to family systems throughout their interviews. Specifically, PoPVs indicated the need for more opportunities to engage in family- and couple-oriented therapies, more supports and resources specifically geared to family members of PTSD veterans, greater involvement in the veterans’ care, and the need to be acknowledged by the broader mental health and military-related systems. These findings are supported by previous literature in which PoPVs expressed a desire for both individual and family-oriented therapy but only one third of participants had received any form of the two (Sherman & Sautter et al., 2005). Furthermore, the content of services being offered to PoPVs was described as incompatible with their needs (Lyons & Root, 2001). Specifically, American PoPVs perceived an overemphasis on psychoeducational programs about PTSD and a lack of resources and interventions regarding coping, stress reduction, and social isolation (Lyons & Root, 2001). Interestingly, PoPVs in the current study expressed the need for more of the former and the latter, suggesting that military

and veteran psychoeducational resources on PTSD for PoPVs' in Canada may lag behind the U.S. Also consistent with the current study, prior research has found that PoPVs were deeply concerned about how the veterans' PTSD was impacting their children (Yambo et al., 2016), but few services directed toward children of veterans with OSIs exist (Tam-Seto et al., 2016). These findings suggest that more resources and supports are required to address the effects of PTSD on all members within the veteran family unit, further emphasizing the need for family-centered models of care.

Previous research has consistently revealed that PoPVs wish for greater involvement in the veteran's care (Mansfield et al., 2014; Sautter et al., 2006; Yambo et al., 2016). Family involvement has been found to facilitate assessment and treatment planning for veterans with PTSD, and is linked with greater satisfaction among family members (Monson, Schnurr, Stevens, & Guthrie, 2004). Furthermore, previous research has found that family treatment engagement has enhanced treatment outcomes for patients by educating and training family members, predominantly partners, in how to respond best to symptoms and behaviours (Falloon et al., 2002; Monson et al., 2004). Interestingly, an earlier study found that a significant barrier to partner engagement in veterans' PTSD treatments was PoPVs' reluctance to participate (Sautter et al., 2006). This finding is in contrast to the perspective of PoPVs in the current study, and highlights the importance of exercising caution when drawing conclusions about Canadian military mental health services from non-Canadian literature.

Research suggests that there are several important considerations in determining whether family-centered care is indicated for a PTSD-affected veteran family. First, Sherman and Sautter et al. (2005) found that American PoPVs who reported higher frequencies of contact with veterans exhibited less preference for individual therapy over other formats. Second, older

PoPVs exhibited less preference for family therapy in comparison to their younger counterparts (Sherman & Sautter et al., 2005). Third, in couples where the veteran reported more severe PTSD symptomatology, PoPVs cited greater preference for family-oriented services (Sherman & Sautter et al., 2005). Interestingly, the current study provides some support for these findings in that PoPVs expressed disappointment that services directed toward them appeared to be designed for the previous generation of veterans and their families. However, in contrast to Sherman and Sautter et al.'s (2005) findings, no references to the severity of PTSD symptoms as a barrier or facilitator to engagement were indicated in the current study. Overall, the degree to which Sherman and Sautter et al. (2005) study is transferable to Canadian veteran families is unknown. However, in light of the current study findings, it is clear that assessing and considering the needs, preferences, and unique context of each family is critical to determine the most suitable intervention format or combination thereof.

It is also important to note that previous research has found that first-line treatments for PTSD do not necessarily address or improve couple and family functioning (Lunney & Schnurr, 2007; Monson, MacDonald, Vorstenbosch, et al., 2012). At the same time, couple- and family-oriented therapies are not indicated as a first-line treatment for service-related PTSD (Monson, MacDonald, & Brown-Bowers, 2012), in part because of the paucity of research demonstrating its effectiveness. As such, couple- and family-oriented therapies have not been widely applied to PTSD-affected veteran families, despite PoPVs overwhelming preference for these treatments in the current study. Furthermore, clinical guidelines assume that the priority concern for all PTSD-affected veteran is to ameliorate their PTSD symptoms (Monson, Macdonald, & Brown-Bowers, 2012). While this may be a shared concern for all PTSD-affected veterans, improving couple-

and family-functioning may in fact be the priority concern of many veterans, further highlighting the need to consider the unique needs and concerns of each veteran family.

PoPVs also expressed the desire for the broader mental health and military-related systems to acknowledge, recognize, and respond to their needs, experiences, and challenges. These findings are also consistent with previous research on PoPVs. In a study conducted by Mansfield et al. (2014), American PoPVs indicated that they had never been queried about their perspective, preferences, or opinions by the Department of Veterans Affairs, despite the fact that they had been living with the secondary impact of PTSD for many years. Together, these findings suggest that PoPVs' feel their voices are underrepresented, ignored, and undervalued in decision-making around the veterans' care, the design and implementation of services and supports, and allocation of government funding in support of military and veteran families. However, the important role of PoPVs in veterans' well-being and rehabilitation, and their increased risk of developing poor mental health outcomes, provides an even stronger impetus to engage PoPVs at every level of designing supports and services for veteran families.

Implications

From the beginning, this research aimed to inform key strategies to improve mental health information, supports, and services for Canadian PoPVs. As such, the recommendations put forth here are not exhaustive but rather intend to serve as a point of departure for further discussion, research, and practice specifically regarding mental health service engagement among Canadian PoPVs and their families:

Recommendations for Mental Health Professionals and First-Contact Care Providers

- Given PoPVs' strong preference for alternatives and adjunct therapies (e.g., equine therapy, art therapy), engage in collaboration across disciplines and provide a range of holistic options in addition to talk-based interventions for PoPVs and their families.
- Undergo specialized training in military culture, trauma (including STS and its variable presentations), and family systems to increase provider competency and the effectiveness of interventions provided to PoPVs.
- When discussing the benefits of mental health services with veterans, it is also important to emphasize the benefits of PoPVs engaging in various forms of formal and informal supports. This will promote positive dyadic coping and encourage veteran couples to engage in individual-, couple-, or family-oriented services.
- Beliefs and fears that contribute to self-stigma may need to be challenged, normalized, explored, and/or reframed by mental health providers to promote family members' participation and optimize the benefits of treatment.
- Explicit attention and thorough assessment of suicidal ideation should be conducted with all members of the family unit on an ongoing basis to address each members' distress before life-threatening mental health emergencies arise.
- Recognize that family-centered interventions are not indicated for everyone; work with PoPVs and the family to determine individual and collective needs.
- While education is important, education alone is unlikely to meet the needs identified by PoPVs. Education must be balanced with appropriate therapeutic interventions that address the diverse concerns cited by PoPVs, including coping skills, social isolation, physical health conditions, and more severe forms of psychological distress.

Recommendations for Government, Military Institutions, and Policy Makers

- Orchestrate a concerted effort to provide widespread education and training for PoPVs on the detection and recognition of: (a) symptoms and experiences associated with caregiver burden, (b) common mental and physical health conditions experienced by PoPVs, (c) distress and/or suicidal behaviours in family members, including children, and (d) unusual or disruptive alterations in family relational patterns.
- Appropriate and innovative steps must be taken to address the broad range of barriers that are contributing to disparities in engaging mental health information, supports, and services for PoPVs across Canada.
- Undertake routine assessment of PoPVs' needs and perceptions of institutional accountability and transparency. Asking PoPVs about their experiences with military and governmental institutions will not only guide future practices, it will also acknowledge their perspective and involve them in their own mental health care and well-being. Most importantly, assessments must be followed by tangible, concrete actions that honour PoPVs' needs and preferences.
- Although initial steps have been taken to highlight the need for PoPVs' autonomy with respect to accessing VAC-sanctioned health benefits and supports, concrete measures must be taken to ensure that a universal policy is instated and fully implemented, and that the actions and outcomes associated with such a policy are properly evaluated and altered to meet the evolving needs of PoPVs.

Recommendations for Mental Health System Design and Delivery

- Services are needed to address crises that happen after business hours and overnight. Thus, the continued need for 24-hour crisis lines that assist families affected by service-related PTSD cannot be understated.

- Movement toward a family-centred model of care that both integrates and is informed by the expressed needs, preferences, and requirements of PoPVs and their family members is needed. The assemblage of information about PoPVs' participation in and experiences with mental health services should be a routine procedure in planning, design, and delivery of care for PTSD-affected families. Furthermore, the children of veteran families affected by PTSD should be integrated into mental health services when appropriate and as often as possible.
- Relapses in PTSD symptoms can and will recur throughout the lifespan, requiring periodic access to support for veterans and their families. Service design needs to reflect an understanding of the course and trajectory of trauma responses and be prepared to meet the recurring and evolving needs of families throughout the life cycle of PTSD.
- Ensure the delivery of flexible, efficient, and accommodating services, recognizing that PoPVs are managing multiple roles, responsibilities, and demands. Provide concurrent groups for children and veterans so that all members of the family are having their needs met.
- A wide variety of media and communication technology should be implemented, including print and internet resources, online support groups, and crisis/information lines, to provide improved ease of access and to overcome disparities in resource availability among geographically dispersed veteran families.
- Outreach strategies and interventions need to be tailored specifically to PoPVs whose socio-historical contexts or current situations do not facilitate mental health service engagement. Specifically, PoPVs who endure significant social isolation, coupled with

residing in rural or remote areas, may require new or advanced use of digital technologies (i.e., Skype counselling) in order to benefit from established supports and services.

Study Limitations

The current study used a purposive, snowball sampling technique to explore PoPVs' experiences with mental health service engagement. As such, PoPVs' descriptions of their experiences may not be representative of all Canadian PoPVs' experiences with mental health service engagement. Therefore, the results of the current study cannot be generalized beyond the current sample. However, the aim of this investigation was not to generalize findings but rather to understand and bring attention to an underexplored phenomenon, and provide new insights to guide key stakeholders in future mental health support and service design and policy development.

Additional limitations of the current study include the absence of male, non-English speaking, non-Caucasian, and LGBTQ participants. Although established programs and supports serve all PoPVs, the current study was unsuccessful in securing representation from these diverse groups. Although bilingual participants from French-speaking regions of Canada participated in this study, the perspective of non-English speaking PoPVs is absent. In addition, the current study was unsuccessful in securing representation from the provinces of Newfoundland/Labrador, Manitoba, and Saskatchewan, as well as the Canadian territories. Furthermore, all participants in this study had pursued some form of advanced schooling beyond primary and secondary education. Therefore, this sample had limited heterogeneity and had this sample been more diverse, different incidents and contextual factors may have been identified.

There are several study delimitations worth noting. Firstly, participation in the current study required that veterans had engaged in treatment for PTSD either previously or at the same the study was undertaken. While this screening criteria served the purpose of increasing safety

for both the participant and veteran partner, it also excluded this particular subgroup from the potential benefits of participating in this research. Therefore, the unique barriers and needs associated with this specific subgroup of the veteran population remain unknown. Future research should consider ways of including this subgroup in research while also addressing ethical concerns related to safety for the veteran couple and/or family. Secondly, the collection of socio-demographic information such as family rank, time between onset of PTSD and access to treatment and/or VAC benefits, reason for release/discharge, and the family's phase of transition would have provided additional context for the current findings. Thirdly, participation in the current study required veterans to have been diagnosed with service-related PTSD. However, because this study focused on PoPVs and did not include veterans, diagnostic confirmation through medical reports was not obtained. Furthermore, the mental health and physical health diagnoses of PoPVs were offered voluntarily and no medical reports were requested for confirmation. However, eliciting this information may have provided additional insight into whether specific incidents corresponded with particular mental health or physical conditions.

Several challenges and limitations related to the ECIT methodology were noted over the course of this study. Firstly, it was observed that there is no general consensus on the philosophical paradigm underpinning the ECIT. Secondly, there are no formal guidelines on how to analyze the contextual data. Thirdly, there is no established rhetorical structure for reporting contextual and CI findings. These elements of the ECIT would benefit from greater clarification and formalized procedures, which would contribute to a more consistent and standardized methodology across studies and disciplines. Finally, in accordance with the ECIT protocol, incidents that do not meet the full criteria of a CI or WL item (i.e., the meaning/importance/example could not be provided by the participant) cannot be included in the

data analysis, even though it may provide important insights to the topic under investigation. Thus, future researchers should consider the potential implications of using the ECIT in studies that espouse social justice principles of privileging participants' perspectives.

Recommendations for Future Directions

Based on the findings and limitations of the current study, the following directions for future research are recommended. Above all, research on Canadian PoPVs is sorely needed. A combination of large-scale population-based studies and qualitative research would provide a coherent picture of mental health service engagement, and provide concrete directions for service planning and design. The paucity of research on Canadian PoPVs suggests that little is known about the unique needs, preferences, and interests of a population who is at increased risk of deleterious social, emotional, psychological, physical, and vocational outcomes. Furthermore, studies need to include PoPVs from diverse communities in order to determine whether supports and services are meeting their unique needs. With more research in this area, services, supports, and resources may be optimized and lead to improved outcomes for PoPVs across Canada.

Future research in the area of PoPVs' mental health service engagement may also assess whether the effect of specific facilitators or barriers depends on critical time points following the emergence of the veterans' PTSD symptoms. Future research may explore further the interrelationships between barriers and facilitators to seeking, accessing, and utilizing mental health services among PoPVs, and investigate whether these factors conflate in a cumulative manner to facilitate or hinder mental health service engagement. In addition, future studies may explore the relative influence of barriers and facilitators on PoPVs' seeking, accessing, and utilizing, and determine whether facilitators are more powerful than barriers.

It is critical that future research explore applications of family-centered models of care for PTSD-affected military and veteran families in Canada. Evidence for the effectiveness of

family-centred care is limited with respect to military and veteran families affected by trauma, and to date, no Canadian studies have been undertaken to examine its value for alleviating the systemic impact of PTSD for family members' of veterans. Without such efforts, it is unlikely that family-oriented therapies and family-centered care will emerge as first-line approaches for military and veteran families in the future.

With respect to military and mental health care systems, future research needs to consider the systemic impact of service-related PTSD on children. Furthermore, the experiences and reflections of adult children of veterans with PTSD can provide increased awareness of unmet needs and opportunities to better support families. Future research may also give greater attention to the role of military and governmental institutions in exacerbating or alleviating the distress of PTSD-affected military and veteran families. Finally, additional research is needed to identify the most supportive and effective case management practices for PTSD-affected military and veteran families.

Summary and Conclusions

This study explored the barriers and facilitators to mental health service engagement among Canadian PoPVs who self-identified as having experiences that necessitated help-seeking through the use of ECIT. Collectively, PoPVs identified 202 helping CIs, 237 hindering CIs, and 98 WL items, which were subsequently grouped into 13 categories. While this research does not claim to offer guaranteed solutions to alleviating barriers or facilitating engagement, it does provide insight into unmet needs and suggestions for improving mental health services and supports from the perspective of PoPVs. As such, this research provides valuable information for designing supports, services, and interventions, important considerations for evaluating the quality and effectiveness of care, and highlights important directions for future research in this area.

A comparison of the contextual component findings and the critical incident results with the literature on PoPVs and mental health service engagement provides some notable similarities and novel contributions. The existing literature provide some support for all 13 categories, indicating that the present study adds to the current state of knowledge on PoPVs' mental health experiences and service engagement. At the same time, the current findings revealed novel insights into the unique experiences and ecologies of Canadian PoPVs as they navigate SOCs. As this study is exploratory, additional quantitative and qualitative research will extend these findings and validate solutions for mitigating barriers to and facilitating engagement with mental health services for PTSD-affected military and veteran families.

Broadly, the current research contributes new insight into understanding mental health service engagement as an ecological phenomenon. To date, much of the extant literature has focused on the role of intra-individual factors in PoPVs' mental health outcomes and service engagement. While some attention has been drawn to the role of broader systems, the importance of this research stems from its explicit attention to the role of extra-individual factors in Canadian PoPVs' mental health service engagement. Through the application of EST, the current study revealed that the majority of barriers and facilitators to mental health service engagement among PoPVs occur at extra-individual levels. These findings do not suggest that prior research and its emphases on intra-individual factors are overstated or inaccurate. Rather, it suggests that if we are to design and deliver effective, relevant mental health services, we as policy makers, researchers, providers, and government officials must move beyond cursory acknowledgement of extra-individual forces. Specifically, we must consider, understand, and respond to the powerful effects of economic, political, geographical, social, and cultural factors that contribute to PTSD-

affected military and veteran families' distress, well-being, and efforts to seek and engage support.

From a social justice perspective, we have a civic and fiduciary responsibility as stakeholders to remain accountable to the far-reaching impacts of deployment-related traumatic events, to prioritize the welfare of families who have served and sacrificed on behalf of the Canadian public, and to effect meaningful and enduring change in military and veteran family mental health service engagement. Yet, if we are to fulfill these responsibilities, it is vital that the voices and perspectives of PoPVs are acknowledged, included, and upheld at all levels of decision-making pertaining to their well-being. In the very least, the findings from this study instills hope that through broader, multilevel, ecological approaches to understanding and resolving barriers to mental health service engagement, existing conditions and overlapping systems can be modified to effectively support and alleviate the struggles of PoPVs, PTSD-affected veterans, and their families.

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APPENDIX B: RECRUITMENT ARTICLE

Researcher seeking to give a voice to military spouses of veterans with PTSD



Touched by the story of a veteran and his family, Tiffany Beks, a masters student at the University of Calgary, is conducting a nation-wide study to give a voice for spouses of veterans diagnosed with PTSD.

"I really want to hear the stories of spouses in this position. I want to honour their experience and honour their stories and; hopefully, from listening to their experiences and looking at the themes that transcend their stories, the information gathered through this process can help to inform future service delivery specifically for spouses of veterans with PTSD, but also the family as a whole," said Beks.

Beks, who studies Counselling Psychology in the Werklund School of Education, first became interested in counselling psychology after conducting research for the Calgary Counselling Centre where she gathered information on topics ranging from domestic violence to eating disorders.

Beks interest in choosing this topic for her independent program of research for her studies developed after witnessing the journey of a military family Beks had known her entire life.

"I had the wonderful privilege of hearing their story and their struggles and witnessing the challenges they'd experienced; throughout the whole trajectory of him first learning that he had been diagnosed with PTSD and how they responded, the struggle they had in determining and understanding what to do next, and the challenges that accompany PTSD and how that impacts the family system," stated Beks.

And, so, Beks decided to conduct her research on how spouses of veterans diagnosed with PTSD are impacted. Initially, she started by looking at the data already published on this topic; however, most of the material she found was out of the U.S.

"So I really wanted to know how this was impacting Canadian spouses and what kind of challenges and success stories they had in locating and engaging in mental health services to meet their needs and access support," noted Beks.

The study began in October and she hopes to complete in late summer. Beks intends to present the research at the 2017 Canadian Institute for

Military and Veteran Health Research Forum with an aim of having it published in a relevant journal. She also hopes to inform Canadian social policy related to military families affected by PTSD through the study.

The researcher is still looking for participants. Spouses or partners interested in taking part in the study can be located anywhere across the country and interviews can be conducted via Skype, telephone or in-person.

Individuals who decide to take part in the study first undergo a brief screening questionnaire. Then, an initial interview takes place for 60 to 90 minutes consisting of the individuals experiences obtaining mental health services. Spouses are invited back for follow-up discussions and to look at transcripts from the initial interview.

To take part in the study, you must be over the age of 18 and are a co-habiting partner of a veteran who has experienced combat-related PTSD. Partners must be co-habiting with the veteran for a minimum of 12 consecutive months. Veterans must have previously received treatment or are currently receiving treatment from a recognized mental health professional. Couples cannot currently be involved in a separation or divorce process.

The study is on a volunteer basis and can withdraw at any time.

If you are interested in taking part in the study, **contact Tiffany Beks via email.**

APPENDIX C: PARTICIPANT SCREENING

SCREENING FORM

“The following questionnaire asks some questions to determine your entry into the study. These questions are asked of all prospective participants.”

Name: _____

Inclusion criteria

1. Are you 18 years of age or older?

Yes (Proceed to question 2)

No (Discontinue screening questionnaire)

2. Have you and your partner been living together for a minimum of 12 consecutive months?

Yes (Proceed to question 3)

No (Discontinue screening questionnaire)

3. Has your veteran partner experienced PTSD?

Yes (Proceed to question 4)

No (Discontinue screening questionnaire)

4. Has your veteran partner received treatment for PTSD from a recognized mental health professional?

Yes (Proceed to exclusion criteria)

No (Discontinue screening questionnaire)

Exclusion criteria

1. On a scale of 1 to 10, 1 being no concern and 10 being extremely concerned, how concerned are you about your or your partner's safety?

If respondent rates concern at 6 or above, participants will be excluded from the study due to significant distress and safety concerns. A rating at 6 or above warrants that the researcher provide information and referrals to the following community services and supports as required:

Alberta Health Services, South Calgary Walk-In Counselling
2nd floor, 31 Sunpark Plaza SE
403.943.9374
No-fee, drop-in counselling.

Alberta Health Services, ACCESS Mental Health
Several locations across the city
403.943.1500 ext. 2
No-fee. Referral must be made by a doctor

Distress Centre Helpline
 Suite 300, 1010-8th Ave SW
 403.265.4357 (HELP)
 No-fee telephone support.

Eastside Family Centre
 255 495 36th St NE (Northgate Mall)
 403.299.9696
 No-fee, walk-in counselling.

Calgary Counselling Centre
 #200, 940-6 Ave SW
 403.265.4980
 Fees are subsidized according to income.

Calgary Military Family Resource Centre
 4225 Crowchild Trail SW
 403.410.2320 x 3590
 Connects military families with resources and funding.

If respondent rates from 2 to 5 on the scale, they will be included in the study but their distress and safety will be monitored.

2. Are you and your veteran partner currently involved in a separation or divorce process?

Yes (Discontinue screening questionnaire)

No

If prospective participant meets all inclusion and exclusion criteria, provide the following study invitation script:

“Thank you for answering the screening questionnaire. You are eligible to participate in the study. I will email you a study information package shortly, which will provide more details about the study, what you will be asked to do, the type of questions you will be asked, and the potential risks and benefits to you as a participant. Once you have reviewed this material, and decide that you would like to participate, you can contact me to set up an interview time.”

If the prospective participant does not meet all inclusion and exclusion criteria, provide the following study exclusion script:

“Thank you for expressing your interest in this study. Based on responses, you are not eligible to participate in the study at this time. If you have any questions, please feel free to contact me. Thank you again for your time.” Referrals will be provided to those excluded from participating in the study.

APPENDIX D: CONSENT FORM



Name of Researcher, Faculty, Department, Telephone & Email:
 Tiffany Beks, MSc Student in Counselling Psychology, Werklund School of Education,
 Educational Psychology, (xxx) xxx-xxxx, tiffany.beks@ucalgary.ca

Supervisor:
 Dr. Sharon Cairns, Counselling Psychology, Educational Psychology

Title of Project:
 Barriers and Facilitators to Seeking, Accessing, and Utilizing Mental Health Services among
 Partners of Veterans with Posttraumatic Stress Disorder

Sponsor:
*This research was supported by the Social Sciences and Humanities Research Council of
 Canada, Canada Graduate Scholarship*



Social Sciences and Humanities
 Research Council of Canada

Conseil de recherches en
 sciences humaines du Canada

Canada

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.

Purpose of the Study

The purpose of this study is to explore factors that influence seeking, accessing, and utilizing mental health services among cohabiting partners of veterans with posttraumatic stress disorder (PTSD). The majority of research in this area has focused on survey research with partners of veterans outside of Canada. Therefore, this study addresses important elements lacking in

previous research by exploring the experiences of Canadian partners of veterans with PTSD. Please note that as a participant you will not be receiving therapy from the researchers as part of your participation.

What Will I Be Asked To Do?

You will be asked to participate in two Skype/telephone interviews with the primary researcher. The initial interview will consist of several questions about your experiences in seeking, accessing, and participating in mental health services. The exact questions have been provided to you in advance so that you are fully aware of the topics being covered in the interview. Your participation in the initial Skype/telephone interview portion of the study will require approximately 60 – 90 minutes of your time. Interviews will be audio-recorded in order to enable the primary researcher to revisit the interview at a later date, transcribe the conversation that took place, and analyze the discussion that occurred.

Approximately 4-6 weeks after the initial interview, you will be asked to schedule a brief second interview. You will receive an invitation to view a password-protected transcript (i.e., word document) of the initial interview through a secure, web-based software. This gives you the opportunity to review the discussion that took place, clarify sections of the interview, and request changes.

Prior to reporting the results of this study, the primary researcher will contact you and provide an opportunity to schedule a third follow-up Skype/telephone meeting to review the overall findings of the study with you. This gives you the opportunity to provide feedback and determine whether the findings from the study accurately reflect your experiences. Your participation in the follow-up meeting is completely voluntary.

Participation in this study is completely voluntary and you may refuse to participate altogether. You may also refuse to participate in parts of this study and you may decline to answer any and all questions. You may withdraw from the study at any time up until the second interview (i.e. after you have reviewed the interview transcript).

What Type of Personal Information Will Be Collected?

Should you agree to participate, you will be asked to share your experiences with seeking, accessing, and using mental health services. Prior to the interview, you will be asked to provide your full name, telephone number, and email address.

Only the primary researcher and the academic supervisor will have access to your name, telephone number, and email address, and this signed consent form. Only the primary researcher, the academic supervisor, research assistants, and a transcriber will have access to the audio-taped interviews and accompanying transcripts. A research assistant will review the results of the data analysis to check for credibility and validity.

Prior to audio-recording, you will have the option of creating a pseudonym to which you will be referred to throughout the interview. Using a pseudonym ensures that your name will not be linked to the audio-recording in the future.

There are several options for you to consider if you decide to take part in this research. You can choose all, some, or none of them. Please review each of these options and choose Yes or No.

I wish to remain anonymous, but you may refer to me by a pseudonym: Yes: ___ No: ___

The pseudonym I choose for myself is:

You may quote me and use my pseudonym: Yes: ___ No: ___

I wish to be emailed a copy of the study findings: Yes: ___ No: ___

I wish to participate in the follow-up interview via Skype/telephone: Yes: ___ No: ___

Are there Risks or Benefits if I Participate?

There are no foreseeable risks, harms, or inconveniences to you as the participant. The interview questions will ask about personal experiences related to seeking, accessing, and using mental health services. The focus will be on the factors that either helped or hindered your ability to seek, access, and use mental health services, and how these experiences impacted you. You will also be asked about what would have been helpful to you during these times. If the interview topics bring about negative memories or experiences, you are encouraged to let the researcher know, and a list of community resources and supports will be provided to you.

You may find it interesting and helpful to talk about experiences that have both hindered and helped you seek, access, and use mental health services. Your participation in this study may also help to identify ways that mental health service delivery and design can be improved and better meet the needs of military families affected by PTSD. The information you provide can also help to identify services that are needed but do not yet exist.

You will also be entered into a draw prize for a \$100 gift certificate to a restaurant of your choice in appreciation for your participation.

What Happens to the Information I Provide?

Participation is completely voluntary and confidential. You are free to discontinue participation at any time during the study. If you choose to withdraw from the study, you will be asked if the information provided up to that point can be kept for analysis, and your decision will be honoured. The researcher will schedule a second Skype/telephone interview to discuss any necessary adjustments or corrections to your interview transcript. Suggestions for adjustments will be incorporated into the results. Following this second interview, your data cannot be withdrawn from the study.

No one except the researcher, her academic supervisor, the research assistant, and the transcriber will be allowed to see or hear any of the answers to the questions or the interview recording. There are no names on the transcript or audio-recording. The information of all participants will be summarized for any presentation or publication of findings. Participants may consent to the use of direct quotes with pseudonym identifiers. Personal information, including name, email, and telephone number, are kept in a locked filing cabinet only accessible by the primary

researcher and her academic supervisor. The audio-recordings and interview transcript will be stored on a password-protected computer file for five years, after which time it will be permanently erased. The information you provide will be used toward the completion of a Master's thesis, a conference presentation, and a potential publication.

There is the potential for you to reveal information that would require the primary researcher to breach confidentiality and report to law enforcement or other legal authorities. The following information would require confidentiality to be breached: 1) if you disclose intent to harm either yourself or someone else; and 2) if you report child abuse or neglect.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and 2) you agree to participate in the research project.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature: _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Ms. Tiffany Beks
Werklund School of Education, Department of Educational Psychology
tiffany.beks@ucalgary.ca
and Dr. Sharon Cairns, Werklund School of Education, Department of Educational Psychology
(403)-220-3671, scairns@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at (403) 210-9863; email cfreb@ucalgary.ca.

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

APPENDIX E: DEMOGRAPHIC FORM

Name: _____ Date: _____

Please answer the following questions:

1. Age: _____ years 2. Gender: _____

3. Highest Educational Level:
_____4. Occupation:
_____5. In your own words, how would you describe your cultural background? (i.e., Euro-Canadian)
_____6. Annual family income:
_____7. Relationship Status: Married Common-law Partnership8. Have you been married before? Yes No9. Number of children with current partner:
_____10. Number of dependent children living in household:
_____11. When did the first symptoms of PTSD appear in your partner?
_____12. When did your partner receive an official diagnosis of PTSD?
_____13. Does your partner receive disability benefits as a result of PTSD? Explain:
_____14. Do you receive any mental health-related benefits as a result of your partner being diagnosed with PTSD? Explain:

15. Are you currently participating in mental health-related services (i.e., counselling, support groups) for concerns that have developed since your partner was diagnosed with PTSD?

 Yes No

APPENDIX F: INTERVIEW GUIDE

Semi-Structured Interview Guide: “Seeking, Access, and Utilization” Facilitators and Barriers

Pseudonym: _____

Date: _____

Interview start time: _____

1. Contextual Component of Interview: Initial Rapport Building

Preamble: As you know, I am investigating the factors that influence seeking, accessing, and using mental health services and supports among partners of veterans affected by posttraumatic stress disorder. This is the first of two interviews, and its purpose is to collect information about the events and incidents you have experienced that have facilitated or interfered with your seeking, accessing, and using mental health services and supports.

a. As a way of getting started, perhaps you could tell me a little bit about your current situation (i.e., family composition, employment status, living situation) as a partner of a veteran with posttraumatic stress disorder.

b. You volunteered to participate in this study because you identified yourself as having experiences that affected your life and may benefit from mental health supports and services (i.e., therapy, counselling, support groups). What experiences preceded the desire or need to seek mental health supports and services?

2. Critical Incident Component

a. Transition to Critical Incident questions: I’m going to ask you some questions around seeking services and supports. *Seeking* refers to the act of searching for mental health information, supports, and services that may be of benefit to you. What has helped you in seeking mental health supports and services? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example of this incident/factor? How did that help you access the service?)

Helpful Factor & What It Means to Participant (What do you mean by...?)	Importance (How did it help? Tell me what it was about [insert event] that you find so helpful)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

b. Are there things that made it more difficult for you to seek mental health information, supports and services? What kinds of things have happened that made it harder for you to seek information, supports and services? (Probes: What was the incident/factor? How did it impact

you? Can you give me a specific example of this incident/factor? How did that hinder you from accessing the service?)

Hindering Factor & What It Means to Participant (What do you mean by....?)	Importance (How did it hinder? Tell me what it was about [insert event] that you find so unhelpful.)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

c. We've talked about what's helped you to seek mental health services and supports [name them], and some things that have made it more difficult for you [name them]. Are there other things that *would have* helped you, or would help you, to seek mental health information, supports and services in the future? (Alternative question: I wonder what else might be helpful to you in seeking supports and services that didn't exist before?)

Wish List Item & What it Means to Participant (What do you mean by...?)	Importance (How would it help? Tell me what it is about [name wish list item] that you would find so helpful.)	Example (In what circumstances might this be helpful?)

d. Now I'm going to ask you some questions around accessing services and supports. *Accessing services* refers to initiating contact and engaging with a mental health support or service i.e., making an appointment and going to the first appointment). What has helped you in accessing mental health supports and services? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example of this incident/factor? How did that help you access the service?)

Helpful Factor & What It Means to Participant (What do you mean by...?)	Importance (How did it help? Tell me what it was about [insert event] that you find so helpful)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

e. Are there things that made it more difficult for you to access mental health supports and services? What kinds of things have happened that made it harder for you to access supports and services? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example of this incident/factor? How did that hinder you from accessing the service?)

Hindering Factor & What It Means to Participant (What do you mean by....?)	Importance (How did it hinder? Tell me what it was about [insert event] that you find so unhelpful.)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

f. We've talked about what's helped you to access mental health services and supports [name them], and some things that have made it more difficult for you [name them]. Are there other things that *would have* helped you, or would help you, to access mental health services and supports in the future? (Alternative question: I wonder what else might be helpful to you in accessing supports and services that didn't exist before?)

Wish List Item & What it Means to Participant (What do you mean by...?)	Importance (How would it help? Tell me what it is about [name wish list item] that you would find so helpful.)	Example (In what circumstances might this be helpful?)

g. Now I'm going to ask you some questions around utilizing services and supports. *Utilization* refers to following through with a mental health service or support. What has helped you in continuing to participate in or use mental health support and services? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example of this incident/factor? How did that help you use the support or service?)

Helpful Factor & What It Means to Participant (What do you mean by...?)	Importance (How did it help? Tell me what it was about [insert event] that you find so helpful)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

h. Are there things that made it more difficult for you to follow through with or continue using mental health services and supports? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example of this incident/factor? How did that hinder you from using or continuing to use the support/service?)

Hindering Factor & What It Means to Participant (What do you mean by....?)	Importance (How did it hinder? Tell me what it was about [insert event] that you find so unhelpful.)	Example (What led up to it? What was the incident? What was the outcome of the incident?)

i. We've talked about what's helped you to continue to use mental health services and supports [name them], and some things that have made it more difficult for you [name them]. Are there other things that *would have* helped you, or would help you, to continue to use mental health services and supports in the future? (Alternative question: I wonder what else might be helpful to you in accessing supports and services that didn't exist before?)

Wish List Item & What it Means to Participant (What do you mean by....?)	Importance (How would it help? Tell me what it is about [name wish list item] that you would find so helpful.)	Example (In what circumstances might this be helpful?)

3. Is there anything else you would like me to know about your experiences of seeking, accessing, and using mental health supports and services?

Interview End Time: _____

Length of Interview: _____

Interviewer's Name: _____

APPENDIX G: DEBRIEFING FORM

Thank you for participating in this study designed to explore the factors that influence seeking, accessing, and utilizing mental health services among partners of veterans with PTSD. It is anticipated that your input will contribute to improvements in mental health services for military families affected by PTSD.

If your participation today has brought on distressing thoughts, memories, and feelings, and you would like the support of a mental health professional, please contact one of the following services:

The Walk-in Counselling Clinic
Offered at several locations within the Champlain region:
Jewish Family Services of Ottawa
300-2255 Carling Avenue, Ottawa, ON
1-613-722-2225

Family Services Ottawa
312 Parkdale Avenue, Ottawa, ON
1-613-725-3601

North Renfrew Family Services
109 Banting Drive, Deep River, ON
1-613-584-3358

Counselling and Support Services of Stormont, Dundas, & Glengarry
26 Montreal Rd., Cornwall, ON
1-613-932-4610 ext. 24807
No-fee, drop-in counselling for individuals, couples, and families.

Distress Centre for Ottawa and Region
1-613-238-3311
No-fee telephone support.

Ottawa Military Family Resource Centre
330 Croil Private, Building 471, Ottawa, ON
1-613-998-4888
Connects military families with resources and funding.

If you have any questions about the study from now until you receive a copy of the final results, please feel free to contact me at tiffany.beks@ucalgary.ca.

If you would like to learn more about this area of research, the following articles are easily and freely accessible via the internet:

Link, P. E., & Palinkas, L. A. (2013). Long-term trajectories and service needs for military families. *Clinical Child and Family Psychology Review*, 16(4), 376-393. Retrieved from <http://www.researchgate.net/>

Sherman, M. D., Sautter, F., Lyons, J. A., Manguno-Mire, G. M., Han, X., Perry, D., & Sullivan, G. (2005). Mental health needs of cohabiting partners of Vietnam veterans with combat-related PTSD. *Psychiatric Services*, 56(9), 1150-1152. Retrieved from <http://ps.psychiatryonline.org/>

If you wish to express any concern about this study or the way you have been treated as a participant, please feel free to contact the Research Ethics Analyst, Research Services Office, University of Calgary, at (403) 210-9863; email cfreb@ucalgary.ca.

Thank you again for your participation!

APPENDIX H: TRANSCRIBER PRIVACY AND CONFIDENTIALITY FORM**Confidentiality Agreement for Research Assistants / Transcribers/Translators**

Name of Researcher: _____

Title of Project: _____

Before we can hire you to transcribe research interviews, we must obtain your explicit consent not to reveal any of the contents of the tapes, nor to reveal the identities of the participants (i.e. the students and supervisors interviewed and their place of employment). If you agree to these conditions, please sign below.

Print Name_____
Signature

APPENDIX I: CATEGORY CREATION LOG

Date of Critical Incident/Wish List Extraction	Participant #	Date Categorized	New Categories Emerged?
November 2 nd , 2016	7	November 4 th , 2016	
November 3 rd , 2016	3	November 4 th , 2016	All new categories emerged
November 3 rd , 2016	9	November 4 th , 2016	
November 4 th , 2016	6	November 6 th , 2016	
November 4 th , 2016	1	November 6 th , 2016	8 new HE, 5 new HI, 3 new WL categories
November 5 th , 2016	10	November 6 th , 2016	
November 9 th , 2016	11	November 11 th , 2016	
November 10 th , 2016	14	November 11 th , 2016	2 new HE, 1 new HI categories
November 10 th , 2016	8	November 11 th , 2016	No new categories emerged
November 12 th , 2016	13	November 13 th , 2016	No new categories emerged
November 12 th , 2016	4	November 13 th , 2016	No new categories emerged
November 13 th , 2016	16	November 13 th , 2016	No new categories emerged
November 14 th , 2016	2	November 15 th , 2016	No new categories emerged
November 14 th , 2016	5	November 15 th , 2016	No new categories emerged
November 15 th , 2016	12 (10% left to end)	November 30 th , 2016	No new categories emerged
November 16 th , 2016	25 (10% left to end)	November 30 th , 2016	No new categories emerged

Note: HE=Helping Critical Incidents; HI=Hindering Critical Incidents; WL=Wish List Items

