https://jmvfh.utpjournals.press/doi/pdf/10.3138/jmvfh-2023-0042 - Wednesday, May 01, 2024 6:30:08 PM - IP Address:193.114.121.145

RESEARCH

Families' moral distress when supporting military Veteran and public safety personnel mental health: Conceptual model

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ABSTRACT

Introduction: Families are vital in supporting the mental health and well-being of military Veterans and public safety personnel (PSP; e.g., police, ambulance, fire, and emergency services), yet they can feel that services exclude them. The objective of this study was to describe families' experiences of supporting Veterans/PSP seeking help for mental health concerns and formulate a conceptual model to illustrate the impacts of these experiences on families. **Methods:** The conceptual model was informed by thematic analyses of in-depth semi-structured interviews conducted in Australia with 25 family members of Veterans/PSP. **Results**: Families were deeply embedded and aligned to their family member's role in the community, with significant empathy for sense of duty, and a profound sense of betrayal and distress when attempts to support family members were perceived as blocked or challenged. The conceptual model demonstrates families' help-seeking processes and how they may vicariously experience moral distress from being caught in a liminal space in which they can see the problem and potential support solutions but have no options to realize timely supports for family members. **Discussion:** This study offers a detailed model of how moral distress can arise for families of Veterans/PSP who experience mental health concerns. It demonstrates how organizational culture at Departments of Defence, Veterans' Affairs, and public safety groups exclude families, exacerbating a sense of moral distress. Implications and recommendations for Veteran/PSP organizations and health professionals to promote more meaningful involvement and consideration of families is discussed.

Key words: Australia, caregivers, family, help-seeking, mental health, military, moral distress, organizational culture, public safety personnel, Veterans

RÉSUMÉ

Introduction : Les familles sont essentielles au soutien de la santé mentale et du bien-être des vétéran(e)s militaires et du personnel de la sécurité publique (PSP; p. ex., services policiers, services ambulanciers, services d'incendie et services d'urgence), mais peuvent avoir l'impression que les services les excluent. Cette étude visait à décrire les expériences des familles qui soutenaient des vétéran(e)s ou des PSP à la recherche d'aide en santé mentale et à proposer un modèle conceptuel pour démontrer les effets de ces expériences sur les familles. **Méthodologie :** Le modèle conceptuel était éclairé par l'analyse thématique d'entrevues semi-structurées approfondies, réalisées en Australie auprès de 25 membres de familles de vétéran(e)s ou de PSP. **Résultats :** Les familles adhéraient foncièrement au rôle du (de la) membre de leur famille dans la communauté et ressentaient une grande empathie envers leur sentiment de devoir, mais éprouvaient un profond sentiment de trahison et de détresse devant l'impression que leurs tentatives pour soutenir le (la) membre de leur famille étaient bloquées ou remises en question. Le modèle conceptuel démontrait les processus de recherche d'aide des familles et la détresse morale qu'elles pouvaient éprouver indirectement en raison du point de vue et des solutions potentielles de soutien restreints dans lequel elles étaient maintenues, sans possibilité d'apporter un soutien opportun aux membres de la famille. **Discussion :** Cette étude propose un modèle détaillé de la détresse morale possible chez les familles de vétéran(e)s ou de PSP qui ont des problèmes de santé mentale. Elle démontre que la culture organisationnelle des ministères de la Défense, des Anciens Combattants et des groupes de sécurité publique exclut les familles et

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exacerbe l'impression de détresse morale. Les répercussions de cette situation sur les vétéran(e)s, les PSP et les professionnel(le)s de la santé et les recommandations de promouvoir une implication plus significative et une meilleure prise en compte des familles sont discutés.

Mots clés : Australie, culture organisationnelle, détresse morale, famille, militaire, personnel de la sécurité publique, proches aidant(e)s, recherche d'aide, santé mentale, vétéran(e)s

LAY SUMMARY

Families offer vital mental health and well-being support to Veterans and public safety personnel. This study offers a model of how families can experience moral distress from service cultures that exclude them, leaving families stuck, exacerbating a sense of moral distress resulting from perceived organizational betrayal felt in the context of families' help-seeking experiences. The model was informed by in-depth interviews conducted in Australia with 25 family members with experience seeking help and providing support to a family member who is a Veteran or public safety personnel. The interviews provided a detailed description of how embedded and aligned families were to a member's service role, and their profound sense of betrayal and distress when attempts to support family members' mental health were thwarted. Families may experience moral distress from identifying the problem and potential support solutions, but having nowhere to go to realize those supports for their family member. The implications for Veteran and public safety organizations as well as health professionals to promote more meaningful involvement of families is discussed.

INTRODUCTION

Families are vital in supporting the mental health and well-being of military Veterans and public safety personnel (PSP; e.g., police, ambulance, fire, and emergency services) because they are embedded in the person's daily life. Informal support from family and friends protects mental health and can support formal help-seeking.[1-9] Yet the knowledge, roles, and experiences of families may be invisible to, and unacknowledged by, Veteran/PSP organizations and health services, resulting in exclusion from formal care when Veterans/PSP experience mental health concerns. When care is not provided in accordance with the families' expectations of what is right, it can lead to them perceiving organizational betrayal of their family member by the Departments of Defence, Veterans' Affairs, and public safety organizations. Families may consequently experience moral distress (MD).

Moral injury and MD

Two concepts prominent in their association with organizational betrayal are moral injury and MD. It is important to differentiate between them, given current debates and efforts to clarify these concepts.[10,11]

Moral injury is defined as "a betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation.[12(p. 183)] Litz et al. argue moral injury arises from dissonance between what someone experiences in what they receive from an authority and a moral belief about what they should receive.[13] Jamieson et al. noted moral injury as "arising from a conflict, violation or betrayal, either by omission or commission."[14(p. 1,049)] Institutional betrayal was empirically linked to exacerbations of posttraumatic stress (PTS) and other mental health conditions, and intensified suicidal ideation among Veterans[15,16] and PSP.[17] Moral injury has traditionally been applied to Veteran populations and clinical domains,[18] and increasingly beyond these contexts.[18-20]

MD was first conceptualized in the 1980s.[20] The American Association of Critical-Care Nurses defines MD as occurring "when you know the ethically correct action to take but you are constrained from taking it … [and it] profoundly threatens our core values."[21] MD has been applied to nurses,[10,20,22] and the COVID-19 pandemic health care workforce.[23]

Cartolovni et al., in reviewing moral injury conceptualization applied to health professionals, argues that moral injury and MD can each include an event and a psychological outcome; however, they differ in the context in which they occur, their ability for amelioration, and the severity of resulting consequences for the individual — the former creating "a deep emotional wound," and the latter resulting in "psychological disequilibrium and negative feeling states."[11(p. 297)] Deschenes et al.[10] contrasted attributes, antecedents, and consequences of MD for nurses, in particular, re-examining the role of external constraints (e.g., institutional/systemic) and internal constraints (e.g., psychological disequilibrium, personal limitations). They conclude that more weight should be given to external constraints in creating MD (i.e., greater system responsibility) and that internal constraints language needs to acknowledge the role of external constraints in thwarting an individual's ability to act on their moral beliefs and values.[10]

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Research on experiences of MD for family/carers is limited and has occurred predominantly in cancer and dementia research.[24,25] Ullrich et al. explored MD experiences of family/carers of people with advanced cancer, in the context of difficult decision making, such as when family/carers could not act or decide according to their own moral expectations and values (e.g., respect for the cancer patient's autonomy), leaving them feeling powerless or helpless, guilty, self-blaming, and so forth.[24] Weigel[25] explored experiences of family/carers of those with Alzheimer's disease and asserted fulfillment of their sense of agency toward the person, and the caring role may also be perceived as fulfillment of moral agency, with non-fulfillment experienced as powerlessness and personal inadequacy.

Families of Veterans/PSP with mental health conditions are one group who often find themselves unpaid caregivers, providing intensive support to a family member. At a minimum, the concept of MD can apply to families of Veterans/PSP and the broader social and systems contexts in which they are situated, particularly as it relates to families' experiences of help-seeking for mental health support and services for family members. The authors acknowledge the challenge articulated by Morley et al. in their systematic review examining the conceptual foundations of MD, where "much of the research exploring [MD] has lacked conceptual clarity, complicating attempts to study the phenomenon."[26(p. 646)] This article describes a conceptual model of MD experienced by families, arising from research conducted in Australia with families of Veterans and PSP with mental ill-health.[27]

METHODS

Design and aims

A qualitative phenomenological approach was used, with interviews exploring families' experiences of help-seeking support and the meaning attached to these experiences.[28] From this, the authors sought to develop a conceptual model of family help-seeking to explain how institutional responses (or lack of) can impact family/carers and cause MD. Ethics approval was granted by the Australian Department of Defence and Veterans' Affairs Research Ethics Committee (no. 203-20) and the Flinders University Human Research Ethics Committee. All participants received a participant information sheet and provided informed consent. A complete description of the methods is provided in a prior paper.[27]

Participants

The participants were 25 family members (19 women, 6 men) who had experienced seeking help and providing support to an Australian Veteran/PSP in the last 10 years.

Procedure

Opportunistic recruitment involved the electronic (emails, newsletters, social media) distribution of project flyers to Australian community-based organizations that support Veterans, PSP, and/or their family members.

Measures

A Project Reference Group facilitated the development of the interview guide. Interviews were conducted between October 2020 and March 2021, with most (n = 19) conducted in person and the remainder (n = 6) by phone or videoconference. Interviews were between 60 and 150 minutes long and audio-recorded with the participants' consent, and then professionally transcribed.

Data analysis

Interview data was analyzed independently, then together thematically,[28,29] by three research team members, with interpretation supported by extensive field notes. The finalization of themes involved the wider research team and Project Reference Group. Data management was supported by NVivo software. Following the finalization of themes, the multidisciplinary research team (Veteran/PSP Lived Experience Reference Group members) held regular fortnightly workshop sessions (April-June 2021) to undertake deeper discussions and robust debate about the meaning of the findings, prompted by findings that suggested MD was present for families. Workshops explored how best to represent the model components pictorially to capture processes, events, and outcomes that the participants described during the interviews. At each decision point, the team revisited themes and raw data sources, bringing insights from theoretical and lived experience perspectives to discussions (e.g., as a sociologist, health services researcher, family carer, Veteran) to ensure the components and linkages represented were true to participant descriptions. This enabled the development of a conceptual model representing layers and relationships between participants' help-seeking experiences and the impacts on families.

RESULTS

A detailed description of the 25 participants and thematic exploration of their experiences appears else-

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where.[27] Themes are summarized here, followed by a description of the model of help-seeking and related MD for families.

Summary of themes

The participants described a long, protracted journey in supporting a Veteran/PSP family member to seek help. The journey involved recognizing the need for help (for the family member and themself), working with the family member to decide how, where, and when to access support, and actively navigating support systems. Descriptions involved traumatic exposures of the Veteran/PSP in the workplace that included bullying and lack of organizational support. Help-seeking was often described as an ongoing and fraught process, challenged primarily by stigmatizing organizational service cultures and processes, and organizational failure to acknowledge the interpersonal, relational context in which Veterans/PSP mental health struggles are apparent.[27] The six key themes of families' help-seeking experiences, summarized in Table 1, provide context for the conceptual model. Brief excerpts from the interviews[27] are provided to exemplify events (antecedents and attributes) and outcomes (consequences) for family/carers, informed by processes followed by Deschenes et al.[10] Theme 1 aligns with antecedents (factors or events prior to MD), Themes 2 to 5 comprise various attributes (components or factors at the time of MD), with Themes 1 to 5 producing a range of impacts and consequences for family carers.

Table 1. Themes arising from qualitative interviews with family participants

Themes	Example quotations	Impacts/outcomes/ consequences for family/carer
1. The job is different from others Having family members in Veteran and PSP occupations requires families to provide a level of emotional support not required by other occupations because of the unpredictability of the work and the often-daily risk of exposure to physical and psychological harm. There is significant organizational culture surrounding these professions that includes a pervasive role identity and occupational pride, which are also taken on by families.	"I'd be awake until all hours of the morning when he got home, and I'd listen to him debriefing … I was his sounding board constantly." "Even if I don't necessarily want to hear what he's saying. For him it's a cleansing that he needs to get out."	Stress Anxiety Pride in the uniform Confidence keeping Self-sacrifice Main responsibility for household/ children
2. Making a change first involved recognizing that something is wrong Participants could identify when they first noticed changes in their family member's emotions, behaviours, and mental health as part of their intimate and relational knowledge and experience of them.	"I put it down to me being the issue at the time." "I felt like I was walking on eggshells all the time. He was irrational about everything, and it went on and on … I was saying 'I'm going to leave'… get away from this." "He'd come back from his first deployment … He was verbally abusive … he's not normally aggressive."	Stress Anxiety Frustration Anger Self-blame Confusion Powerlessness to help Avoidance/denial
3. The tipping point — deciding that something needs to be done The path from recognizing the family member's distress as not normal and encouraging them to seek help was often slow and distressing, and usually only in the context of reaching a crisis or tipping point where the concerns could no longer be ignored or dismissed.	"It was so sad … I said 'You need to talk to someone, you need to be honest about what is going on.' And so … he'd gone and checked himself into the medical centre and said 'I'm not leaving, like I cannot … I'm going to wrap myself around a tree'… it was a blessing in disguise." "He had a drowning, he had a hanging, and he had a person with a heart attack all in the one day … the peer slipped through and he never got anything."	Distress Fear Family violence Carer mental ill-health Concerns for safety of Veteran/PSP, self, children Divorce/separation Resolve to seek help Relief

(continued)

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Table 1. (Continued)

Themes	Example quotations	Impacts/outcomes/ consequences for family/carer
4. Barriers to help-seeking — trust in the help-seeking process Once the decision to seek help was reached, families still experienced barriers to supporting their family member through that process. Participants lacked trust in the organization when they perceived stigma arising from an organizational culture in which help-seeking for mental health problems was seen as "weak and a potential 'career killer.'" Bullying of the Veteran/PSP and breaches of privacy about their health status were experienced, resulting in a reluctance to seek mental health support through the organization. Families perceived their inability to trust as a result of a lack of support by the organization, which they considered a betrayal of their Veteran/PSP's dedicated service to both the organization and the community.	"He was told by the police psychiatrist that if he had written in his report PTSD, well then, that would be the end of his career." "It's the toughen up princess … I don't want to be known as you know, some sort of girl … I need to prove to everyone that I'm worthy of wearing the uniform." "I just had to beg and plead because [the counselling service] were telling me that they just nominate somebody, you have to ring a number and whoever you get … they didn't want to speak to me because I was ringing on behalf of him. But he was rocking in a corner like he was suicidal you know."	Betrayal Hopelessness Powerlessness Breach of trust/ privacy Fear
5. Families' critical role in supporting help-seeking Participants considered that when organizations fail to recognize the significant role of families in providing social and emotional support, then they abrogate their responsibility for the Veteran/PSP's well-being. Many viewed the organization as complicit in the development of the Veteran/PSP's problem and in hindering family members' efforts to provide and seek support by dismissing and excluding them.	"It's me getting the call at eight o'clock at night, going into the [inpatient ward] to stop my husband. It's not the nurses that are on charge there taking care of my husband, it's me who's had to walk in there and stop him from wanting to run out and take his car and wrap it around a tree." "I said …'there's one person leaving this room, and it's not him' … because I said, 'Yeah, I'm done, like you [the organization] need to — he's not okay, and it's your responsibility to do something about it, you are — like you owe me and my boys something … because he's coming to work doing what you're telling him to do, and you don't care how he falls apart when he gets home. You don't care about the impact it's having on my children or on my own mental health.'"	Exclusion/not listened to Resilience Loss of trust in system and organizations Increased vigilance Family strain Carer burden Moral distress
6. What families need from organizations Participants wanted recognition of family members as being part of the support team for Veterans/PSP, which also involved families being suitably informed and educated by the organization. They wanted organizations to acknowledge and address workplace-related trauma, return-to-work policy and processes, and organization-based cultural stigma. They wanted health services to include families as partners in care and not treat them as invisible.	"When are they [the organization] going to acknowledge the people who do most of the groundwork and actually keep them together? … the key to it, it's involving the spouses from the get-go … when someone comes off deployment, you need to interview the family … then three months later — how are they going, how's everything at home, does everything seem okay, are you happy, does he come home from work okay?" "I noticed that there are absolutely no resources for families for facing that kind of situation on how you would approach it [counselling her young daughter who was distressed by her father returning to work]." "They [Veterans/PSP] need regular workshops on understanding themselves and mental wellness … psychological first aid needs to be considered just as important as the physical because … it help[s] with recognizing symptoms for themselves."	

Conceptual model of help-seeking by families of Veterans/PSP experiencing mental health concerns

Figure 1 outlines how perceived MD was experienced by families in their attempts to seek help for a Veteran/PSP family member. The model has four interrelated sections. Section 1 contextualizes and frames the mental health issue, describing personal, interpersonal, and socio-cultural factors (triggers and influences) that determine how meaning is prescribed to the issue. Section 2 is a key section connecting expectations to past experiences of help-seeking and where meaning is applied to this help-seeking experience, leading to a sense of MD. Section 3 includes defining the problem, deciding to seek help, and supporting selection. The process is generative — the three parts build and inform each other. Section 4 outlines practical steps to address the MD that families experienced by recognizing their role and generating a proactive response for inclusion.

Section 1: Triggers and influences

Section 1 summarizes the key personal, interpersonal, and socio-cultural factors that family members encountered as they watched a Veteran/PSP struggle with mental health concerns. The first and third sections of the model are based on the work of Liang et al. who described help-seeking and change as "defining the problem, deciding to seek help and selecting a source of support."[30(p. 71)]

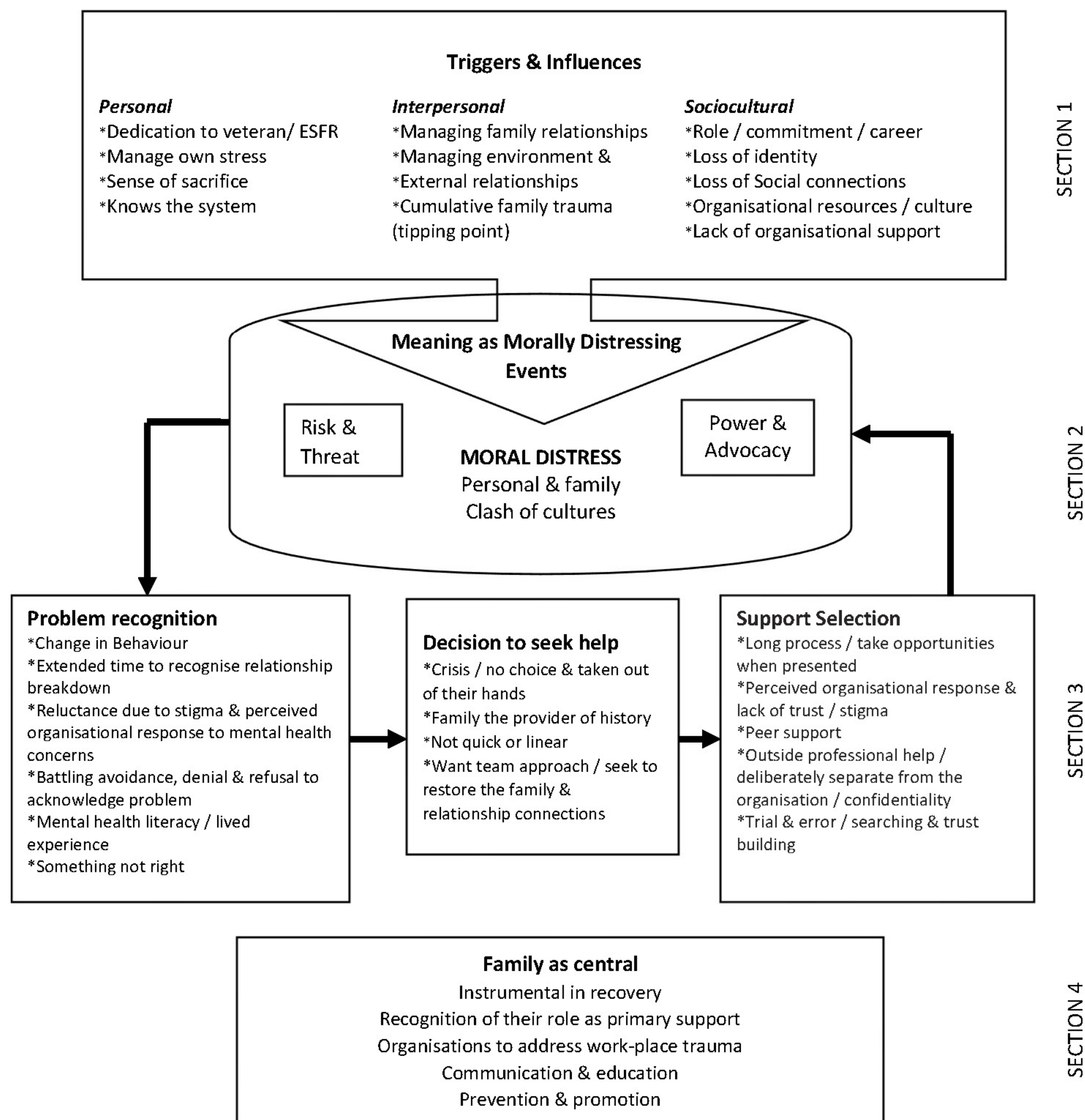

Figure 1. A conceptual model of help-seeking, and families of Veterans and PSP experiencing mental health concerns

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In this section, the family unit buffers the influences of stress and is a place where attempts to manage that stress propagate other challenges. Navigating relationships and the needs of the Veteran/PSP place constant interpersonal strain on the family unit. The participants described exposure to vicarious trauma, such as hearing raw details of traumatic work-related incidents, and having to manage the Veteran/PSP's high distress in providing the details, and events witnessed directly by the family member, such as intervening in suicide attempts, bearing witness to traumatic flashbacks (with some being mistaken for the "enemy" and waking with the Veteran attempting to strangle them), and the need to manage these high-stakes situations alone. Family members also described managing their own mental health needs as well as protecting other family members during periods when a Veteran/PSP was particularly distraught (emotionally and in some instances physically), while being the central pillar of support for the Veteran/PSP through their strong sense of loyalty. The participants constantly managed the environment and external relationships. Some were current or former Veteran/PSP themselves, which afforded systems knowledge. Those lacking prior experience encountered communication barriers between the Veteran/PSP's experience and a desire to care for them, leaving families with little or no concept of what the Veteran/PSP's role entailed and what to expect, and the Veteran/PSP feeling unable to communicate with their loved one.

The participants described how significant life events at home, in the context of cumulative effects of direct trauma and the vicarious trauma of the family, often culminated in the need for help (the tipping point). Participants felt abandoned and challenged when trying to get support for a Veteran/PSP through the organization. They were not given information about how to recognize mental health concerns. They felt they were "going in blind," excluded from decision-making, and faced with a lack of resources, organizational recognition, and support.

Participants demonstrated a strong commitment to their role as a main supporter (carer, advocate, protector of the family unit), and this was a key motivator to establish help-seeking. Threats to the Veteran/PSP's career and forced changes to identity and role (e.g., medical discharge, sick leave, return to lesser duties, change of position in the family) often led to a sense of stigma, felt and/or actual social disconnection, and isolation from informal support networks associated with the service community, not only for the Veteran/PSP but also the family who became more vigilant and overwhelmed. Participants found that their own goals, sense of self, and place were often dramatically co-opted to support the Veteran/PSP whether they wanted to or not and whether they felt competent in this new role or not (e.g., being partner and carer, advocate, family organizer, counsellor, debriefer), as the Veteran/PSP increasingly became distressed with their role, struggled to maintain work, and ultimately (for some) went on sick leave or left the service role due to mental ill health. The participants found themselves changing plans, being less available to their social networks, and increasingly putting other needs on hold to support the Veteran/PSP family member.

The participants also experienced disconnection between the culture of the organization and what they expected as their right to care and support from the organization. They believed that the organization had a clear moral responsibility to provide this support, given that the Veteran/PSP dedicated themselves to the organization and community, but had largely been left to fend for themselves.

Section 2: Meaning: MD, risk and threat, power, advocacy, and the clash of cultures

Section 2 describes perceived MD as a consequence of participants' experiences of organizational barriers to help-seeking. In participants' perceptions of a Veteran/PSP (and vicariously, the family) being abandoned by the organization, they viewed the organization as complicit in the member developing a problem and did not trust the organization to respond appropriately. Along with their own sense of not being recognized and supported as a helper, they felt the organization betrayed the Veteran/PSP in service to their community and country. Participants' emotional descriptions revealed pride in the person for wearing the uniform and in the values service represents. Their sense of betrayal occurred when the organization failed to recognize distress, demonstrate care, and uphold these service values. Institutional betrayal was also apparent in the participants' accounts of breaches of confidentiality that posed significant barriers to Veterans/PSP seeking help within their organizations.

Two moral violations perceived by family emerged from the findings. The first set of events centred on the organization's betrayal of the Veteran/PSP. The second set of events and outcomes/consequences for family/

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carers centred on the organization's betrayal of the family through a failure of obligation to the Veteran/PSP. The first violation encompasses family members who experienced a changed person because of mental health struggles that were perceived as directly related to the nature of their role and the organization's culture. The family perceived the person as letdown, exposed to trauma without adequate acknowledgement, resources, or support from the organization. This left the family with the sense that the organization neglected its obligation to the member by maintaining a culture that does not readily accept or deal with mental health concerns or psychological trauma, regardless of knowing the job is the cause of the trauma.

The second perceived violation is that the family unit is faced with direct emotional and physical threats and risks to interpersonal relationship(s), such as interpersonal conflict, Veteran/PSP self-harming (or potential or actual risk of suicide), or aggression and violence leading to the need to protect children, other family members, and themselves, as a consequence of organizational inaction or support for the Veteran/PSP when they became increasingly distressed and unwell. Families occupy an outsider position that makes these events and circumstances high stakes. With little real or perceived support, these circumstances go against a sense of justice, care, and protection that families feel the organization is morally obligated to provide.[31] The participants described the impacts and outcomes of these moral violations as guilt, anger, hopelessness, judgement by others, and dissonance between their values and beliefs and what they experienced through the help-seeking journey. Unfortunately, for some participants, this led to personal mental health struggles, a total breakdown in the interpersonal relationship with the Veteran/PSP, and poor outcomes for the Veteran/PSP and other family members such as children (e.g., mental distress, school refusal, delinquency, and aggression toward others).

The participants' experiences of MD were a balance between these violations and how empowered they felt managing a changing person, circumstances, level of support and access to it, and readiness to adopt a primary support and advocacy role. For Veterans/PSP and their families heavily invested in service roles and identity of service, the balance toward MD can lead them to question prior acceptance of the military/PSP organizational cultures that influence how psychological trauma is framed. These cultures emphasize self-sufficiency, competency, stoicism, and an ability to cope with role demands, reinforced by structures that promote emotional distance as self-protection against witnessing trauma. These qualities constitute a dominant masculinity focused on instrumental — as opposed to relational — aspects of life. Displaying vulnerability is often interpreted as a sign of weakness, which means possible marginalization from the group.[32] The family experience of Veteran/PSP trauma is one of vulnerability and caring to cope. It is useful to consider this disconnect as a liminal space; that is, between the organizational values and beliefs previously held by families and what they now value and believe as a moral right to organizational support that is not being provided.

The term liminal, or liminality, was traditionally used in anthropology to describe transition in social position and the social space between moving from one social role to another (e.g., civilian to police officer, or Veteran to civilian).[33] Liminal space is an opportunity for change; however, it can also be a disconnected space if change does not lead to new stability following transition. Instead, any obstacles can diminish communicability and create conflict. For participants, the moral violations they perceived from the organization left them stuck in the liminal space, trying to negotiate the gap between needed support for the Veteran/PSP and family against that provided by the organization, hence being the foundation of their sense of MD.

Section 3: Problem recognition, definition, and decision to seek mental health support

In Section 3, the model moves from the central concept of MD and the interplay between culture, risk, threat, power, and advocacy to outline how this influences the way changes in mental health and its symptomology are defined, recognized, and acted on by the family. This action is seen in the ultimate decision to seek help and the support selected.

Severity of MD manifests via the problem, its recognition, and how it disrupts the family and interpersonal relationships. Recognition encompasses clear changes in the Veteran/PSP's behaviour that were completely out of character for the person (e.g., an increasingly short fuse in communications with the family, emotional withdrawal from the family members, increased alcohol use) and indicates that something is not right. This is affected by the level of mental health literacy of family members, or prior experience, or by the progressive breakdown in intimate relationships (e.g., heightened interpersonal

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conflict, threatened or actual violence toward family members). The reluctance to acknowledge mental health concerns and refusal to seek help by a Veteran/PSP can be complicated by perceived and real stigma from the organization and peers, and the realization that it may end their career and impact their identity and sense of purpose. These concerns can also inhibit help-seeking by the family, either because the Veteran/PSP has hidden or denies symptoms, or because the family does not wish to negatively impact the Veteran/PSP's career. Therefore, the decision to seek help is not quick, nor linear, unless hastened by a crisis such as a suicide attempt, domestic violence, or police involvement.

Section 4: The family as central

Section 4 places families as central to mental health recovery which should be recognized by Veteran/PSP organizations, and formally and practically included in the helping process, with education to develop helping skills, and by communicating with families when designing and implementing organizational support structures. Mental health education and literacy, and easy access to support for members and their families, needs to be a priority, with a clear focus on promoting early intervention and prevention, which includes organizations addressing workplace trauma and its short and long-term effects on families.

DISCUSSION

MD and families

MD was pervasive across participants' accounts of their experiences. This was apparent in events creating the sense of betrayal felt when organizations failed to recognize distress and demonstrate care toward Veterans/PSP and their families, and outcomes for families/carers. This research describes just how embedded and aligned families were to a Veteran/PSP family member's organizational role in the community, demonstrated through significant empathy for the person's sense of duty. When Veterans/PSP struggled, families felt it personally and profoundly because of a high level of empathy. Empathy was hypothesized as key to developing moral injury and MD. Ter Heide[32] argued that, when potentially morally injurious events (PMIEs) occur, empathic or moral behaviour is expected; however, if this does not eventuate, distress is not alleviated, and a sense of moral injury can develop. The participants' descriptions suggest that families are performing this moral behaviour in lieu of the organizations. Also, because of the poor organizational responses that many families perceive when attempting to navigate help-seeking, they can be caught in a liminal space in which they can see the problem, and grasp potential support solutions, but have nowhere to go to realize those supports for family members. Deschenes et al.'s analysis of power and the role of institutions and systems, which highlighted individuals "being given no alternative,"[10(p. 1143)] aligns with the liminality that family/carers experienced. Descriptions of internal constraints as "more indicative of an individual's prior or current responses or perceptions to imposed power or resulting from a lack of reciprocity … rather than certain inherent failings of the individual"[10(p. 1143)] also align with family/carers' experiences of being shut out and excluded from decisions, despite their efforts. As with Deschenes et al.'s call for greater responsibility for creating MD being attributed to systems, the authors argue that Departments of Defence and Veterans' Affairs and public safety organizations hold significant responsibility for creating MD for family/carers.

The participants provided rich descriptions of how they directly and indirectly bore the consequences of organizational failures through the reluctance of the family member to seek help, and the distress and trauma it created for the family. These consequences were largely portrayed, and arguably masked, in mental health family "carer burden" research.[34] Likewise, significant attention focused on the distress experienced by Veteran couples, impacts of Veterans' mental ill-health conditions on parents and children, and how family distress can exacerbate a Veteran's PTS.[35-37] The problem is therefore seen and situated only within interpersonal relationships. Organizational responses to families (or lack of) are rarely examined as contributing to that distress. Prior research on moral injury and MD has focused on that experienced by Veterans and their families as a result of deployment-related trauma[35] and not that arising from the perceived absence of organizational support for families' help-seeking efforts.

Given the bidirectional reciprocity between family member and Veteran well-being, Lester et al. proposed a framework for routine inclusion of families in the prevention, engagement, and treatment of PTS for Veteran populations.[35(p. 423)] This framework included personalized psychoeducation for family members, early engagement in care and decision making, treating PTS in the context of family relationships, family-centred interventions, and more research on family engagement. This research demonstrated that families often try hard to

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engage with organizations but are neglected by them. Lester et al.[35] acknowledged that broad system-level reforms are also required but did not elaborate on what these reforms would look like. A review of police officer stressors by Violanti et al.[38,39] proposed that PMIEs are major contributors to poor mental health. While they acknowledged police culture created barriers to help-seeking, they offered solutions focused on organizational peer support and, contrary to our research findings, stressed the potential hazards of seeking support from family and friends.

Morley et al. concluded that MD is an epistemic injustice, "a wrong done to someone specifically in their capacity as a knower."[26] The participants in this study were knowers; they saw the problem but were excluded from potential solutions by organizations. Morley et al. further explained: "A person may experience psychological distress linked to life events but to be properly labelled [MD], it seems necessary that the distress is directly causally related to a 'moral event'."[26] Lack of acknowledgement and responsibility-taking from the organisation for the harms to its members has been researched by others.[40,41] However, this research is the first to more fully describe the harms that contribute to MD as a result of perceived organizational betrayal felt in the context of Veteran/PSP families' help-seeking experiences.

Limitations

This research involved a small sample of Australian family/carers. This limitation, combined with the breadth of age profile (18 to 70+ years), meant more nuanced analyses by family/carer age could not be done. The sample included family/carers with varying lengths of experience as carers; to ensure the currency of experience, the caring time frame was within the last 10 years. The study also combined perspectives of families of Veterans and PSP. Implications of sex and gender were not a specific focus of analysis, though 19 of the 25 participants identified as women, and it is well recognized that women are disproportionately represented in informal mental health caregiver roles.[42] Further research to provide a more nuanced understanding of family/carers' experiences of MD, strengthened by more detailed analysis (e.g., using Morse's methodology applied by Deschenes et al.[10]) is warranted.

Implications

This research, and the model of MD arising from it, suggests implications across three core areas. First, families of Veterans/PSP could be better supported and prepared for a serving family member's role and for coping and responding to emerging mental health concerns. The authors developed a guide for families and health professionals that was informed by this research.[43,44] It includes a range of advice that acknowledges and helps families to understand that the Veteran/PSP role is different than others, increases awareness of early warning signs of mental health distress, informs that help-seeking is a complex ongoing process, and provides strategies for looking after their own well-being, including where they might seek further support and knowledge.

Second, Veteran/PSP organizations could change how they engage with families across a person's service career. Smith and Freyd[15] highlight organizational barriers to change in how they might respond to issues of perceived betrayal, accountability, and inadequate support provision. They note that organizational denial of responsibility can be maintained by the words that organizations use, which, applied to the current research, would exclude discourse about MD and family impacts as part of the Veteran/PSP experience. Smith and Freyd's[15] recommendations include transparency and self-examination by organizations to make usually invisible institutional structures and processes more visible. The current Australian Royal Commission into Defence and Veteran Suicide (RCDVS) is an example of this process.[45] A second recommendation is protecting members through policy change, such as eligibility for access to mental health supports. A third recommendation is ensuring that health professionals working within such organizations understand their own potential to contribute to moral injury for Veterans/PSP and MD for families.[14]

Descriptions of organization betrayal described by participants also relate fundamentally to family/carers' distress arising from the perceived lack of care by organizations toward Veterans/PSP. When the well-being of Veterans/PSP is core to organizational culture (e.g., when help-seeking for mental health is encouraged and not stigmatized or perceived as weakness), this also benefits outcomes for family/carers. Therefore, fundamental change in the culture of how these organizations view and support members is recommended. The intention of the authors is to influence policy and cultural change through direct dissemination of research findings to policy makers and Veteran/PSP organizations. The report of the Australian RCDVS makes several recommendations about the need for fundamental

improvements to organizational culture of defence and Veteran services.[45]

The third focal area is implications of this research for educating and training mental health professionals and their subsequent practice. MD among family members, as demonstrated here, is so salient it needs better integration into mental health professionals' understanding of organizational culture and presenting concerns of Veterans/PSP and their families. The authors intend to develop a guide for mental health professionals, informed by this research.

Conclusion

This study offers the first detailed model of how MD can arise for families as an extension of the caregiving roles and interactions with organizations tasked with supporting Veteran/PSP family members' mental health during and after service. It demonstrates how service cultures that exclude Veteran/PSP families can leave them stuck in a liminal space, exacerbating their sense of MD.

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COMPETING INTERESTS

S Lawn is the board director of Lived Experience Australia, Mental Health Australia, and Australian Self-Care Alliance.

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https://jmvfh.utpjournals.press/doi/pdf/10.3138/jmvfh-2023-0042 - Wednesday, May 01, 2024 6:30:08 PM - IP Address:193.114.121.145

https://jmvfh.utpjournals.press/doi/pdf/10.3138/jmvfh-2023-0042 - Wednesday, May 01, 2024 6:30:08 PM - IP Address:193.114.121.145

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ETHICS APPROVAL

This study was approved by the Flinders University Human Research Ethics Committee in Australia (no. 2790) in 2020. It was also reviewed by the Departments of Defence and Veterans' Affairs Human Research Ethics Committee (no. 203-20) in Australia in 2020.

INFORMED CONSENT

N/A

REGISTRY & REGISTRATION NO. OF THE STUDY/TRIAL

N/A

ANIMAL STUDIES

N/A

FUNDING

This research was funded by a grant from The Road Home — The Colonel Susan Neuhaus CSC (Ret'd) Fellowship.

PEER REVIEW

This study has been peer reviewed.

ACKNOWLEDGEMENTS

The authors would like to thank the family members of Veterans and emergency services first responders who generously provided their time and shared their experiences as participants in this research. They also wish to thank the members of the Project Reference Group who provided their expertise in recruitment and the synthesis of the findings. They particularly acknowledge Chad McLaren, Tiffany Sharp, and the Defence Force Welfare Association of South Australia. They also thank Jeff Fuller for their review of an early draft of this paper.

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