Phoenix
AUSTRALIA

Wellness Action Through Checking Health

WATCH Project Report
Family Members Addendum

Acknowledgements

Phoenix Australia acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of Country throughout Australia and pays respect to all Elders, past and present. We acknowledge the continuing connection of Aboriginal and Torres Strait Islander peoples to land, water and communities – places of age-old ceremonies, of celebration and renewal – and their unique contribution in the life of these lands. We are committed to fostering an environment in which the relationship between Aboriginal and Torres Strait Islander peoples and their fellow Australians is characterised by a deep mutual respect, leading to positive change in our nation's culture and capacity.

We would like to acknowledge Joint Health Command and the Department of Defence for funding the WATCH Project. We recognise the family members who volunteered their time to help us better understand health behaviours in members of the Australian Defence Force. The WATCH Project was conducted in collaboration with the Department of Defence.

Key Investigators:

Phoenix Australia

A/Professor Lisa Dell
Ms Kelsey Madden
Dr Alyssa Sbisa

Department of Defence

Ms Carolina Casetta
Ms Kanny Tait (Project Manager)
Dr Helen Benassi

All images in this report are sourced from images.defence.gov.au/assets.

Citation

Dell, L., Madden, K. & Sbisa, A. (2022). Wellness Action Through Checking Health: WATCH Project Report Family Members Addendum. Report prepared for Department of Defence. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Disclaimer

This report is based on qualitative research and the results may therefore not truly reflect family members of the whole Defence workforce population. Numerical data presented in this report is solely based on frequency and does not indicate statistical significance. The views and recommendations stated in this report are solely those of Phoenix Australia and do not reflect those of the Department of Defence or the Australian Government.

For enquiries:

A/Professor Lisa Dell | Director Military Mental Health
Phoenix Australia| Centre for Posttraumatic Mental Health
Department of Psychiatry | The University of Melbourne
Level 3, Alan Gilbert Building, 161 Barry Street, Carlton VIC 3053
T: +61 3 9035 5599
lisa.dell@unimelb.edu.au | www.phoenixaustralia.org

Contents

Chapter 1
Background

Brief overview of the WATCH Project

Phoenix Australia – Centre for Posttraumatic Mental Health has partnered with the Department of Defence (Defence) to undertake the Wellness Action Through Checking Health (WATCH) Project. The WATCH Project is a multi-component project that broadly aims to increase understanding of subthreshold symptoms of mental health disorders (i.e., symptoms that do not meet the criteria for clinical diagnosis) in current serving Australian Defence Force (ADF) members. The first component of the project involved conducting interviews and focus groups with Health Service Providers (HSPs) and current serving ADF members. Findings from these components of the WATCH Project indicated that leadership, such as Command and family members, may be well placed to identify early changes in ADF members' mental health. Thus, the scope of the WATCH Project was expanded to include interviews and focus groups with family members of current serving members and Uniformed Supervisors. The WATCH Report and The WATCH Report – Command Addendum are available separately to this addendum. The WATCH Report (main report) includes further information on the design and scope of the study (Dell, Madden, & Jones, et al., 2021).

Ultimately, the WATCH Project aims to uncover ways to bolster Defence health processes to better manage ADF members experiencing mental health changes and how Defence can better support ADF members manage their mental health. Better management of subthreshold symptoms may reduce the number of ADF members who experience clinical symptoms of mental health disorders and improve work, home, and social life outcomes.

Overview of the literature: families and early symptom identification and support

The Longitudinal ADF Study Evaluating Resilience (LASER-Resilience) Study found that the proportion of ADF members experiencing subthreshold psychological distress progressively increased from enlistment to four years post-enlistment/appointment. At baseline (enlistment or first weeks of training), 11.8% of members reported subthreshold psychological distress, but this increased to 28.1% at the end of initial training (or after one year of service for those undertaking extended periods of initial training) and to 24.5%, 29.3% and 30.8% at subsequent yearly intervals, two, three and four years post-enlistment, respectively (Dell et al., 2019). As considerable numbers of current serving members experience subthreshold symptoms, family members may play an important role in the early identification and mitigation of these symptoms. Given their close proximity to ADF members, family members can observe subtle changes in behaviour from a usual 'baseline' of mental wellbeing. Changes in behaviour may include a variety of early symptoms associated with subthreshold disorder, such as sleep problems, alcohol use, poor physical health (Hansen et al., 2020 [Australian data]), depressive symptoms (Yarvis & Schiess, 2008 [US data]), anxiety (Mota et al., 2016 [US data]), and anger and hostility (Lawrence-Wood, Baur, Lawrence, Forbes, & McFarlane, 2021 [Australian data]). Family members may also be more attuned to symptoms, such as withdrawal, for example, that have direct consequences on their intimate relationship/family functioning. This may include impairments in familial relationships, problems with their spouse or partner, and difficulty

connecting emotionally with their family (Cukor, Wyka, Jayasinghe, & Difede, 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Stein, Walker, Hazen, & Forde, 1997).

Many ADF members do not seek professional help for subthreshold symptoms of mental health disorders (McFarlane, Hodson, Hooff, & Davies, 2011). Instead, ADF members turn to friends and family members for support, meaning family members are well placed to encourage members to seek help (Forbes et al., 2018 [Australian data]; Naifeh, Colpe, Aliaga, Sampson, Heeringa, Stein, Ursano, Fullerton, Nock, & Schoenbaum, 2016 [US data]). This is reflected in a report that shows US military personnel with partners are more likely to seek support from mental health services than those without partners (Sayer, Clothier, Spoont, & Nelson, 2007). Further, the Pathways to Care, Mental Health and Wellbeing Transition Study showed that approximately 60% of transitioned ADF members who sought help for their mental health did so at the recommendation of their family and friends (Forbes et al., 2018). This research also found that family and friends helped members access support for their mental health in the Pathways to Care, Mental Health and Wellbeing Transition Study. While family members may be well placed to identify the presence of subthreshold symptoms, they are not always equipped with the knowledge or skills to effectively support a family member whom they feel needs to seek help (Wilson, Gettings, Hall, & Pastor, 2015 [US data]). Thus, more research is needed to elucidate the unique challenges associated with this role and strategies to overcome them.

When mental health symptoms are at early low levels, members are less likely to independently seek support to get on top of these symptoms. In fact, research has shown that even when symptoms become severe, help-seeking behaviour is still relatively rare. Several studies explored this phenomenon and reported that there are several barriers to help-seeking and access to care for military personnel: adverse beliefs about mental health treatment (e.g., distrust in the military healthcare system) (Fikretoglu, Guay, Pedlar, & Brunet, 2008 [Canadian data]; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012); anticipated stigma from admitting psychological problems (e.g., being perceived as 'weak', being treated differently by unit leadership) (Sharp et al., 2015; Zinzow et al., 2012); self-stigma (where individuals internalise the stereotypical negative attitudes about mental illness and help-seeking) (Blais & Renshaw, 2013 [US data]); and practical or logistical barriers to accessing care (e.g., demanding work schedules, inability to get time off work, reduced deployability) (McFarlane, Hodson, Hooff, et al., 2011 [Australian data]; Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015 (US data)). With these factors in mind, it has been proposed that families could play an important role in overcoming these barriers to help-seeking. A study of US National Guard and Reserve personnel with a mental health disorder by Naifeh

et al. (2016) found that a large majority of personnel who did not receive treatment felt they did not need it as they talked to family or friends instead (Naifeh, Colpe, Aliaga, Sampson, Heeringa, Stein, Ursano, Fullerton, Nock, Schoenbaum, et al., 2016). Thus, early evidence suggests that military personnel will often talk to family members in preference to seeking professional help for mental health symptoms, highlighting the importance of family members in facilitating and supporting help-seeking.

Despite the relatively small amount of research in this area, there are indications that families can actively facilitate help-seeking behaviours in military personnel. A qualitative study of the role of social networks, including family members, in leading US veterans to seek treatment for posttraumatic stress disorder (PTSD) found that social networks encouraged help-seeking, helped veterans recognise PTSD symptoms, and helped veterans find resources and health service providers and schedule appointments (Sayer et al., 2009). Veterans described initiating treatment with the encouragement of family members, despite not feeling the need for help on an individual level (Sayer et al., 2009). Interestingly, veterans with PTSD in the US (Sayer et al., 2007) and Canada (Fikretoglu et al., 2006) who were married were more likely to receive treatment than those who were unmarried. Recent studies of current serving military members have reported similar results, with one large study of 10,400 US soldiers showing that those who were married used more mental health services than those who were not (McKibben et al., 2013).

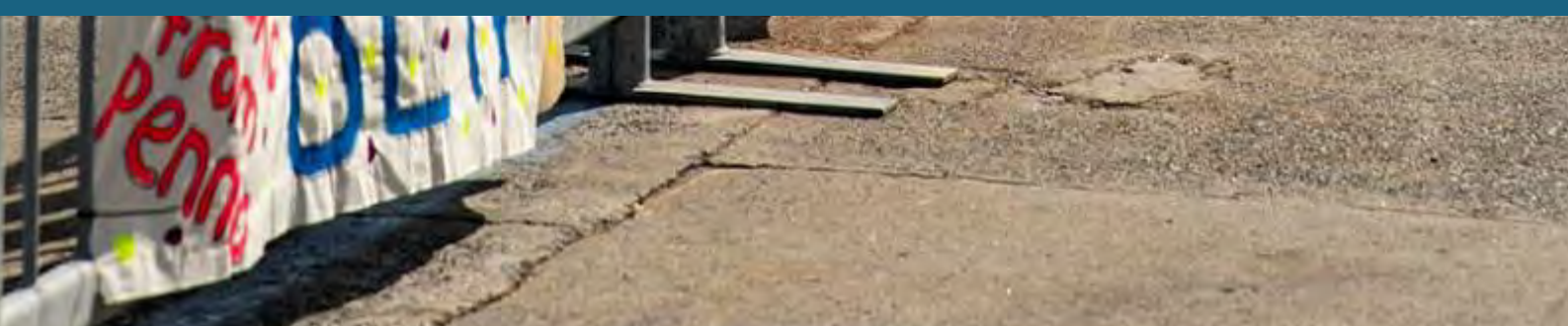
In another study of US soldiers who sought help for mental health symptoms, the most frequently reported reason for seeking help was encouragement from family members, with soldiers expressing a want to become a 'better person' for their families (Zinzow et al., 2013). This theme was echoed in a subsequent study of active serving US soldiers, where the most highly endorsed external benefit of help-seeking was 'to be a better person for family' (Pury, Britt, Zinzow, & Raymond, 2014). Additionally, a study of 3294 active US military soldiers, the most highly endorsed proposed strategy for overcoming barriers to help-seeking was encouragement from family and friends (58%) (Warner, Appenzeller, Mullen, Warner, & Grieger, 2008). Soldiers preferred this strategy over guarantees of no negative consequences from their unit, confidentiality from their colleagues and zero career impact. The research clearly demonstrates that families can play a critical role in encouraging help-seeking and overcoming barriers to care.

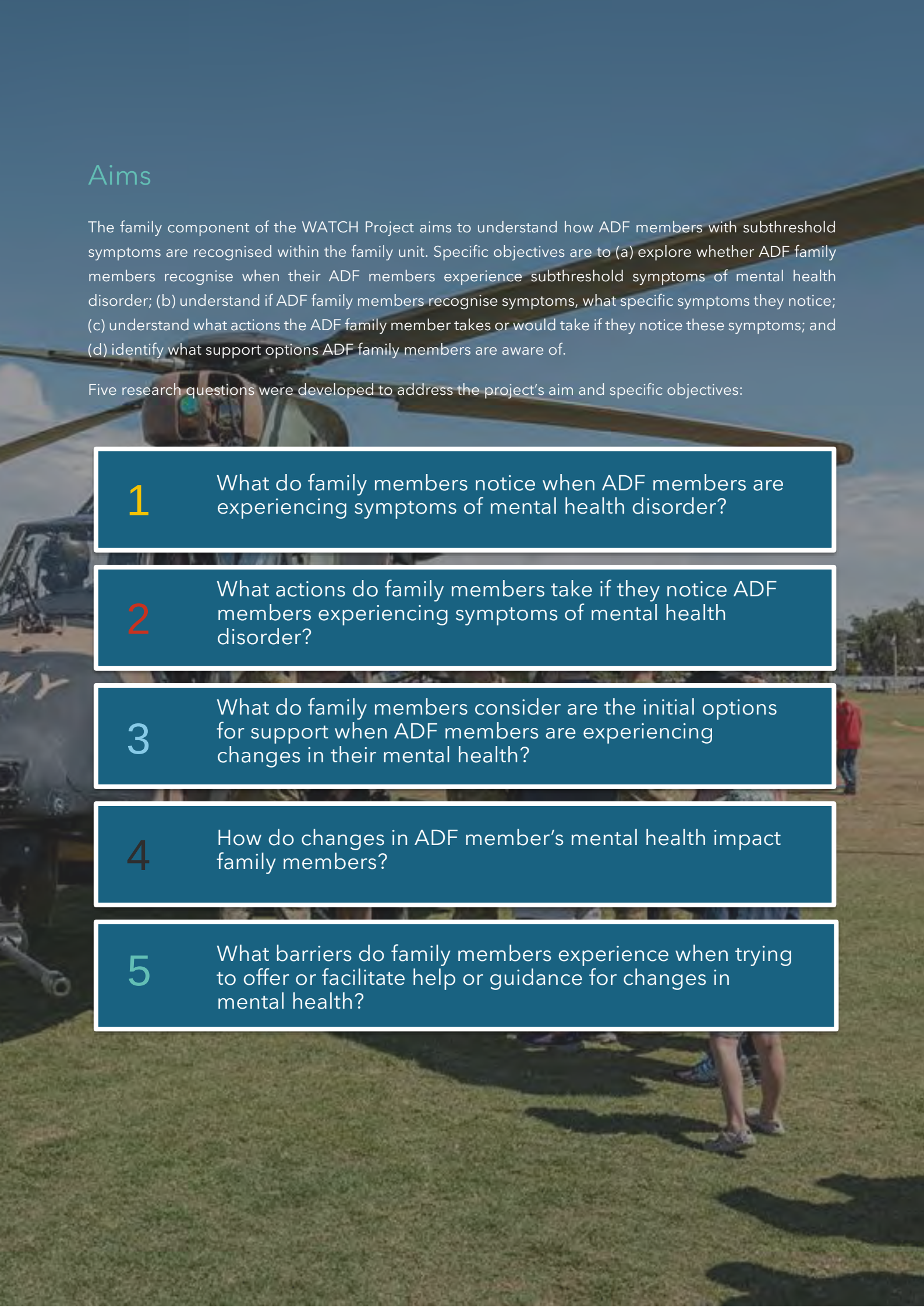
A study by Wilson et al. (2015) asked family members of US military personnel about perceived barriers to encouraging their military member to seek help for post-deployment mental health symptoms. They identified four themes: (1) getting them (the service member) to recognise the problem without implying

they are not normal, (2) convincing them to seek help without implying they are weak, (3) being persistent but patient, and (4) wanting them to open up without implying they (family member) could not understand (Wilson et al., 2015). A more recent qualitative study of US military service members and their spouses (N = 100) reported the same four barriers as the study by Wilson et al. (2015) and added two more: wanting to get help but having difficulty within the military context and wanting to broach the difficult topic while feeling reluctant to disrupt normalcy (Peck & Parcell, 2021). The barriers articulated by family members in these studies provide important insight into the challenges faced by family members when discussing mental health symptoms and encouraging help-seeking. The US Department of Veteran Affairs recently launched a telephone-based coaching service, 'Coaching into Care', which provides family members with educational resources and referrals to help them overcome these barriers and become more effective at supporting veterans in the decision to seek care. A review of 165 calls placed to the service over a six-month period found that veterans who used the program significantly increased their use of mental health services (Sayers, Hess, Whitted, Straits-Tröster, & Glynn, 2021). This study provides preliminary evidence that providing families with strategies to encourage family members to seek help may improve help-seeking behaviours.

A glimpse into the impact of families on members with more substantive mental health symptoms has shown that close familial relationships may also be protective against symptoms of PTSD. For example, Carter et al. (2011) found that deployed male US soldiers who frequently communicated with their spouse and reported high marital satisfaction reported lower levels of PTSD symptoms post-deployment than soldiers who communicated less frequently. Similarly, Olson and colleagues (2018) found that support from a partner provided a buffer against the effects of stressful deployment experiences, moderating PTSD symptoms in US Air Force personnel (Olson, Welsh, Perkins, & Ormsby, 2018). Research conducted in Australia has shown that family members provide substantial support while transitioning out of ADF services and are likely to recommend help-seeking for depression, anxiety, relationship problems and anger (Forbes et al., 2018; Muir, 2018). These studies highlight the importance of family member support to encourage help-seeking for members experiencing symptoms of mental health decline and as a preventative measure. The research findings presented above, in conjunction with the findings of the WATCH Project, suggest that family members are in a pivotal position to observe the early expression of mental health symptoms and that their support may protect members from further development and exacerbation of mental health symptoms. Family members may also be able to provide insight into barriers to help-seeking and devise improved strategies to encourage and motivate service members, who may not perceive a need for treatment, to seek help when experiencing early symptoms of ill mental health.

Chapter 2
Method





Aims

The family component of the WATCH Project aims to understand how ADF members with subthreshold symptoms are recognised within the family unit. Specific objectives are to (a) explore whether ADF family members recognise when their ADF members experience subthreshold symptoms of mental health disorder; (b) understand if ADF family members recognise symptoms, what specific symptoms they notice; (c) understand what actions the ADF family member takes or would take if they notice these symptoms; and (d) identify what support options ADF family members are aware of.

Five research questions were developed to address the project's aim and specific objectives:

1. What do family members notice when ADF members are experiencing symptoms of mental health disorder?
2. What actions do family members take if they notice ADF members experiencing symptoms of mental health disorder?
3. What do family members consider are the initial options for support when ADF members are experiencing changes in their mental health?
4. How do changes in ADF member's mental health impact family members?
5. What barriers do family members experience when trying to offer or facilitate help or guidance for changes in mental health?

Design

The family component of the WATCH Project utilised the same design as the HSP and ADF member components of this project, that is, a qualitative research design. Data was collected through focus groups and phone interviews. Demographic information was collected at the time of calling participants to discuss their expression of interest and participation in the project. Focus groups and interviews were audio recorded with participants' consent.

Data analysis used the inductive approach known as thematic analysis and followed the guidelines developed by Braun and Clark (2006). In brief, 1) a WATCH Project team member familiarised themselves with the data by reading through the transcripts; 2) initial descriptive codes were generated, and the data were categorised to each code; 3) codes were collated into themes; 4) themes were reviewed and discussed in relation to codes and the entire dataset; 5) themes were refined, defined and named. These themes were continually checked against the initial codes and transcripts as the database and analysis progressed to ensure they were representative within the context of the larger dataset.

Participants

The WATCH Project recruited a range of family members with various relationships to current serving ADF members. The participant inclusion criteria are presented in Figure 1.

Inclusion

- 18 years or older
- Family member of a current serving ADF member (permanent/regular) (i.e., spouse, partner, son, or daughter, parent or other close family member)

FAMILY

Figure 1. Inclusion criteria

Procedure

Ethics

An ethics amendment was submitted to the Departments of Defence and Veterans' Affairs Human Research Ethics Committee for the inclusion of focus groups and interviews with family members of current serving ADF members. Ethics approval was granted on 21 June 2021 (protocol number 227-20).

Recruitment

Family members from across Australia were recruited via social media advertisements on platforms for Defence Members and Family Support, Open Arms – Veterans and Families Counselling (Open Arms), Defence Families Australia and Phoenix Australia. Additionally, communications internal to Defence were published, including Spotlight and ForceNET articles (see Figure 2). Promotional social media posts contained a direct link to a REDCap online survey.

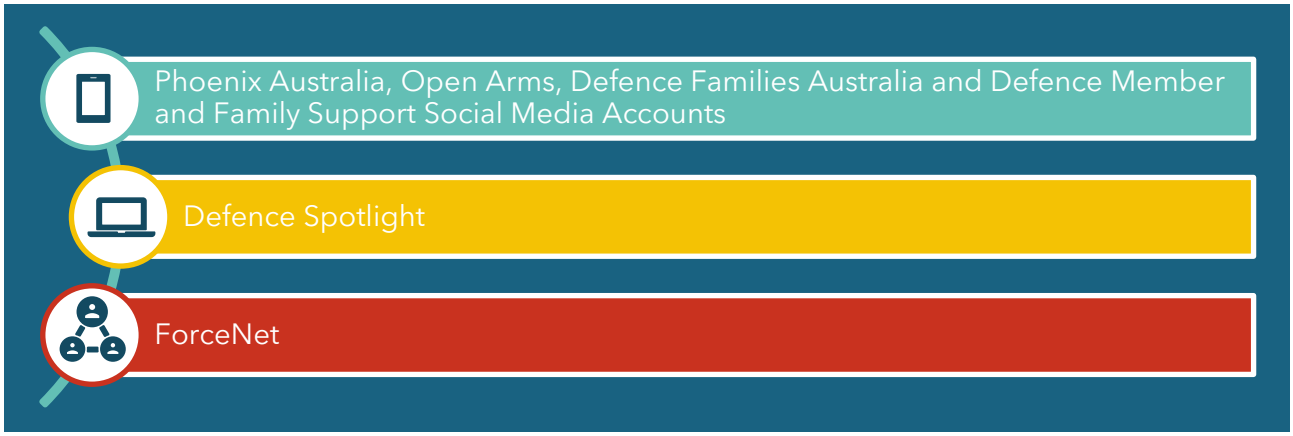


Figure 2. Family recruitment channels

Data collection

Data was collected over six weeks between August and September 2021. Participants provided consent on REDCap before being screened for inclusion. Participant's expressed interest in the project by providing personal and contact details in REDCap. A member of the project team subsequently contacted participants to arrange a focus group or interview time. Focus groups were run over Zoom and lasted approximately one hour. Each focus group included 2–4 family members. Focus groups were kept small to ensure in-depth data could be collected from each participant. Family members could join the focus group using an alias created by an online random name generator.

Participants who expressed they were not comfortable attending a focus group were invited to have a one-on-one phone interview with a researcher.

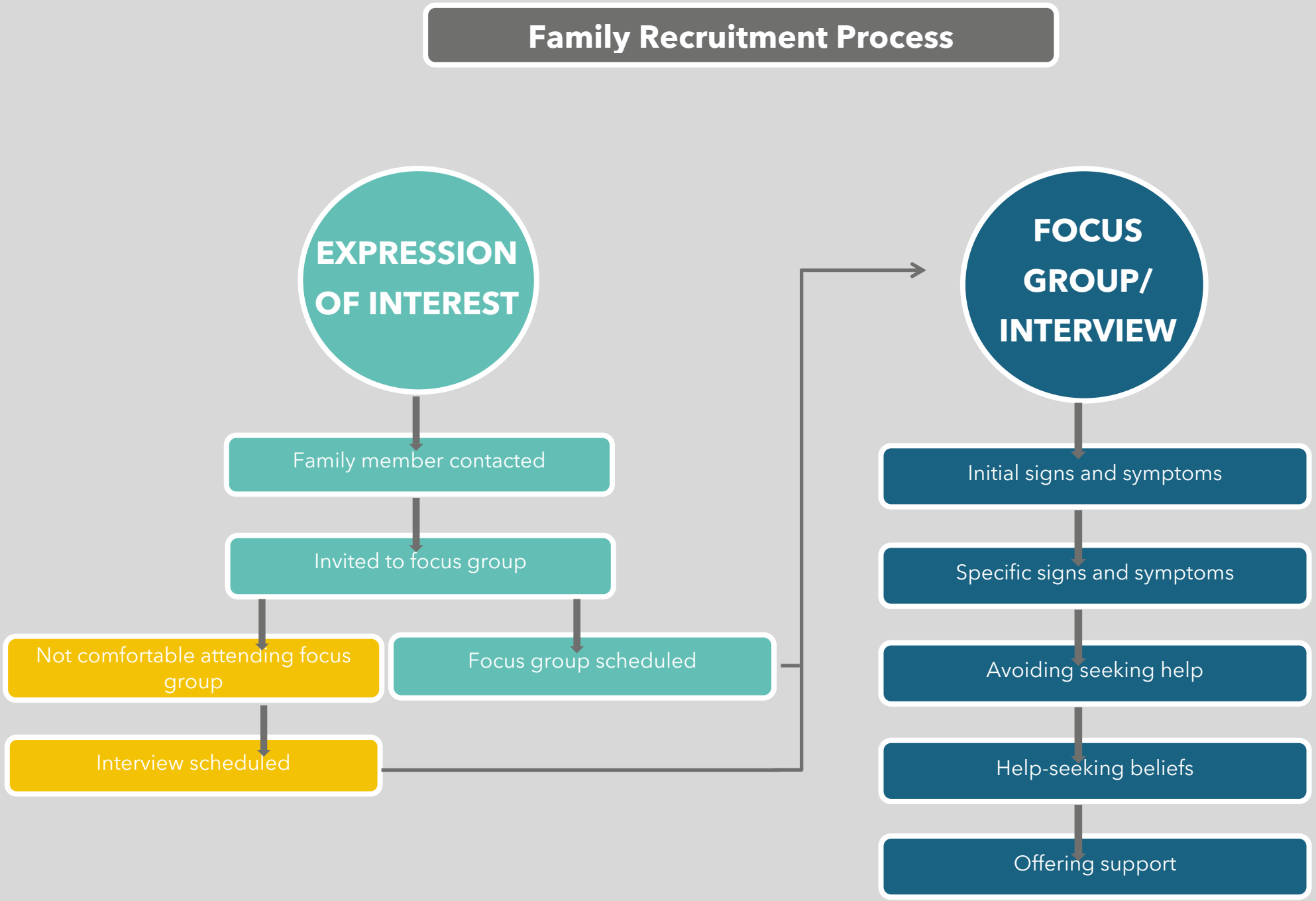


Figure 3. Family recruitment process

Family Member Focus Group Questions

What symptoms are you aware of that may suggest your family member is having issues with their mental health?

Have you ever noticed your family member having trouble with sleep/anger/connecting with friends/coping/doing activities they enjoy/interacting with family/children, or seeming disengaged from activities at home or different to their usual self?

Yes

What things did you first notice? How long had these symptoms been presenting when you noticed they were having an impact? Was there anything you did, or felt you needed to do to support your family member at that time?

No

If you did start to notice them having trouble with this, at what point would you do something about it? What would you do and why?

Do you think your family member avoids getting help with mental health issues that they should get support for when they first emerge?

Are these strategies effective?

What do they do instead?

What do you think members should do when problems like those we have discussed first start to arise? Do you think there are any gaps in the support options?

When early changes in mental health start to arise, we know that family members can also be impacted. What resources are you aware of that may be useful in helping you understand and talk about these changes when they first arise?

Is there anything else that you think would be useful to help you support your family member, but are currently not available?

Has your ADF member ever come to you for help or guidance?

Yes

Have you been able to offer help or support? What, if any barriers have you faced? How have you found that conversation?

No

Have you raised the issue with them? How did it go? What was challenging about that?

Figure 4. Family member focus group questions

Family data

Figure 5 shows the flow of recruitment of family members. A total of nine focus groups and one interview were completed, with 22 family members engaged in the project overall. Analysis of demographic information was used to identify sample characteristics.

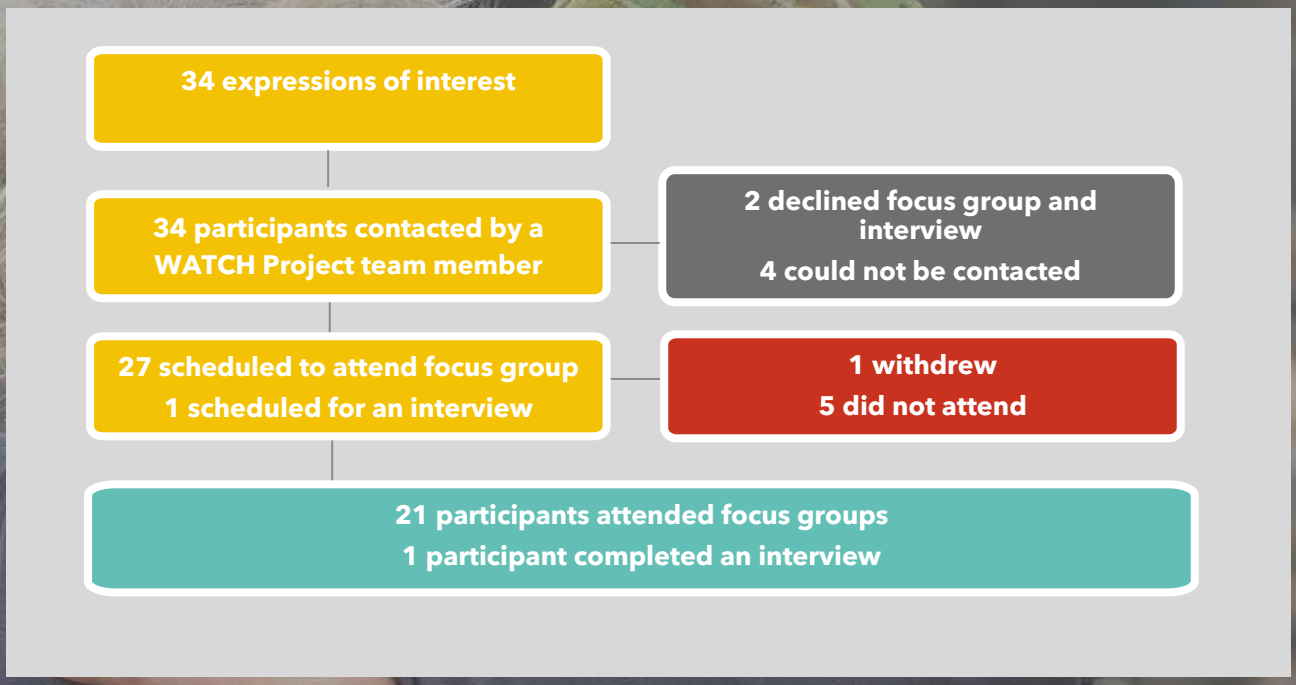


Figure 5. Family member recruitment outcome

Demographics

The majority of family members were female (91%) and spouses/partners (91%) of current serving members (see Figure 6). Over half (55%) of participants had children aged unborn to 25 years. Over half of the ADF members travel for work and spend time away from home. Most respondents noted that members who did not currently travel, often travelled before the introduction of COVID-19 restrictions over the past 18 months. Members' career lengths ranged from two to 33 years. Most were likely to have a long career (45%) and be in the Army (43%).

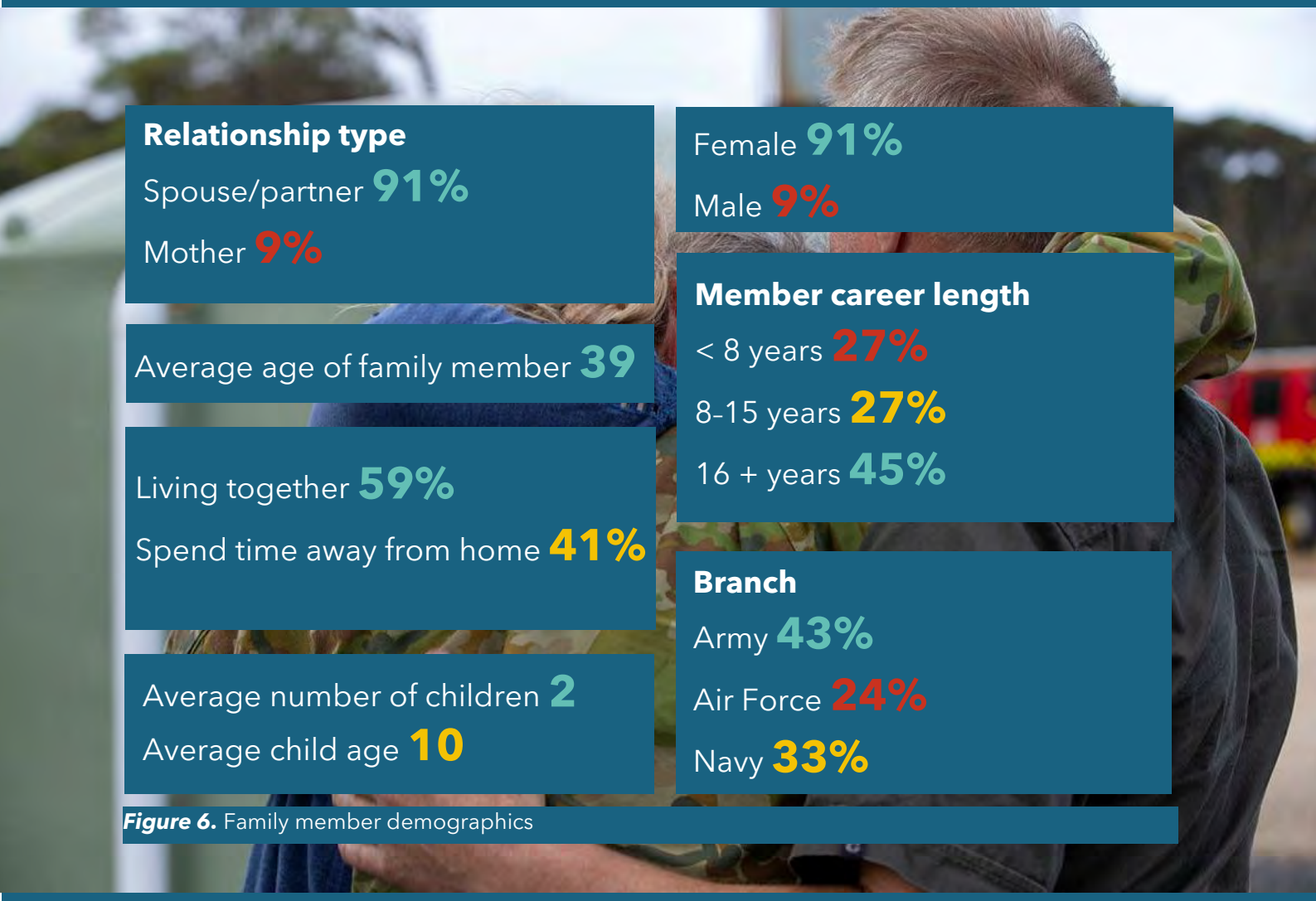


Figure 6. Family member demographics

Chapter 3
Results

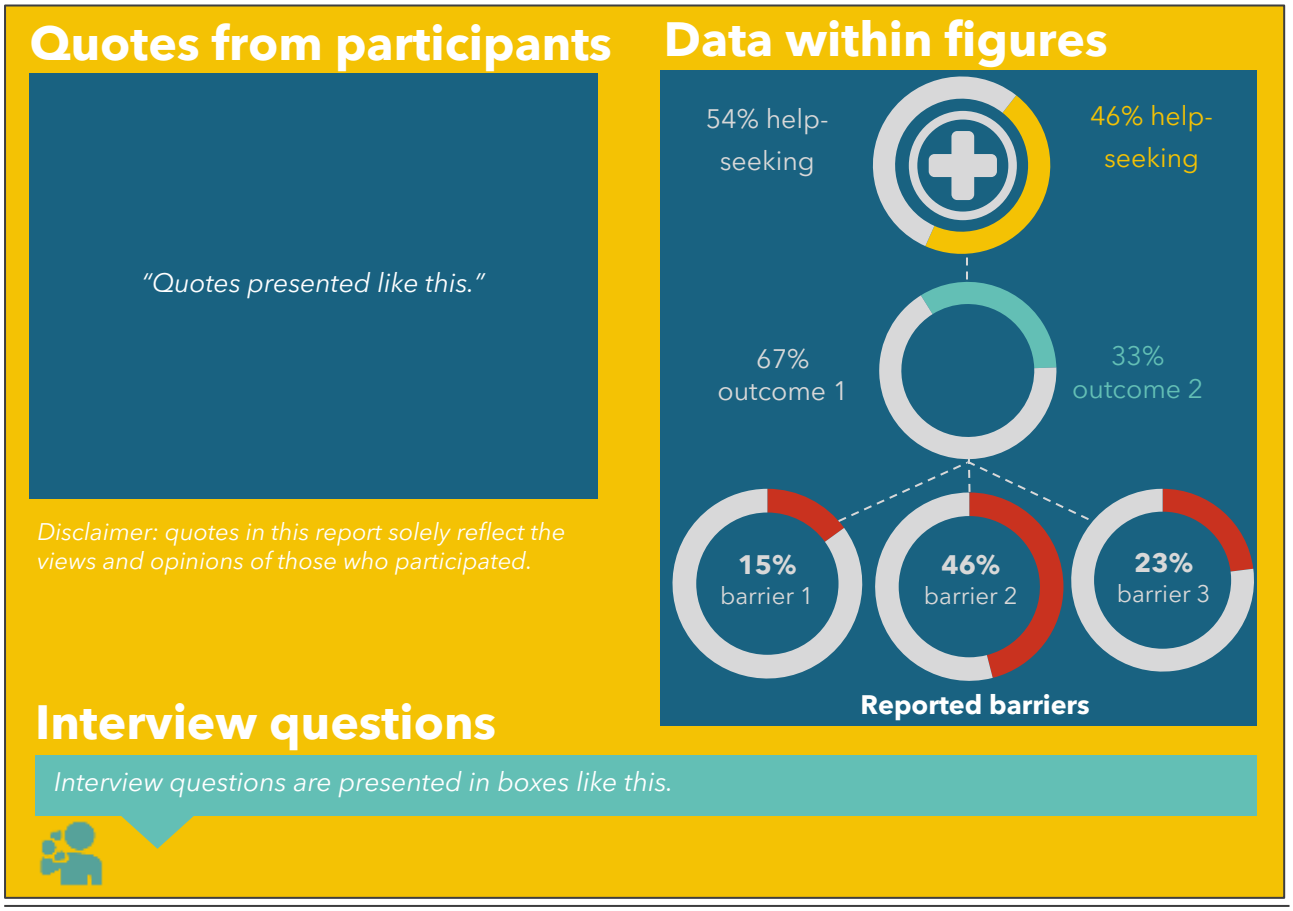
How to read this report

The report includes a number of graphics and visual prompts to improve readability. The following information has been provided to assist with orienting the reader to the style of this report.

Tree plots are used throughout the report to visually endorse themes that emerged from the focus groups/interviews (see Figure 7). The size of the boxes within the tree plots corresponds to the proportion of participants who endorsed each theme (e.g., the number of participants who mentioned a specific barrier). As participants could mention more than one theme in response to a question, the data in these plots do not always total 100%. These plots are descriptive only and do not represent a statistical test of differences among responses.

Figure 7. Example tree plot – mock data

Other report elements include quote boxes, question boxes, figures and doughnut charts. Throughout the report, you will find these presented as per the examples below:



Initial signs and symptoms

What symptoms are you aware of that may suggest your family member is having issues with their mental health?

Family members reported noticing withdrawal (73%) as the first sign that suggested their member may be having issues with their mental health (see Figure 8). This included ADF members saying they "just want to be alone", members were "not there" when having a conversation, they were "checked out", "a bit distanced", and gave short "yes" / "no" responses rather than engaging in conversation. This withdrawal extended to social settings, and family members said their ADF members did not want to engage in any social interaction and had been "withdrawing from absolutely everybody".

All family members noted that the observed withdrawal behaviour impacted them (and their children). They felt they were unable to communicate with their ADF member meaningfully. They reported that this occurred because their ADF member was "just not present in the moment" or they needed to "pull information out of [them]", making interactions effortful and leaving family members feeling like their ADF member was "not present".

Family members reported that agitation, irritability, short temper, frustration and less patience (45%) were signs of issues with mental health. Family members noted that their ADF members were easily triggered and subsequently "either very agitated or won't speak at all", "not engaging or the extreme is yelling", that their patience "starts to diminish", and they have a "shorter fuse" or "short temper".

A proportion of family members also reported that their members used maladaptive coping strategies (23%). These strategies included smoking or vaping more than usual, increased alcohol and caffeine consumption and unhealthy eating.

"When he, sort of, starts to withdraw it's like you have to be pulling information out of him."

"His mind is so occupied that even if you try and have a discussion about other things, it's like he's not there. He's just not present in the moment."

"I've just really been noticing recently that he's checked out. When we talk, he's not present or he's making all the yes, yes, sure, you know, those kind of filler comments, without really acknowledging or being present for the information in the exchange."

"[He's] just not interested in the day-to-day stuff like, you know, saying hey, how are you? when he walks in the door."

"The first one is probably anger, so a lot of anger and very quick anger responses, so being triggered by the children or by the colour of the paint on the walls."

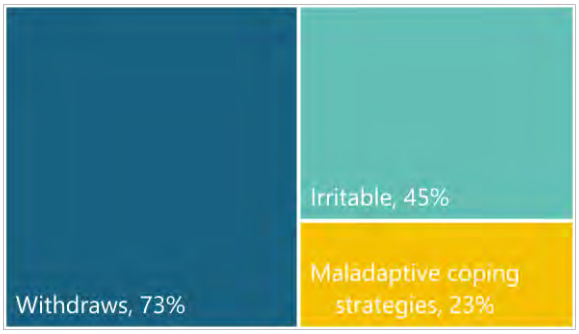


Figure 8. Initial signs and symptoms family members notice

Specific signs and symptoms

Have you ever noticed your family member having trouble with sleep/anger/connecting with friends/coping/doing activities they enjoy/interacting with family/children, or seeming disengaged from activities at home or different to their usual self?

When prompted with other signs and symptoms known to be indicative of early mental health challenges (Bryant et al., 2019; Dell et al., 2019; Forbes et al., 2018; McFarlane Hodson, Van Hooff, & Davies, 2011; Van Hooff et al., 2018), family members revealed a variety of indicators that they had noticed in their ADF member (see Figure 9). Similar to responses to the first question, family members continued to emphasise withdrawal (45%), noting that this was one of the most apparent early changes. Specific feedback from family members included that their spouse would rather "spend time [with] himself to withdraw, rather than spending time with the kids", had "become more antisocial recently", would "isolate himself", that "he doesn't want to go out" and "the disengaging is a coping mechanism".

Figure 9. Specific signs and symptoms family members reported noticing

Just under half of family members also reported noticing their ADF member was having issues sleeping (41%). These family members reported seeing their ADF member struggling to fall asleep, not getting much sleep, "tossing and turning a lot" and "having vivid dreams" that were "never pleasant". Other family members noted that their ADF member had trouble falling asleep but once asleep, they "could sleep for days".

"If I ask him to do something, it results in a very disproportionate reaction, like I just asked you to mow the lawns. I didn't ask you to donate a kidney."

"I can definitely relate to the short fuse thing and overreacting to things that are out of his control or that have absolutely nothing to do with him."

"If I walk in the door or he walks in the door, pretty much his response or the way he talks is a good indicator [of his mood]."

Family members also reported that their ADF members spend a lot of time watching TV, on their phone or playing video games (36%). This was also associated with withdrawal as family members highlighted that their ADF member would "retreat" or "lock himself" away to play video games. Family members also reported noticing their ADF member overreacting or having up-and-down emotions (23%). This included having no patience, fluctuations between "being angry" and "being needy" or that small things, such as people forgetting to indicate when driving and being asked to mow the lawn, would set off a disproportionate response. Some family members (23%) also indicated

that they could determine their ADF member's mood by looking at or talking to them. Specifically, family members reported that "it's just visual" in the way they walk, saying their spouse "marches in" the house; in their posture, such as "in the way [he] would sit when he's talking to you"; or the way they speak. Some family members spoke about the way their ADF member communicated with them, stating that they have to "chime back" and remind their spouse that they're not "one of his soldiers" or "I'm not a co-worker, you don't need to speak to me like that".

Family members reported that fluctuating emotions and withdrawal particularly impacted the family. For example, they reported that children could be a "trigger" for their ADF members' anger. This impacted the interactions that children had with their family members because the ADF member began to treat their children "the same way that Defence might treat their staff" expecting that everything be done "like clockwork" or disengaging from children, reducing the amount of time the child would spend with their parent. Family members were also impacted by fluctuating emotions when they reduced the ADF member's capacity to cope with everyday tasks, for example, in situations where "putting the kids' lunchboxes together is just too much" or they "don't want to help" with maintaining the family home.

When family members were asked how long before they noticed these symptoms were impacting, the responses varied – ranging from very recently to three to ten plus years. Some family members said signs were evident when they first met their spouse. Family members reported that signs were most apparent during times of transition (23%). Family members reported that signs of mental health challenges were apparent with "every unit he gets posted to", "when returning from field exercises", and that it was "not just after deployments" but also when returning to visit the family while being members with dependants unaccompanied (MWDU).

Family members were asked whether there was anything they had done or felt they needed to do to support their ADF member. The most common response was that they recommended their ADF member talk to someone about it (45%), such as a counsellor, someone at work, a chaplain or Open Arms. Other family members (41%) provided emotional support by reminding them "you're doing something you love", bringing them into family activities or explicitly asking if they were okay and whether they wanted to talk. Some family members also suggested that their ADF member engage in active self-management activities such as journaling.

"It's give or take every unit he gets posted to. It happens every two years in a different unit, so it has been ongoing, but, he graduated being an officer three years ago and they have gotten worse since he is now an officer than what he was when he was just a digger."

"It's a little bit of a struggle to separate work from home in that they treat the children or[their] partner to the same level that the Defence Force might treat their staff. They expect things done by a certain time and [expect that] everything works like clockwork."

"My husband gets affected by the lack of tasks, 'cause when he's away [he's] in shift work and that sort of thing so he knows what he has to do… [when he's home] you find him aimlessly wandering around the house feeling a bit lost."

Help-seeking behaviours

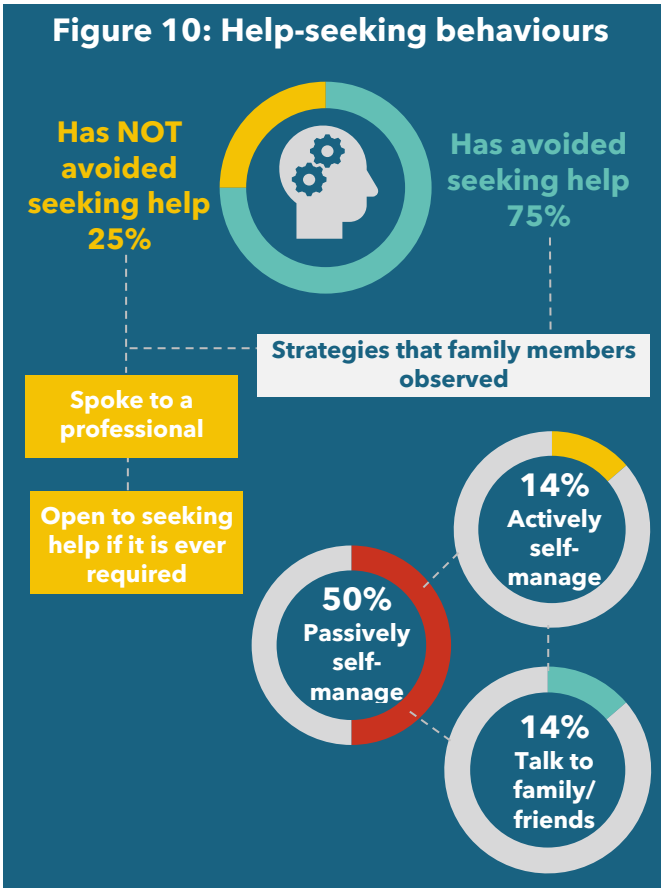
Do you think your family member avoids getting help with mental health issues that they should get support for when they first emerge?

Three-quarters of family members reported that their ADF member avoids seeking help for mental health issues when they first emerge (see Figure 10).

Of the 25%, some saw a psychologist, and others noted that their ADF member had not yet needed help, but if they did, they would likely be open to speaking to family or friends or seeking professional help.

All family members were asked how their ADF member manage their mental health when issues arise (see Figure 10). The most commonly reported strategy was passive self-management (i.e., self-management strategies that do not require physical or mental effort) (50%). Strategies included watching TV to avoid addressing issues, ignoring issues until they get to "crisis point in our relationship", "going to the shed", "refusing to admit he needs help", anger, "shutting down", "disengaging", wanting "to be left alone" and needing "that time away from us" (the family).

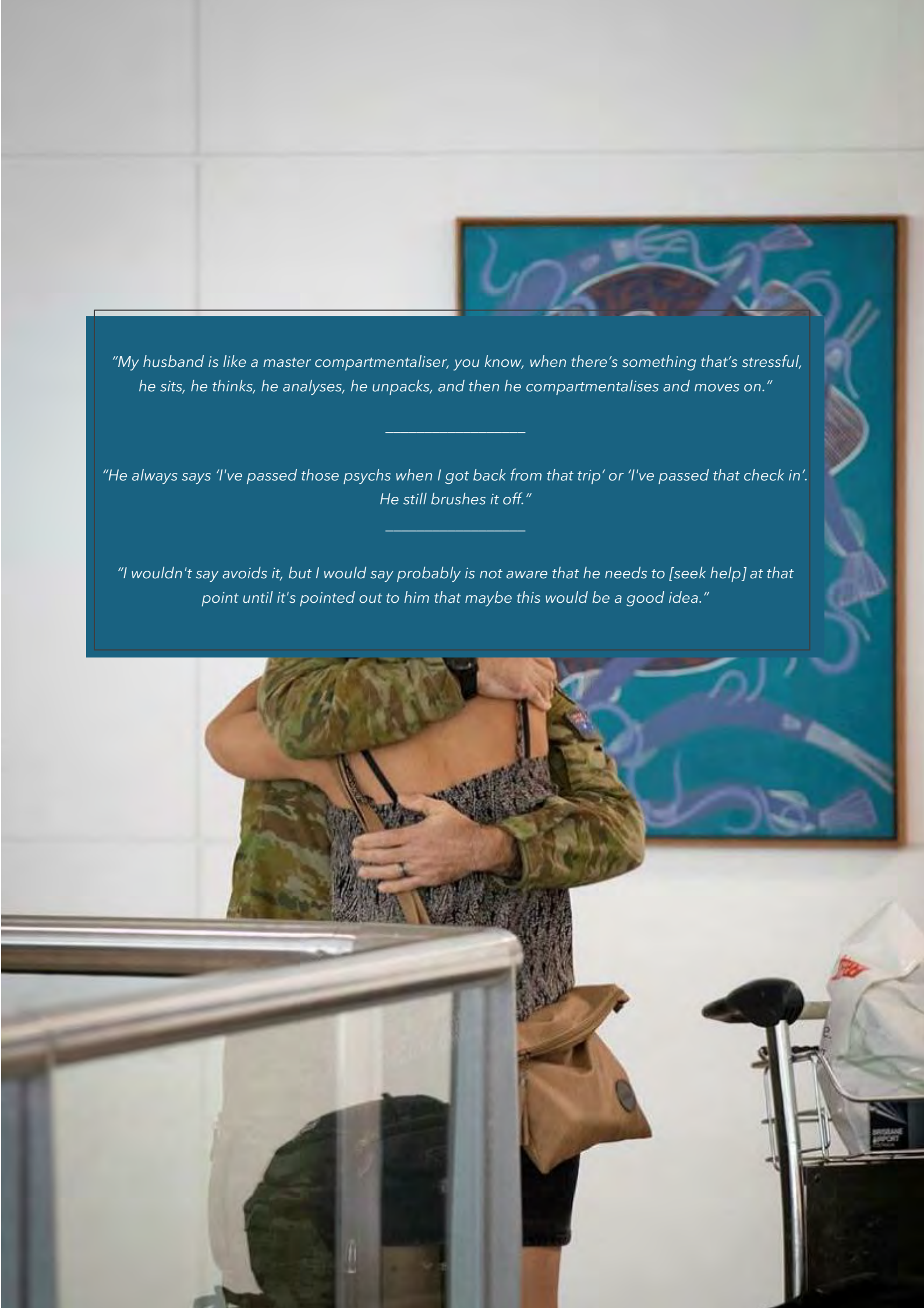
Figure 10: Help-seeking behaviours



Others also reported that their ADF member talks to family/friends or actively self-manages (14% each) using techniques such as mindfulness, listening to audiobooks, reading a book, compartmentalising, booking a holiday or cooking dinner for a week. The family member who mentioned cooking described this as a "band-aid solution" as the ADF member would quickly fall back into passive self-management strategies.

Some family members had spoken to a health professional (e.g., psychologist, chaplain). However, they noted that this strategy was not always effective if the ADF member did not think the advice was helpful/useful.

Several family members noted that their ADF members are "so well trained that they know how to just fly under the radar", indicating that some members go out of their way to avoid seeking help.



"My husband is like a master compartmentaliser, you know, when there's something that's stressful, he sits, he thinks, he analyses, he unpacks, and then he compartmentalises and moves on."

"He always says 'I've passed those psychs when I got back from that trip' or 'I've passed that check in'. He still brushes it off."

"I wouldn't say avoids it, but I would say probably is not aware that he needs to [seek help] at that point until it's pointed out to him that maybe this would be a good idea."

Help-seeking beliefs

What do you think members should do when problems like those we have discussed first start to arise?

Under one-third (27%) of family members reported that they believed their ADF member should seek professional help from a psychologist or counsellor. A similar proportion (23%) also believed that talking to a family member, their commanding officer or chaplain, or having a buddy system would be a good place to bring up problems when they arise.

Not all family members could provide an answer on what they thought their ADF member should do. This was because they identified barriers to supports that would, if functioning optimally, otherwise be a good point of call when problems arise. A number of family members (27%) recognised that their ADF member should go to their chain of command; however, they perceived issues with this process that may stop the ADF member from accessing this support. For example, "once it goes up the chain nothing seems to happen", they are told to 'get over it', or they get dismissed by command.

"From what I observe, there is this automatic self-preservation that happens at the leadership level when members try to address their issues and say, 'I'm feeling overwhelmed. I'm feeling stressed and I need help.' Then the chain [of command] just dismiss [and] minimises it, because they don't want to be penalised or [it] be a consequence to them. So they push it back onto the member. It's your problem, [it's] not anything that we're doing."

"A lot of the time with that chain of command, whoever's in charge, if something bad happens to the people under their watch, they're responsible for it. So they don't want to take any ownership for it or be at fault in any way. So even just someone saying, "I'm having problems because of this", they don't want to [know]– they just want it swept away and taken away from them."

Family members were asked whether they thought there were gaps in the support options available to ADF members. The most commonly reported gap was for a timely service that ensures confidentiality and is less formal than booking an appointment with a psychologist (41%). Family members believed that the current processes for accessing support "take too long"' and that accessing support is not confidential and would "get back to his job". Family members emphasised that conversations should be "totally in private", in a more "informal setting" and "totally confidential".

Family members were asked what resources they were aware of that could help them understand and talk about changes in their ADF member when they arise. Most family members (73%) were aware of external organisations, including Open Arms, Defence Member and Family Support (DMFS), Mates4Mates and SoldierOn. Some family members (31%) noted that while they were aware of these organisations, they would not use them. This was primarily due to personally having bad experiences, or knowing others that had bad experiences, with these services. For example, some family members reported reaching out to these organisations and having a staff member promise a call back that did not occur.

Some family members (23%) were also aware of social groups such as Returned Services League groups, military wives' groups and private Facebook groups set up by other Defence family members within the region. Family members reported that Facebook groups with other Defence families were useful as a place to have questions answered when they did not know where to go or what to do. Fewer family members (14%) were aware of internal Defence supports such as chaplains, Defence Community Organisation social workers and welcome events put on by Defence for families.

> *"If you go to medical then it's on your documents and people are worried about that. I know the padres are an option but padres are sort of everyone's friend. They won't sit down and say, "right, you guys have got a problem in your unit. You've got a section of seven and four of them are seeing the psych, what's going on here?" I guess it's a bit more people skills in leadership would be better for mental health I reckon."*

> *"I would love to see an external services accessible in an informal setting, so it's not so scary [that] they're not going to sit in an office and talk to someone."*

When asked if there was anything else that would be useful to help support their ADF member, a substantial proportion of family members (41%) reported that having more awareness of what supports are available (for both the family member and the ADF member) and having more options would be helpful (see Figure 11). This included knowing who their chain of command is so they know to whom their ADF member can speak to, a hard copy information pack with phone numbers that ADF members can call if they "need to talk to somebody and they want to remain separate from the establishment where they're training or where they're working", increasing awareness of organisations and "outside help" that is available and greater resources, such as leaflets and magnets for ADF members living in non-Defence housing. Some family members were unaware of organisation events mentioned by other family members in the focus group discussions.

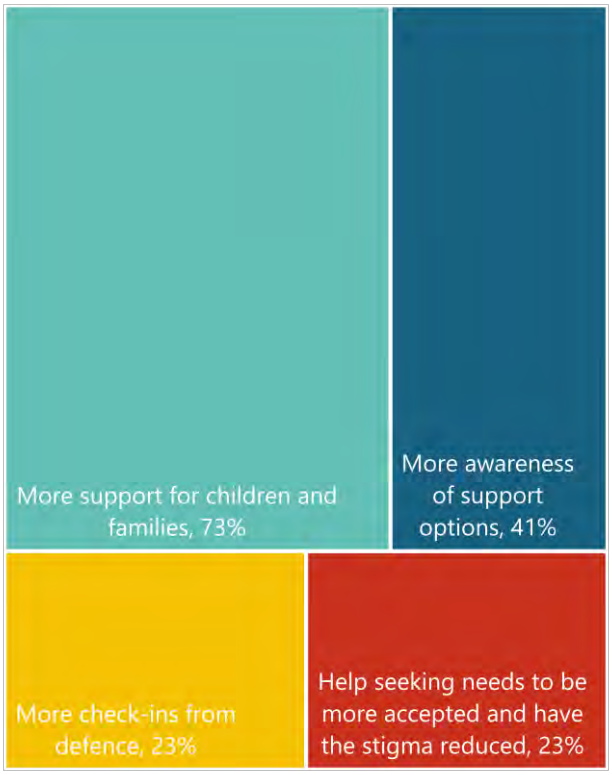


Figure 11. Reported changes that would help family members to support their ADF member

Almost three-quarters (73%) of family members also strongly believed that having increased support for the family would be useful, with many reporting negative experiences with some Defence supports. For instance, taking a long time to get access to support, lack of consistency with mental health providers meaning that family members felt like they had to tell the same story over and over, and finding it difficult to find a service that helps them build their own coping skills. Importantly, family members suggested other types of supports they thought would be helpful, such as checking in with families more consistently when their ADF member is on deployment, as they often felt 'left behind', and ensuring that activities like the Open Arms family weekends start up again.

Family members reported that their ADF member feels "quite unsupported and bitter towards Defence" when they think their family is not being supported, and that it distresses them to know the family has not been offered support from Defence. Subsequently, ADF members can become "worried about their partners at home" when they are deployed.

> *"That sort of stuff actually distresses my husband because he asks me have you heard? And it's like, no, sorry, I haven't, and that distresses him because he doesn't feel like I'm being supported."*

Some family members (18%) reported that more check-ins from Defence could help identify issues early. These family members noted that regular ad hoc and less formal mental health check-ins with the ADF member could work as a "self-awareness reminder" as many members do not take the time to consider how they may be feeling. Family members believe this would be a better process than waiting for people to seek support.

Finally, almost one-quarter of family members (23%) reported that it is important to reduce stigma and ensure that help-seeking is accepted. These family members noted that "help-seeking needs to come from the top down and be more encouraged", "there shouldn't be stigma in having a chat with someone" and there should be more recognition of early issues rather than considering a person is fine if they are not obviously unwell.

Offering support

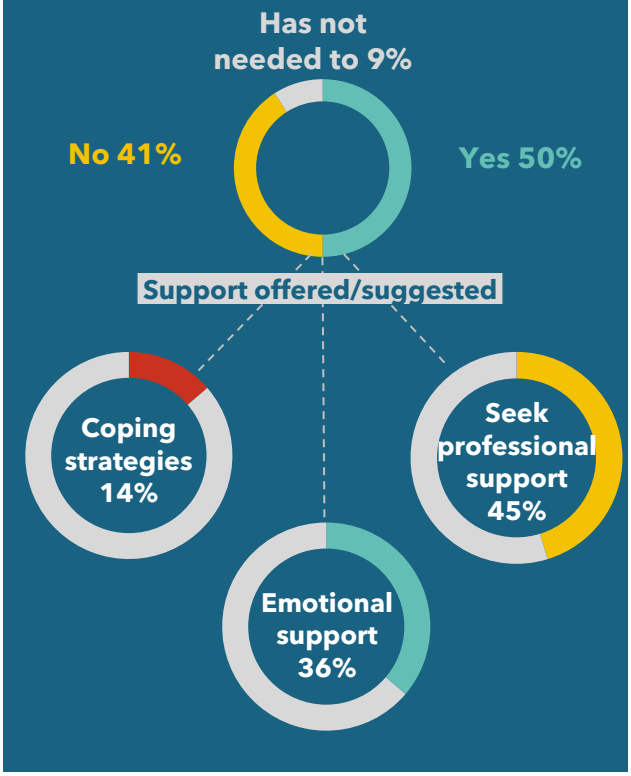
Has your ADF member ever come to you for help or guidance?

Half of family members (50%) reported that their ADF member had come to them for help or guidance. Some family members noted that it depended on the issue, given that some things are confidential and cannot be shared with family members. This could stop ADF members from going to their family members for guidance. Some of the reasons their ADF member came to them were to seek clarification on whether they should take the advice, or to say "I'm feeling a bit down". For others, their ADF member came to them saying "I'm struggling", asking "what's wrong with me" or asked for help "only after being brushed off by everyone else". These family members felt things were likely to be quite bad if their ADF member came to them for help.

"we've had arguments, we've had the tears and we've had the begging [to get professional help]."

"It's quite difficult for him to accept when I say 'you need professional help.'"

Figure 12: Members who have sought help from their family



Just under half of family members (41%) reported that their ADF member had never come to them for help or guidance. These family members were asked whether they had ever raised any issues around mental wellbeing with their ADF member, how the conversation went and what challenges they faced. They reported that their ADF member was "ignorant to his behaviours until they are pointed out", they are "oblivious", they don't want to feel "soft" for talking about the way they feel and that their spouse is "very ashamed of crying"' – all of which were felt to be challenging for family members to manage. A small number of family members (9%) did not believe their ADF member had ever had a reason to come to them for help (see Figure 12).

When asked whether they had been able to offer help or support, family members were most likely to report that they recommended that their ADF member seek professional support (45%). This included help from chaplains, counsellors and psychologists.

Over one-third (36%) of family members also offered emotional support such as "giving him some downtime", recommending their partner follow a

health professional's advice, "just listening" and talking about things. Some spouses mentioned that "it's generally pretty emotional when we do talk about it" and "there's a lot of tears".

> *"I guess all I can do is just give him some down time to do what he wants to do and be there in a way that he needs me to be there"*

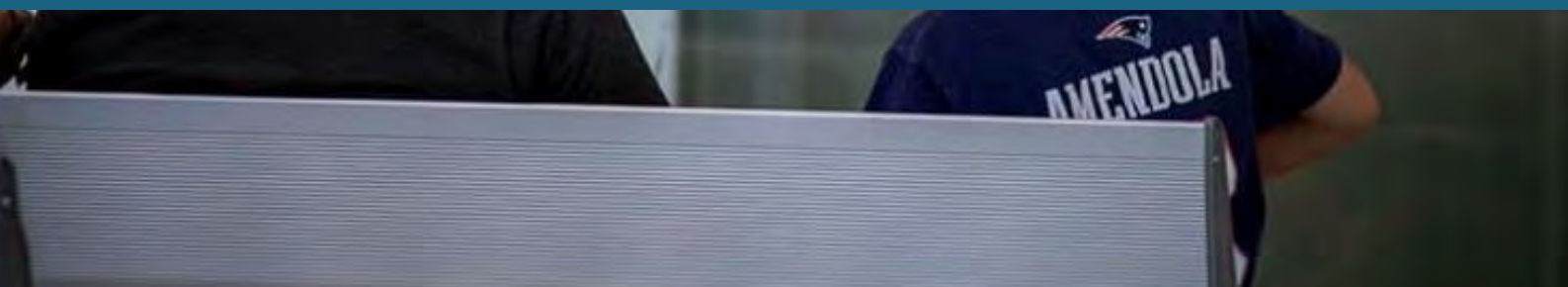
The last type of support that family members offered to their ADF member when they came to them for help or guidance was offering coping strategies (14%). This included suggesting "being more open-minded" and offering "a different perspective" when situations arose at work that their ADF member did not agree with, meditating and encouraging their ADF member to catch up with friends.

Family members were asked whether they had experienced any barriers when a family member had come to them for help (see Figure 13). Just over one-third of family members (36%) suggested that their ADF member was resistant to receiving their support. Family members said they "often have to drag it out of him" when something is wrong and that their ADF member "often doesn't talk about it until it's gotten bad enough that there's been an argument", is "afraid to admit he needs help" or will blatantly say "no" when the family member suggests they speak to someone. The same proportion of family members (36%) felt that a reason for this resistance was their ADF member's fear that seeking help may impact their career. In particular, their ADF members feared that if they spoke to anyone about their struggles they would "be kicked out" or discharged, it would "go on your file" or they would experience "ramifications".

Family members (27%) also reported that their ADF member does not recognise when they have an issue, which can also create a barrier to offering them support. Family members described their ADF member as "oblivious", that they are not "able to recognise it" and think it's "everyone else's problem but theirs'.

Figure 13. *Reported barriers to providing support to their ADF member*

Chapter 4
Addressing the research questions



RQ1: What do family members notice when ADF members are experiencing symptoms of mental health disorder?

Family members are quick to notice when their ADF member starts to experience changes in their mental health and wellbeing. The early signs that are most indicative of these changes include withdrawal, irritability and maladaptive coping strategies. When prompted about specific symptoms, family members further emphasised withdrawal and confirmed that issues with sleep, increased time on electronic devices and watching television, irritability, fluctuations in emotions and difficulty with everyday tasks were associated with subthreshold mental health challenges. Due to their close relationships and familiarity with the ADF member's usual behaviour, family members told us they could pick up on more subtle changes using visual cues, such as their ADF member's demeanour. Changes in mental health and wellbeing were most noticeable to family members when their ADF member was going through different stages of transition, such as transitioning from deployment, into new roles or returning from being MWDU.

RQ2: What actions do family members take if they notice ADF members experiencing symptoms of mental health disorder?

Almost all family members were proactive in attempting to provide support and suggestions when they noticed changes in the mental health of their ADF member, whether their ADF member directly came to them for help or not. Family members were most likely to recommend that the ADF member talk to someone (such as a health professional, colleague or chaplain) about their symptoms or suggest coping strategies (such as being more open-minded) and provide general emotional support. Family members said that they often had to approach the ADF member with these suggestions and options, which sometimes resulted in challenging and difficult conversations. Despite their attempts to provide support, family members told us that some ADF members continued to avoid seeking help for the mental health challenges they were experiencing. The most commonly perceived reasons the ADF members avoided seeking help were fear that it could impact their career or that they could not recognise and accept the issues their family member was trying to make them aware of.

Family members observed that their ADF members were most likely to manage their mental health through passive self-management strategies by shutting down, disengaging and ignoring issues until they were at crisis point. Less frequently, family members did notice them actively self-managing at times; for example, ADF members would use mindfulness, reading and compartmentalising as coping strategies.

RQ3: What do family members consider are the initial options for support when ADF members are experiencing changes in their mental health?

Support from a health professional, either internal or external to Defence, was one of the initial options family members considered for ADF members experiencing early changes in their mental health. They also endorsed other avenues such as speaking to a chaplain, family member or friend.

Family members identified numerous barriers that they felt impacted an ADF member's ability to access the supports available to them, including issues with the chain of command. They were of the opinion that the chain of command does not always take action when ADF members go to them for help. Family members also felt that some of the current support services are not timely (with regards to getting appointments) and suggested that confidentiality is not maintained, as ADF members have told their families that they cannot access support without others in Defence finding out about their attendance at an appointment.

When considering options for support for themselves, family members were aware of several available support services. Most commonly, family members were aware of external Defence organisations (such as DMFS, Open Arms and SoldierOn); however, family members were sometimes apprehensive about using these services due to poor experiences in the past. Family members reported having good experiences with more informal forms of support, most notably Facebook groups, where they could connect with other family members of current serving members. Some family members were also aware of internal Defence supports, such as access to the chaplain; however, awareness of these supports was less common.

RQ4: How do changes in ADF member's mental health impact family members?

Family members shared that they are impacted by their ADF member's mental health. As noted earlier, family members are quick to notice when their ADF member becomes withdrawn or more irritable and drinks more alcohol than usual. Families also told us that these behaviours result in ADF members spending less time with their families and more time on their own, not wanting to engage. This impacted family members who tried to engage with their ADF member but could not communicate with them in a meaningful way. Family members reported that withdrawal and irritability impacted their children as their ADF member had less time and patience for the children, affecting the quality of the children's interactions with their parents. They also shared that ADF members who were having challenges with their mental health also struggled with everyday tasks in the home environment, creating added pressure for caregivers who felt, at times, unsupported.

Family members noted that their ADF member experienced additional pressure when balancing Defence work and home life. This was particularly pertinent when spending time away from the family on

deployment, training or being MWDU, as times of transition back into the family are challenging. Transition periods following their ADF member being deployed or relocated were particularly challenging and another time where family members felt unsupported. Challenges associated with these transitions were the most common reason family members wanted more awareness of the range of available support options. During transition periods following deployment or being MWDU, family members felt they could not offer the support they hoped they could and wanted to be more aware of the support options available to help them support their ADF member.

RQ5: What barriers do family members experience when trying to offer or facilitate help or guidance for changes in mental health?

Although half of family members reported that their ADF member had come to them for help or guidance at some point, it was almost always because their symptoms were worsening and starting to have a more significant impact on the ADF member and the family. As such, it was felt that ADF members were not actively reaching out early enough.

The main barrier experienced by family members when trying to support their ADF member was resistance. Despite family members being able to identify changes in mental health and wellbeing early on and wanting to offer support, they felt that the resistance from ADF members was caused by the fear that seeking support would impact their careers.

When discussing ways to combat these barriers, family members felt that Defence should focus on strategies to reduce the stigma (and increase the acceptance) of help-seeking, particularly with the support of command, as well as having a mechanism for more regular, informal check-ins for ADF members. In thinking about themselves, family members noted that having conversations with their ADF member about their mental health when experiencing challenges was often difficult and led to heightened emotions and stressful situations. Family members indicated that increased education on how to approach these conversations would be useful.

Chapter 5
Implications

Family members are in a unique position to observe early changes in the mental health and wellbeing of their current serving ADF member. The data from the family member component of the WATCH Project provides an insight into the signs and symptoms of early mental health changes observed in ADF members, how these changes impact family members, what actions the family member takes, their awareness of support options, and their perception on barriers to providing support.

This addendum has identified several possible opportunities to assist family and ADF members to identify mental health symptoms early and create optimal support-seeking pathways and strategies. These opportunities represent the next steps for Defence to consider when implementing the findings of this research.

Having the conversation about mental health

Most family members who participated in this study were already trying to support their ADF member when early signs of mental health changes were evident. A number of them spoke about the challenges associated with this and expressed a desire to have more support, guidance and mentoring when these situations arose. Specifically, family members felt that education about how conversations about mental health can be approached and how to manage the ADF member's reaction throughout the conversation would be very useful. This could potentially be coordinated through Defence Families Australia (DFA) or DMFS.

The data from this study also demonstrates the need to routinely educate ADF members about the potential impact of mental health symptoms on the family unit and to recognise that behaviours driven by these symptoms may have a flow-on effect. The importance of early intervention can be emphasised by showing that this can cause stress or concern within their family.

There may be an opportunity to touch on family relationships during initial triaging into the Defence health service system or during mental health screening processes. This concept links to the implications from the ADF member component of the WATCH Project, which could assist with conversations in the family unit, or future support-seeking and strategies.

Fostering connections and support networks

It is well known that social support is a protective factor against symptoms of poor mental health. Similarly, social support can be a protective factor for the wellbeing of people who are supporting someone with mental health symptoms. A number of family members spoke of the importance of connecting with other Defence families and having like-minded support networks. The impact of COVID-19 has resulted in fewer opportunities for face-to-face meetings and connections among the families of ADF members. However, as we move out of the pandemic, there is an opportunity to restrengthen networks and relationships between Defence families and members.

Ensuring opportunities for connection are sustained and offered regularly would be most useful for family members. Some families noted a lack of awareness about opportunities for organised connection, aside

from welcome days and social media groups; therefore, an initial step may be to provide information to families about what is currently available. It is important to note that a variety of modalities for connection (i.e., in person, online, large groups, small groups) would be most beneficial as preferences for types of connection differ.

Reach out during transitions

A notable period of time changes to mental health and wellbeing may arise in ADF members is during transitions (e.g., new roles, locations, postings). Family members recognised the impact of transition times for their ADF members and suggested that this would be a useful time to have more proactive check-ins from Defence. These check-ins would ensure the family members are coping and check if they need any additional support or resources. Having a proactive reach-out program would provide an opportunity for family members to reflect on the behaviour of their ADF member and any impacts this behaviour may be having and to reflect on whether they themselves could benefit from some extra support. A proactive reach-out program may also ease the burden on family members who feel they need support but are unsure of where to go or whom to reach out to.

A resource for family members

While the family members who participated in this study were aware of several available resources and supports, they felt it would be useful to have a hard copy of Defence family resources to refer to as needed. They reported that, at times, an issue might arise within the home, and the Defence family member may be unsure who to contact for support. It was felt that a booklet detailing options for support and guidance (about a number of issues, not just mental health) would be very useful for families. This would also present an opportunity to educate family members on the signs of mental health symptoms (both at non-clinical and clinical levels) to enable earlier reach out from family members for additional support. Such a resource would have an extra benefit for family members who are currently less connected to Defence by raising their awareness of the available options.

A final note

It is important to note that DFA and DMFS are already addressing some of the gaps and opportunities identified in this study. For example, DMFS, working closely with DFA, is currently working on collating an information and resource pack for Defence family members. This will include QR codes to link families to additional resources and have a lived experience focus.

The focus for DFA over the coming months is communication, connection and clarity, which strongly links to the outcomes of this research. The family members in the WATCH Project stressed that communication with their ADF member was so important to support their mental health and wellbeing, connections with other family members is desired, and clarity about the resources and support available for ADF members and families is needed.

Abbreviations

ADF	Australian Defence Force
Defence	Department of Defence
DFA	Defence Families Australia
DMFS	Defence Member and Family Support
HSPs	Health Service Providers
MWDU	Members with dependants unaccompanied
Open Arms	Open Arms – Veterans and Families Counselling
PTSD	Posttraumatic stress disorder
WATCH	Wellness Action Through Checking Health

References

Blais, R. K. & Renshaw, K. D. (2013). Stigma and demographic correlates of help-seeking intentions in returning service members. *Journal of Traumatic Stress*, *26*(1), 77–85. doi:10.1002/jts.21772

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Bryant, R., Lawrence-Wood, E., Baur, J., McFarlane, A., Hodson, S., Sadler, N., . . . Van Hooff, M. (2019). *Mental health changes over time: A longitudinal perspective: Mental health and wellbeing transition study*. www.dva.gov.au/sites/default/files/mental-health-changes-over-time-a-longitudinal-perspective-report.pdf

Carter, S., Loew, B., Allen, E., Stanley, S., Rhoades, G. & Markman, H. (2011). Relationships between soldiers' PTSD symptoms and spousal communication during deployment. *Journal of Traumatic Stress*, *24*(3), 352–355. doi:10.1002/jts.20649

Cukor, J., Wyka, K., Jayasinghe, N. & Difede, J. (2010). The nature and course of subthreshold PTSD. *Journal of Anxiety Disorders*, *24*(8), 918–923. doi:10.1016/j.janxdis.2010.06.017

Dell, L., Fredrickson, J., Cowlishaw, S., Sadler, N., Crane, M., Lewis, V., . . . Forbes, D. (2019). *LASER-Resilience: Patterns and predictors of wellbeing*. Report prepared for the Australian Government Department of Defence. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Dell, L., Madden, K., Jones, K. & Sbisa, A. (2022). *Wellness Action Through Checking Health: WATCH Project Report*. Report prepared for Department of Defence. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Fikretoglu, D., Brunet, A., Schmitz, N., Guay, S. & Pedlar, D. (2006). Posttraumatic stress disorder and treatment seeking in a nationally representative Canadian military sample. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *19*(6), 847–858. doi:10.1002/jts.20164

Fikretoglu, D., Guay, S., Pedlar, D. & Brunet, A. (2008). Twelve month use of mental health services in a nationally representative, active military sample. *Medical Care*, *46*(2), 217–223. doi:10.1097/MLR.0b013e31815b979a

Forbes, D., Van Hooff, M., Lawrence-Wood, E., Sadler, N., Hodson, S., Benassi, H., . . . McFarlane, A. (2018). *Pathways to care, mental health and wellbeing transition study*. Department of Defence and Department of Veterans' Affairs. www.dva.gov.au/sites/default/files/twrp_pathways.pdf

Hansen, C., McFarlane, A., Iannos, M., Sadler, N., Benassi, H., Lawrence-Wood, E., . . . Van Hooff, M. (2020). Psychosocial factors associated with psychological distress and functional difficulties in recently transitioned and current serving regular Australian Defence Force members. *Psychiatry Research*, *286*, 112860. doi:10.1016/j.psychres.2020.112860

Lawrence-Wood, E., Baur, J., Lawrence, A., Forbes, D. & McFarlane, A. (2021). The role of inhibitory processes in the relationship between subsyndromal PTSD symptoms and aggressive behaviour. *Journal of Psychiatric Research*, *143*, 357–363. doi:10.1016/j.jpsychires.2021.09.037

McFarlane, A. C., Hodson, S. E., Van Hooff, M. & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF mental health prevalence and wellbeing study: Full report*. Department of Defence. www.aph.gov.au/DocumentStore.ashx?id=526e5f5f-c5bc-4da0-aa74-86cc54f403d2

McKibben, J. B., Fullerton, C. S., Gray, C. L., Kessler, R. C., Stein, M. B. & Ursano, R. J. (2013). Mental health service utilization in the US Army. *Psychiatric Services (Washington, DC)*, *64*(4), 347–353. doi:10.1176/appi.ps.000602012

Mota, N. P., Tsai, J., Sareen, J., Marx, B. P., Wisco, B. E., Harpaz-Rotem, I., . . . Pietrzak, R. H. (2016). High burden of subthreshold DSM-5 post-traumatic stress disorder in US military veterans. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *15*(2), 185–186. doi:10.1002/wps.20313

Muir, S. (2018). *Family wellbeing study: Part 2: Military family approaches to managing transition to civilian life*. Department of Defence and Department of Veterans' Affairs. https://aifs.gov.au/research/commissioned-reports/family-wellbeing-study-part-2

Naifeh, J., Colpe, L., Aliaga, P., Sampson, N., Heeringa, S., Stein, M., . . . Army STARRS Collaborators. (2016). Barriers to Initiating and Continuing Mental Health Treatment Among Soldiers in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *Military Medicine*, *181*(9), 1021–1032. doi:10.7205/MILMED-D-15-00211

Olson, J. R., Welsh, J. A., Perkins, D. F. & Ormsby, L. (2018). Individual, family, and community predictors of PTSD symptoms following military deployment. *Family Relations*, *67*(5), 615–629. doi:10.1111/fare.12343

Peck, B. S. & Parcell, E. S. (2021). Talking about mental health: Dilemmas US military service members and spouses experience post deployment. *Journal of Family Communication*, *21*(2), 90–106. doi:10.1080/15267431.2021.1887195

Pietrzak, R., Johnson, D., Goldstein, M., Malley, J. & Southwick, S. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression and Anxiety*, *26*(8), 745–751. doi:10.1002/da.20558

Pury, C. L., Britt, T. W., Zinzow, H. M. & Raymond, M. A. (2014). Blended courage: Moral and psychological courage elements in mental health treatment seeking by active duty military personnel. *The Journal of Positive Psychology*, *9*(1), 30–41. doi:10.1080/17439760.2013.831466

Ramchand, R., Rudavsky, R., Grant, S., Tanielian, T. & Jaycox, L. (2015). Prevalence of, risk factors for, and consequences of posttraumatic stress disorder and other mental health problems in military populations deployed to Iraq and Afghanistan. *Current Psychiatry Reports*, *17*(5), 37–48. doi:10.1007/s11920-015-0575-z

Sayer, N. A., Clothier, B., Spoont, M. & Nelson, D. B. (2007). Use of mental health treatment among veterans filing claims for posttraumatic stress disorder. *Journal of Traumatic Stress*, *20*(1), 15–25. doi:10.1002/jts.20182

Sayer, N. A., Friedemann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L. E., Chiros, C. & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry: Interpersonal and Biological Processes*, *72*(3), 238–255. doi:10.1521/psyc.2009.72.3.238

Sayers, S. L., Hess, T. H., Whitted, P., Straits-Tröster, K. A. & Glynn, S. M. (2021). Coaching into care: Veterans Affairs telephone-based service for concerned family members of military veterans. *Psychiatric Services*, *72*(1), 107–109. doi:10.1176/appi.ps.201900113

Sharp, M.-L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N. & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews, 37*(1), 144–162. doi:10.1093/epirev/mxu012

Stein, M., Walker, J., Hazen, A. & Forde, D. (1997). Full and partial posttraumatic stress disorder: Findings from a community survey. *The American Journal of Psychiatry*, *154*(8), 1114–1119. doi:10.1176/ajp.154.8.1114

Van Hooff, M., Lawrence-Wood, E., Hodson, S., Sadler, N., Benassi, H., Hansen, C., . . . McFarlane, A. (2018). *Mental health prevalence, mental health and wellbeing transition study*. Department of Defence. http://www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp

Warner, C. H., Appenzeller, G. N., Mullen, K., Warner, C. M. & Grieger, T. (2008). Soldier attitudes toward mental health screening and seeking care upon return from combat. *Military Medicine, 173*(6), 563–569. doi:10.7205/milmed.173.6.563

Wilson, S. R., Gettings, P. E., Hall, E. D. & Pastor, R. G. (2015). Dilemmas families face in talking with returning US Military Service Members about seeking professional help for mental health issues. *Health Communication, 30*(8), 772–783. doi:10.1080/10410236.2014.899659

Yarvis, J. S. & Schiess, L. (2008). Subthreshold posttraumatic stress disorder (PTSD) as a predictor of depression, alcohol use, and health problems in veterans. *Journal of Workplace Behavioral Health, 23*(4), 395–424.

Zinzow, H., Britt, T., McFadden, A., Burnette, C. & Gillispie, S. (2012). Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review, 32*(8), 741–753. doi:10.1016/j.cpr.2012.09.002

Zinzow, H., Britt, T., Pury, C., Raymond, M. A., McFadden, A. & Burnette, C. (2013). Barriers and facilitators of mental health treatment seeking among active-duty army personnel. *Military Psychology, 25*(5), 514–535. doi:10.1037/mil0000015