Received: 4 August 2021 | Revised: 26 March 2022 | Accepted: 5 May 2022

DOI: 10.1111/hsc.13856

Health and Social Care in the community WILEY

ORIGINAL ARTICLE

Families' experiences of supporting Australian veterans and emergency service first responders (ESFRs) to seek help for mental health problems

Sharon Lawn PhD[1,2,3] | Elaine Waddell DrPH[1,3] | Wayne Rikkers MPH[4,5] | Louise Roberts PhD[1,3] | Tiffany Beks MSc[6] | David Lawrence PhD[4,5] | Pilar Rioseco PhD[7] | Tiffany Sharp BHlthSc[1] | Ben Wadham PhD[1,3] | Galina Daraganova PhD[7,8] | Miranda Van Hooff PhD[9,10,11]

[1]Flinders University, Adelaide, South Australia, Australia

[2]Lived Experience Australia Ltd, Adelaide, South Australia, Australia

[3]Flinders University, Open Door Initiative, Adelaide, South Australia, Australia

[4]Curtin University, Perth, Western Australia, Australia

[5]University of Western Australia, Perth, Western Australia, Australia

[6]University of Calgary, Calgary, Alberta, Canada

[7]Australian Institute of Family Studies, Melbourne, Victoria, Australia

[8]South-Eastern Melbourne Primary Health Network, Melbourne, Victoria, Australia

[9]Military and Emergency Services Health Australia (MESHA), The Hospital Research Foundation Group, Adelaide, South Australia, Australia

[10]University of South Australia Adelaide, South Australia, Australia

[11]University of Adelaide, Adelaide, South Australia, Australia

Correspondence
Sharon Lawn, College of Medicine and Public Health, Flinders University, PO Box 2100, Adelaide, South Australia, Australia.
Email: sharon.lawn@flinders.edu.au

Funding information
The Road Home - The Colonel Susan Neuhaus CSC (Ret'd) Fellowship

Abstract

The objective of this phenomenological study was to describe families' experiences of supporting veterans and emergency service first responders (ESFRs) (known also as public safety personnel) to seek help for a mental health problem. In-depth semi-structured open-ended interviews were undertaken with 25 family members of Australian veterans and ESFRs. Fourteen participants were family members of police officers. Data were analysed thematically. Participants described a long and difficult journey of supporting the person's help-seeking across six themes. Traumatic exposures, bullying in the workplace and lack of organisational support experienced by veterans/ESFRs caused significant family distress. Families played a vital role in help-seeking but were largely ignored by veteran/ESFR organisations. The research provides a rich understanding of distress and moral injury that is experienced not only by the service members but is transferred vicariously to their family within the mental health help-seeking journey. Veteran and ESFR organisations and mental health services need to shift from a predominant view of distress as located within an individual (intrapsychic) towards a life-course view of distress as impacting families and which is more relational, systemic, cultural and contextual.

KEYWORDS
emergency service first responders, families, help-seeking, mental health, moral injury, posttraumatic stress, veterans

1 | INTRODUCTION

Families play a vital role in supporting the wellbeing of veterans and emergency service first responders (ESFRs) (known also as public safety personnel) because they experience what goes on 'behind closed doors' in the private world of familial ties and share emotional relationships with the person in their daily life (Beks & Cairns, 2018; Waddell et al., 2020). Hom et al.'s systematic review (2017), predominantly of U.S. studies, found support from family to seek treatment to be a critical facilitator of service use. Yet family members often feel disconnected from the veteran or emergency service agencies. They may be unaware of what support these agencies offer and may have fewer support networks than other family carers (Ramchand et al., 2014; Waddell et al., 2020). Equally, the role and experiences of families may be invisible to and unacknowledged by these agencies (Keeling, Borah, Kinzle, Kleykamp & Robertson, 2019), leading families to be excluded from the formal care journey when the service member experiences mental health problems.

Veterans and ESFRs have higher rates of self-reported post-traumatic stress (PTS) and depression than the general community (Richardson et al., 2010; AIHW, 2018; Armenta et al., 2018; Rikkers and Lawrence et al., 2021) and are less engaged with support services (Bryant et al., 2019; Van Hooff et al., 2019). An estimated 51% of Australian veterans have experienced a mental disorder or substance use disorder in their lifetime (AIHW, 2018). An Australian national survey of ESFRs found one in three experience high or very high psychological distress compared with one in eight among all Australian adults (Beyond Blue, 2018). Barriers to help-seeking include the nature of military culture, stoicism, stigma, fear of being perceived by self and others as weak, career concerns and lack of self-recognition of need (Coleman et al., 2017; Kulesza et al., 2015; Murphy & Busuttil, 2015; Rafferty et al., 2020; Randles & Finnegan, 2022).

While some veterans and ESFRs share their experiences of work-related trauma with those closest to them (their families), others may choose to withdraw to deal with their psychological stress alone and protect their families from vicarious trauma (Beks & Cairns, 2018; Forbes et al., 2018; Lawn et al., 2019; Lawrence et al., 2018; Van Hoof et al., 2019; Waddell et al., 2016; Waddell et al., 2020). Either way, families are often the first to know when 'something is not quite right'; the first to observe early indicators that the person may be experiencing mental distress (Waddell et al., 2016; Waddell et al., 2020). Research has also highlighted the negative impacts of veteran and ESFR roles on family members, such as poor mental health, emotional distress, relationship strain, loss of identity and feelings of isolation (Beks, 2016; Keeling et al., 2019; McKeon et al., 2020; Murphy et al., 2017; Waddell et al., 2016).

Social support from family is a mitigating factor in the development of post-traumatic stress (PTS) in veterans (Charuvastra & Cloitre, 2008), encouraging help-seeking (Meis et al., 2010) and promoting positive treatment outcomes (Oster et al., 2019; Pukay-Martin et al., 2016). We know less about the role of families in mitigating the development of PTS in ESFRs. Understanding more about families' experiences of help-seeking, how they currently assist in facilitating care for veteran/ESFRs family members and what help they require to connect with the right supports is of vital importance. Families can play a pivotal role in supporting the veteran/ESFR to recognise the need for help, take action to get that help and engage early with professional support providers to address their mental health needs.

In Australia, the 'Pathways to Care' report (Forbes et al., 2018) investigated how recently transitioned and Regular Australian Defence Force (ADF) members access, use and value mental health services, including reasons for seeking care, and attitudes and beliefs about help-seeking. Across all veteran groups (active, transitioning, ex-service and reservists), partners and other family members (40%–50% and 20%, respectively, as reported by veterans) were often those most likely to suggest the

What is known about this topic?

- Informal supports such as family and friends are vital supports for veterans and ESFRs who experience mental health distress.
- This social support is protective of their mental health and facilitates help-seeking.
- Little is known about the impact of occupational exposure to trauma in veterans and ESFRs on their families.

What this paper adds?

- This research has highlighted that developing unique strategies that support improved help-seeking are needed for this population due to their mental health experiences being closely tied to veteran/ESFR organisational cultures that may contribute to poor mental health.
- Veteran and ESFR organisations and mental health services need to understand how distressing adverse experiences of help-seeking for the person's mental ill-health are for families and see trauma and mental health from a life-course trajectory (focusing on the long-term effects of physical and social exposures at various stages of life for the family).
- Moral injury for families occurs through veteran/ESFR organisational failures to prevent mental health harms to veterans/ESFRs and failure to prevent vicarious harm to families who provide them with support. Concerted cultural change is required to better support help-seeking in service members who have sustained harms as a result of their work.

veteran seek assistance for their mental health. A national survey of the mental health and well-being of ESFRs support found high rates of self-reported PTS and psychological distress comparable with ADF veterans; 25% reported high/very high psychological distress (Lawrence et al., 2018; Petrie et al., 2018; Rikkers & Lawrence, 2021). High levels of social and family support were associated with better levels of well-being, resilience and improved long-term mental health. However, ESFRs were often reluctant to seek formal mental health support. Only one in five ESFRs with probable post-traumatic stress disorder (PTSD—as per recognised criteria from the Diagnostic and Statistical Manual of Mental Disorders 5th Edition DSM-5, American Psychiatric Association, 2013) or high/very high psychological distress received adequate help. They often delayed help-seeking for months or years which could significantly worsen symptoms and recovery when help was finally sought. More than 17% with probable PTSD thought they did not need support, and 20% who perceived a need for support either did not seek it or did not receive it. Twenty percent delayed seeking support by more than a year, and 77% of those who did not seek support preferred to deal with issues themselves or with family/friends' support (Rikkers & Lawrence, 2021).

Canadian research with families of veterans with self-reported PTS found that life circumstances for the veteran (roles, responsibilities and demands) and precipitating events (preceding help-seeking) shape their partners' definition of the problem and pathways to help-seeking (Beks & Cairns, 2018). It confirmed the need for large-scale population-based data and qualitative research to provide a coherent picture of help-seeking needs of veterans and families, their mental health service engagement and directions for service planning and design to meet their help-seeking needs (Beks & Cairns, 2018).

The aim of this research was to explore the lived experiences for families in supporting their veteran or ESFR family member to seek help for a mental health problem, and the meaning they attached to these experiences. Veteran and ESFR families were grouped together for this study because available services and processes for accessing them are similar for both groups in Australia. There are many parallels between the service cultures of these organisations in relation to their members. Specific research questions were to explore:

1. How can families be better supported to recognise symptoms of mental health problems?
2. What can family members do next if someone has a problem?
3. Do families feel included as primary supports within the organisational response to mental health concerns? What works and what could be improved?
4. How do family members feel existing structures within organisations, programs and services recognise and support families of those with mental health concerns? What works and what could be improved to better support families?

2 | METHODS

2.1 | Design

The limited research on families' experience and the intent to capture the lived experience of participants supports the qualitative design of this study and the methodological lens of phenomenology to guide the thematic analysis. The analysis was based in the philosophical approach by van Manen (1990) (detailed below).

The research followed the consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (Tong et al., 2007). (See File S1).

2.2 | Ethical considerations

Ethics approval was granted by the Australian Department of Defence and Veterans' Affairs (DDVA) (No.203–20) and Flinders University (No.2790) human research ethics committees. All participants provided informed consent after reading the study's Participant Information Sheet. Given the nature of the research, any potential for distress was managed by providing telephone crisis and support information, and follow-up contact within 1–2 days of each interview. Participants could check their interview transcript and elect to withdraw any comments or their participation up to the point of data analysis; none did so. All data were de-identified and anonymised. Pseudonyms are used to report direct quotes from participants.

2.3 | Recruitment and data collection

Recruitment involved electronic distribution of project flyers to community-based organisations supporting veterans, ESFRs and/or their family members, via emails, newsletters, social media and Project Reference Group (PRG) members' direct links with veteran/ESFR communities. Recruitment information reflected the general aim of the study and the research questions.

The interview guide was formulated by the research team and PRG and reviewed together following interviews with the first two participants (see File S2). Interviews were conducted by two research team members between October 2020 and March 2021. Each interviewer (and the research team) had extensive experience of conducting qualitative research with veterans, ESFRs and their families. Interviewers had no pre-existing relationships with participants. Most interviews ($n = 19$) were conducted face-to-face; with four by phone and two by videoconference. Interviews were between 60 and 150 min, audio-recorded with participants' consent and professionally transcribed. PTS in veterans/ESFRs was based on self-report by family participants; however, almost all stated that this was a formal diagnosis of PTSD given by a mental health professional. Inclusion and exclusion criteria appear in Table 1. No participants were excluded or refused to participate.

TABLE 1 Inclusion and exclusion criteria

Inclusion criteria
Family members (spouse, former spouse, parent, sibling, adult child, other relative) of veterans (transitioned from full-time military service) or ESFRs (current or former serving, from Police, Fire, Ambulance or State Emergency Services) who have supported help-seeking in various forms (e.g. raising concern, provided practical and or emotional support within the past 10 years).
Veteran and ESFRs with PTS or other mental health issue (such as depression, anxiety, suicidality) self-reported by family participant or as a formal mental health diagnosis received from a mental health professional.
Exclusion criteria
Family of veterans who served as reservists only.
Family of veterans or ESFRs with a current claim for compensation under review.
Family members at risk of family violence if their participation in the study was known to the veteran/ESFR.

2.4 | Data analysis

Interview data were analysed thematically by three research team members, with finalisation of themes with the wider research team and PRG of independent experts from the veteran/ESFR community. This ensured robust reflexive discussions and minimised bias. All research team members had experience in veterans and/or ESFR research. Several had lived experience as former service members or as family members.

Data management was supported by NVIVO 12 software (QSR International Pty Ltd, 2018). Two researchers independently coded three interviews, then undertook a series of discussions with two other research team members seeking intercoder agreement and to establish a preliminary coding framework (Cresswell, 2003). They then coded further interviews, with critical insights provided by the research team (inclusive of the PRG) who met weekly to fortnightly, to discuss the emerging ideas. As new themes emerged, coding of earlier transcripts was reviewed as part of constant comparative analysis, supported by interviewer fieldnotes and robust group discussion. All coding and interpretation were then discussed and validated by the research team before finalisation of themes and whole team confirmation of data saturation. This was the point in data collection and analysis when little or no new information is apparent or required to address the research question (Bernard & Ryan, 2010).

Analysis followed van Manen's (1990) methodological approach. It involved reading fieldnotes and transcripts line-by-line several times before going from parts of the text to the whole, enabling detailed exploration and reflection on the use of language, emotion and concepts, as well as silences and gestures. Findings were presented as themes providing coherent narratives about participants' lived experience (Thomas, 2006).

3 | RESULTS

3.1 | Socio-demographic details

Twenty-five family members participated in the study; 15 were current or former partners, with the remainder being mothers, adult children or close friends of the veteran/ESFR. One interview was conducted with both the partner and adult child of a veteran together. Nineteen participants were female, and 20 of the ESFR/veterans were male. Participants ranged from 18 years to being in their seventies. More than half of participants ($n = 14$) were family members of police officers; one police officer spoke about themselves. Of note, over 50% of participants ($n = 14$) had a lived experience of veteran/ESFR service (current- or former-serving) (see Tables 2 and 3).

3.2 | Themes

Six key themes emerged and are summarised below. Further detail of each theme is provided in Appendices 1–6.

TABLE 2 Socio-demographic characteristics of participants ($N = 25$)

Variable	*N*
Sex of participant	
Female	19
Male	6
Age of participant	
18–19	1
20–29	2
30–39	4
40–49	4
50–59	9
60–69	3
70–79	2
Relationship type	
Partner	13
Former partner	5
Parent	2
Adult child	3
Close friend	2
Participant background	
Veteran	7
Police officer	4
Firefighter	1
Paramedic	2
Non-veteran/ESFR	11

TABLE 3 Socio-demographic characteristics of participants' veteran/ESFR family member

Variable	N
Sex of ESFR/veteran	
Female	3
Male	22
Age of ESFR/veteran	
30–39	6
40–49	4
50–59	11
60–69	4
Mental health diagnosis[a]	
PTS-Formally diagnosed	18
PTS-Not formally diagnosed	3
Depression, anxiety-formally diagnosed	4
ESFR/veteran status	
Veteran	7
(7 transitioned from full-time military service)	2
Paramedic	1
(1 operational duty, 1 Workcover)	15
Firefighter	
(1 retired)	
Police Officer	
(11 operational duty, 4 Workcover)	

[a]Formally diagnosed—as per DSM-5 (American Psychological Association, 2013).

3.2.1 | Theme 1. The job is different from others

Underpinning support with help-seeking was recognition that the veteran/ESFR job is different from other jobs, with particularly strong role identity attached for the person and community. These occupations required families to provide levels of emotional support not required with other occupations because of the unpredictability of the work and the often-daily risk of exposure to physical and psychological harm. Many participants used 'we' and 'our' to describe the job, and their experiences. Participants also expressed their pride in the strength of commitment that their family member had, or previously held serving their community and country. In most cases, veterans/ESFRs were described as giving years of dedicated service or an intent to pursue a career which was cut short due to work-related trauma. (See Box 1 and Appendix 1).

3.2.2 | Theme 2. Recognising that something is wrong

Families are fundamentally relational, functioning as a social system in which the behaviour of each member impacts on the emotions of others (Kerr & Bowen, 1988). While the stories varied, all participants were easily able to identify when they first noticed changes in their family member. Common to all descriptions was an understanding that this new behaviour was not part of the person they knew, illustrating the emotional knowledge contained in the family unit. Emotional distancing and anger were commonly described as the first indications that something was wrong. (See Box 2 and Appendix 2).

BOX 1

I would be awake until all hours of the morning when he got home, and I'd listen to him debriefing and all that sort of stuff… I was his sounding board constantly. (Ingrid, former partner of police officer)

Anyway, the trial [in which her police officer husband was a key witness to a fatality] went through, and it just went on so long, we felt guilty so we went back to work when we should have just thought, this is our trial, we should take the time that we want instead of rushing back to feeling like we need to be back at work.(Ingrid, former partner of police officer) (Ingrid, former partner of police officer)

He′s very aware of 'if I take my uniform off, now I know I'm just a dude, whereas before I used to be somebody and now, I'm not.' (Kay, partner of retired firefighter)

BOX 2

I was just seeing that he was very withdrawn … something just wasn't quite right … which was kind of unlike him. (Deborah, partner of paramedic)

And he got very angry at me and the kids; could not say anything, the kids did not move fast enough to do something, and he'd get angry. One of our kids remembers standing there defiantly saying, 'No I'm not going to do it', and he picked her up and physically moved her. And just, just angry and really out of control, not, not, not physical. (Kay, partner of firefighter)

He′d come back from his first deployment, and the signs were there already, the irritability, and his mood swings. He was verbally abusive when things would not go his way… he's not normally aggressive. (Lara, partner of veteran)

3.2.3 | Theme 3. The tipping point—deciding that something needs to be done

The process of recognising that their family member had symptoms of distress, to making a decision that professional help was needed, was not quick or linear for many participants. The initial response was to gently encourage communication with their family member

with a view to help-seeking. In this way, participants revealed how they first focused on communication with the aim to restore equilibrium in their relationship and the family unit. Participants described how this approach worked to move the person towards a tipping point where they realised that something needed to change. However, it also highlights a team approach to the problem and the role of a trusted other in that process. Participants also described a crisis point in the relationship or an external event that eventually prompted help-seeking. Examples included separation from their family member in cases of physical and psychological violence and concern for the safety of the children. (See Box 3 and Appendix 3).

3.2.4 | Theme 4. Barriers to help-seeking—Trust in the help-seeking process

Many participants described help-seeking as ongoing, frustrating and distressing. The family member and veteran/ESFR needed to navigate any changes and gaps in system support, for example, because counsellors, psychologists or psychiatrists left the role or the family relocated, which started the process of searching and building trust all over again. There was a sense of urgency to take action once the veteran/ESFR acknowledged a mental health issue that needed addressing. Decisions about type of support and how to access help were complex. While trust was described as a facilitator in the previous theme, a key subtheme related to support selection was lack of trust in the workplace and perceptions that it was a stigmatising culture. This problem with trust resulted in reluctance to seek mental health support through this avenue. For some, this was related to workplace trauma such as bullying and assault, experiences of privacy being breached, and perceived incompetence of support providers. For others, it related to inconsistency and problems with availability of good service providers, fear of being seen as 'weak', potential impacts on career ambitions, and sense of betrayal by the organisation prompting them to seek support elsewhere. Participants appeared to have their own strong sense of injustice, of being let down, because of how their veteran/ESFR family member was treated by their organisation (See Box 4 and Appendix 4).

BOX 3

I gave him some examples because first of all it was like, 'Oh I do not think so', and I said, 'Well look, this is what's happening, these are some examples.' And then he went, 'Oh okay, I did not realise I was doing that', so he went and got help … well, I did really. (Heather, partner of police officer)
[Explained how her partner eventually agreed to seek support after a domestic violence charge]
It was just – it was so sad – and at that point, I had got him to ring – I do not know whether it was the doctor or someone – I said, 'You need to talk to someone, you need to be honest about what is going on.' And so, he'd either – I think he'd gone and checked himself into the medical centre and said, 'I'm not leaving, like I cannot – like I'm going to wrap myself around [a tree]'…it was a blessing in disguise … and the doctor, who still is his doctor today, had said, 'absolutely, you are not okay, and you need to stay here.' (Lara, partner of veteran)

3.2.5 | Theme 5. Families' critical role in supporting help-seeking is ignored by the organisation

Many participants were visibly and vocally distressed and/or angry during the interviews. They considered that organisations abrogate their responsibility for the veteran/ESFR's welfare and fail to recognise the role of families in providing social and emotional support, and the consequential stress and distress this causes them. For most, contacting the organisation to ask for help was almost never considered as a first option, or even at all, because they viewed the organisation as either complicit in the development of the member's problem or not to be trusted to respond appropriately. It also represented a failure by the organisation to empower or simply enable family members to facilitate support. (See Box 5 and Appendix 5).

3.2.6 | Theme 6. What families need from organisations

There were two key needs identified by participants. First was the need for families to be recognised as part of the support team for veterans/ESFRs. This included their recognition by employment, rehabilitation, mental health and compensation systems and family being suitably informed and educated. The second need was for organisations to acknowledge and address workplace-related trauma,

BOX 4

And then he did go on Workcover back then very briefly and 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. He would just be stuck in an office somewhere in the corner. So, he did not put PTSD down in his report. (Bianca, partner of police officer)
It's the toughen up princess, it's you know, get on with it, you are a bloke, you are a cop, you are a, you know. I do not want to be seen as being you know, falling behind the rest of my team. I do not want to be known as you know, some sort of girl for want of a better word… I need to put on the brave face, I need to prove to everybody that I am worthy of wearing the uniform. (Heather, partner of police officer)

BOX 5

I said, "'there are – there's one person leaving this room, and it's not him … because I said, 'Yeah, I'm done, like you 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 are telling him to do, and you do not care how he falls apart when he gets home. You do not care about the impact it's having on my children or on my own mental health or my own wellbeing, or' – I said, 'but I'm not getting any help at all.' (Lara, partner of veteran)

I said, 'Well actually, I'm not happy with that' and they all kind of you know, 'oh no the wife's talking', you know. So, they all kind of got their fluff up a little bit and I said 'Look, never once have you spoken to me about what he's like at home. In the whole 2 years, I've never heard, you have never contacted me, you have never rung me, you have never got me involved at all in his rehabilitation. Most days he cannot even dress himself. You do not know any of that because you have never asked, and Darren wants to put on the brave face and tells you everything's fine, but everything's not fine.' (Heather, partner of police officer).

BOX 6

I rang the police department…I was crying, I was at work, I was at my wits' end. And I said I do not know how to help my husband and I know it's probably too late for me but what are you doing for other families? And she said to me, 'Oh you know, we do have family days at the academy you know, we try to do the family friendly activities', and I'm thinking that's not the kind of support they need. (Bianca, partner of police officer)

When a veteran goes into [Inpatient unit], it really is a red flag that the veteran's not okay, which therefore means that whoever is surrounding that veteran is not okay as well… the doctor asks you a million questions, and you think, oh, they actually care about me, they actually want to know what's going on and how it's affected my family. And you do not hear from them again after that. (Lara, partner of veteran)

It would have been helpful if I knew some signs of what to pick up when they get to that point, because I thought it was just general hypervigilance and it scared me…I would like to know how to just be with a police person, if you get what I mean? … it would be helpful for me to know how I could be not to hurry that process … or understand what they are going through; and it's not taken personally. But then how do you have a normal life? It would be helpful if I went maybe even once a year to a seminar. (Jennifer, partner of police officer)

including return-to-work policy and processes, by addressing organisational cultural stigma, and being proactive in embedding mental health education across the lifecourse of the role. Participants described an array of support needs for families. These ranged from education about the nature of the job and what to expect, education about mental health symptoms, access to practical support and inclusion in treatment, rehabilitation and return-to-work processes. (See Box 6 and Appendix 6).

4 | DISCUSSION

This research highlights the vital role of families in help-seeking for veterans' and ESFRs' mental health needs, and the impacts for families. In this discussion of the findings, we provide a general narrative review of participants' experiences. This focuses particularly how the organisations often did not recognise families as a part of essential support systems for their members, the consequences of this for the family unit, and how families experienced being left out of information sharing and decision-making regarding what support is available and provided to the person and the family. We then discuss how the findings indicate a sense of moral injury and trauma is at the core of these experiences by families on their own behalf, as well as on behalf of their serving family member. We propose that moral injury shaped how the problem of mental health and PTS is defined, how families respond and how this then influences how help is sought. The need for a life-course approach is then discussed, followed by implications for practice, and strengths and limitations of the study.

The primary barrier to help-seeking was fear of harming the veteran/ESFR's career, and this persisted into civilian life for those who had left the organisation (Beks & Cairns, 2018; Van Hooff et al., 2019; Waddell et al., 2016). This hesitancy often only changed once a 'tipping point' was reached. This could be an innocuous event (a straw that broke the camel's back) or a major event or crisis in the relationship, usually after a long accumulation of events and concerns over months or years. An American qualitative study with 32 first responders (Jones et al., 2020) explored barriers and enablers to mental health help-seeking. Barriers included concern about showing weakness, fear of confidentiality breaches, negative experiences of therapy, lack of access and availability and concerns with burdening their families with the traumas of the role and the desire to protect them. Facilitators included realising they were not alone, support from peers and their organisation, positive experience of therapists and problems reaching a tipping point. Key recommendations were the need to improve education and awareness raising. However, there was no mention of family involvement in facilitating help-seeking or families also receiving education and support.

Our research found significant delays in help-seeking for several reasons, for both veterans/ESFRs and their family members. Many family members were shut out and not provided with sufficient information or education by the organisation about the potential mental health hazards of the role. They were then unsure about what to do and had limited options (nowhere to go) to find out. This occurred because they did not have ready access to the organisation, and because the person's problems were situated within a perceived closed culture. This fostered a situation where families likely waited until the person's problems reached crisis point before they challenged that organisational barrier. Alternatively, where family members were clear in their concern early for the veteran/ESFR's emerging mental health problems, many found that they were 'alone' in their concern and only able to convince the person to seek help once problems reached crisis point. There are clear opportunities to support both service members and their families to identify problems much earlier and for organisational support to be available much earlier if improved communication between them is culturally accepted in the organisation.

Our research also highlighted that help-seeking does not end with access to support. Rather, it is an ongoing, nuanced and often fraught process, challenged primarily by organisational culture and processes, and organisational failure to acknowledge the interpersonal, relational context in which the veteran/ESFR's struggles are apparent. Participants' descriptions involved detail of traumatic exposures in the workplace and also issues of workplace bullying and lack of organisational support (Beks & Cairns, 2018; Lawn et al., 2019; Waddell et al., 2020). Family members reacted to these circumstances with vigilance that embodied and impacted their lives more broadly. Ellingson (2017) has spoken about embodiment as vigilance, preparedness, and a wakefulness to the omnipresence of risk in our everyday world that is felt both in mind and body. In the current research, it was expressed in the couple relationship through interactions. The sense of 'walking on eggshells' is an example of this embodiment that has been captured by many studies with partners of veterans (Beks, 2016; Mansfield et al., 2014; Murphy et al., 2017; Waddell et al., 2016). Also found from the current research, and further linked to the concept of embodiment, was that families of these veterans/ESFRs appeared to take on the values of commitment to serve the community and their worldview. Heightened situational awareness which is a skill vital to be 'safe' on the job also pervaded the relationship, the way children were raised and how humanity was viewed. Hence, when organisational barriers to help-seeking arose, and in the face of the veteran/ESFR's apparent distress and suffering, this presented a clash in values for the family member.

4.1 | Moral injury and families

Pervasive across the family members' experiences, and a clear consequence of experiencing organisational barriers to help-seeking, was the concept of moral injury. Traditionally applied to military populations and to the clinical domain (Atuel et al., 2021), there is growing attention to understanding veteran and ESFR trauma, in some instances, as arising from moral injury (Drescher et al., 2011; Litz et al., 2009; Shay, 1991, 2014). Shay (2014) described moral injury as 'a betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation' (p.183). This sense of incongruence and betrayal was further described by Jamieson et al. (2020) who defined moral injury as, 'the existential, psychological, emotional and or spiritual trauma arising from a conflict, violation or betrayal, either by omission or commission, or break with one's moral beliefs or code(s)' (p.1049). Institutional betrayal has been empirically linked to exacerbations in PTS and other mental health conditions (Smith & Freyd, 2014). In addition, institutional betrayal has been correlated with intensified suicidal ideation among military personnel (Griffin et al., 2019; Smith & Freyd, 2014) and ESFRs (Lentz et al., 2021).

The concept of moral injury is increasingly being applied beyond the military context; for example, to experiences of health professionals responding to the COVID-19 epidemic (Atuel et al., 2021; Griffin et al., 2019). In our research, moral injury was apparent in family participants' strong perceptions of betrayal and abandonment of their family member by the organisation and vicariously, of the family. The organisation was either complicit in development of the member's problem or not to be trusted to respond appropriately. This was coupled with the organisation's failure to empower or simply enable family members to facilitate support for their veteran/ESFR family member. Lack of acknowledgement and responsibility-taking from the organisation for the harms brought onto its members has been researched by others (Wadham, 2013). Whilst the concept of moral injury for military families has been explored previously by Nash and Litz (2013), their research focused predominantly on moral injury in spouses and children derived from deployment-related psychological trauma in veterans. The current study looked across the trajectory of veteran and ESFR families' service experiences. It particularly highlights moral injury arising from organisational betrayal of trust and absence of support as part of help-seeking once the serving member begins developing mental health problems. Our research also differs in that it includes the experience of ESFR families, particularly police families.

We believe that the current research is the first to propose how moral injury can also apply to families supporting those with mental health problems that arise or are exacerbated because of organisational cultures that fail to support the mental health and help-seeking of their members. A proposed model to explain the process of how moral injury develops as part of veteran and ESFR families' experiences of help-seeking, based on the findings of this research, is being prepared for publication.

4.2 | Help-seeking as a lived experience requiring a life-course approach

Supports and services for ESFR populations are notoriously intra-individually focused. For example, Finland studies of moral injury among police officers (Papazoglou et al., 2020; Papazoglou &

Chppko, 2017) make no mention of families or the role of organisational culture. Instead, they focus on incidents within the individual's policing role and clinical responses. In contrast, the current study emphasised the significant role and impact of the organisation itself, and the important place of families in help-seeking and support. Time and time again, family members told us that they want and need a family-focused approach to care. This would place less emphasis on the individual veteran/ESFR as the central focus of the problem, allowing more emphasis on the family as a unit that is connected, interdependent and systemically impacted by trauma/mental health/crisis. Beks (2016) has looked in detail at healthcare system management structures and organisational and cultural influences that act to exclude and prevent veterans' partners from being able to access help unless sanctioned by the serving member. For organisations, a problem requires an intervention focused on the individual in isolation from the person's lived experience and environment. For families, a problem changes their life and everything they know. Organisations need to better understand how life-altering mental ill-health of veterans/ESFRs and organisational responses to it are for the family unit. They need to see trauma and development of mental health issues from a life-course trajectory (Jacob et al., 2017) which includes their potential role across this trajectory.

5 | IMPLICATIONS FOR PRACTICE

More education, awareness raising and training are routinely proffered as solutions to supporting veterans/ESFRs and their families. However, a large US Survey of military carers (Ramchand et al., 2014) found most programs tend to target care recipients and carer tasks to ameliorate veterans' needs. Few programs have focused on veterans and ESFR family carers' mental health needs, even though research has shown that they may also experience high rates of at least one PTS symptom (Renshaw et al., 2011; Klaric et al., 2020). Ramchand et al.'s (2014) recommendations include empowering family carers through increased education and training about their carer role, improving their use of existing supports, increasing public awareness of their unique role and improved acknowledgement by mental health services and military organisations. Our research goes further in suggesting that some families also need support to address moral injury; a view that Nash and Litz (2013) also stress. They propose that, while PTS treatment goes some way to addressing moral injury, clinicians and support providers also need to consider dedicated individual and group programs that incorporate unique features centred on forgiveness, building trust, rapport and acceptance (Nash & Litz, 2013).

The Australian Good Practice Guide (Beyond Blue, 2020) was developed as one solution to help ESFR organisations address the mental health of their members. It states that, 'Providing family members with information about what to expect in the first responder work context can help them understand the positive role they can play and how to best support their loved one through difficult times. By inviting the family to be part of mental health promotion and education activities at work, first responder organisations can help to encourage a broader support system for workers and prepare them for eventual stresses they will encounter' (p.11). However, the only further mention of family in this Guide is two brief statements. These are to: 1) 'Include family in communications about mental health initiatives and services wherever possible'; and 2) 'Include information about how family members can access services on their loved one's behalf, or how to encourage them to seek their own support if required' (p.22). Family involvement or support is absent from sections that provide guidance once mental health concerns are apparent or post-service. This is concerning, given the current study found that acknowledgement that there is a problem appeared to be a significant first step in seeking help, and the important role that family members played in the veteran/ESFR moving towards that acknowledgement. It is also concerning, given social support provided by families, friends and peers has been shown to have a significant positive impact on the mental health of ESFRs (Vig et al., 2020).

Furthermore, it is well documented that, when people are in crisis or unwell, they may be least likely to absorb and make use of information. This makes early education and provision of practical advice critical for families and the facilitation of help seeking. This issue was emphasised by participants in a recent evaluation of an Australian complex case management pilot for medically discharged veterans with high risk of suicidality (Lawn et al., 2021). Of further concern, a recent international systematic review of interventions to improve well-being and resilience to stress of ESFRs (Wild et al., 2020) did not include any interventions that included families. Instead, all included interventions considering ESFRs in isolation from the context in which they live.

In an Australian evaluation of workshops to raise awareness about mental health of ESFRs, participants stressed the importance of lived experience facilitators (Fogarty et al., 2021). This could include workshops or educational materials developed and delivered by those with lived experience as family members of veterans or ESFRs. For example an online survey administered to 1282 UK firefighters (Tamraker et al., 2020) found 48.7% of respondents mainly sought spousal support and a further 23% sought a variety of formal and informal support, including from family. Murphy et al.'s (2017) UK study with partners of veterans found participants wanted to share their experiences with peers who were experiencing the same thing. They also wanted contact with professionals with in-depth knowledge of veteran issues and who could therefore understand their experience.

A recursive non-linear process of help-seeking was also apparent from this research. This suggests the need for cultural community brokers who facilitate access to support in non-dominant communities like veteran/ESFR families. Other studies have found that partners express the desire for family support worker liaison roles within veteran organisations (Beks & Cairns, 2018; Waddell et al., 2016). Also, previous research has shown that gaps in access to appropriate support (Ramchand et al., 2014), and exclusion by organisations,

have driven significant mental health family advocacy (Waddell et al., 2016). This could be clearly linked to post-traumatic growth. For example when family members experienced traumatic events (such as their partner's suicidality or suicide attempts), that challenged their core beliefs, which led to them experiencing psychological struggle then ultimately finding a sense of personal growth (Collier, 2016). As families strived to find meaning and purpose, advocacy could also be interpreted as a response to the moral injury they felt.

A range of general recommendations for organisations, arising from the above discussion, are shown in Table 4.

5.1 | Strengths and limitations

A strength of this research was the level of engagement and involvement of the veteran/ESFR community. Also, several research team members undertook data analysis, then presented the tentative analysis to the larger research team (inclusive of the PRG) before theme finalisation, to improve trustworthiness of the analysis.

This research has several limitations. The relatively small convenience sample was drawn from Australia, with a disproportionate number of families of police officers recruited. While we reached saturation for this extremely under-researched subgroup, and reached saturation for families of veterans given their experiences aligned strongly with existing research, this may not have been so for other subgroups (families of ambulance and firefighters) who were under-represented. Families' experiences may have varied depending on whether children were also present. Recent research by Kishon et al. (2020) highlighted the gap in understanding the impacts of living in a family where the parent is an ESFR with PTS related to their work. Most participants were women and in heterosexual relationships. More research is needed to determine whether help-seeking experiences vary according to ESFR type, gender, family and relationship type.

6 | CONCLUSION

While veteran/ESFR organisations see their members' mental health issues as the individual's problem requiring an intervention, these organisations need to understand how life-altering they are for individual's family. This study's findings highlight organisations' role and responsibility in contributing to mental health issues and challenges with help-seeking for the person and their family. Ensuring the mental health of veterans and ESFRs is therefore also about organisations address systemic and cultural problems within their organisations. It also requires acknowledging family relationships and context by including families across the life-course of the serving member's career.

AUTHOR CONTRIBUTIONS

Sharon Lawn contributed to conception or design of the work, data analysis and interpretation, drafting the article, critical revision of the article, in charge of administrative procedures with the ethics committee and final approval of the version to be published. Elaine

TABLE 4 How organisations can improve support to families of veterans and ESFRs

	Recommendations (based on the research findings and reviewed literature)
1	Education programs that better prepare the person and family for the role. Ideally including: Topics identified by and co-designed with service members and families Delivered as part of recruitment and commencement, with ongoing education available matched to participants' needs. Delivered wholly or in collaboration with service members and family members who are 'experts by experience' on the topics being delivered.
2	Acknowledge and address workplace-related trauma and organisation-based cultural stigma through the development of clear policies that are implemented in practice and accounted for in transparent governance by the organisation (e.g. return-to-work, privacy and confidentiality policies and processes)
3	Introduce Family Support Liaison roles as standard across services
4	Establish family peer support groups
5	Support individual and group treatment and support options that go beyond dominant clinical models, that are more holistic, include the family, and include areas of focus such as those suggested by Nash and Litz (2013) specifically to address moral injury
6	Provide education and training to all managers and leaders within the service on the importance of including families and their role in support. Lead by example.
7	Deliver assessments and interventions tailored to the context in which the serving member lives, not only focused on the requirements of their service role and Return-to-Work requirements of that role
8	Establish clearer in-service peer support which values and encourages a positive service culture

Waddell, Wavne Rikkers and Louise Roberts contributed to data collection, data analysis and interpretation and critical revision of the article. Tiffany Beks, David Lawrence, Pilar Rioseco, Tiffany Sharp, Ben Wadham, Galina Daraganova and Miranda Van Hooff contributed to data analysis and interpretation, critical revision of the article and final approval of the version to be published.

ACKNOWLEDGEMENTS

We 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. We also thank the members of the Project Reference Group who provided their expertise to recruitment and synthesis of the findings. We particularly acknowledge Mr Chad McLaren, Ms Tiffany Sharp and the Defence Force Welfare Association of South Australia.

FUNDING INFORMATION

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

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Sharon Lawn https://orcid.org/0000-0002-5464-8887
Elaine Waddell https://orcid.org/0000-0002-6336-1087
Ben Wadham https://orcid.org/0000-0003-1340-3485

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Armenta, R. F., Rush, T., LeardMann, C. A., Millegan, J., Cooper, A., & Hoge, C. W. (2018). Factors associated with persistent posttraumatic stress disorder among U.S. military service members and veterans. *BMC Psychiatry*, *18*, 48. https://doi.org/10.1186/s12888-018-1590-5

Atuel, H., Barr, N., Jones, E., Greenberg, N., Williamson, V., Schumacher, M. R., Vermetten, E., Jetly, R., & Castro, C. A. (2021). Understanding moral injury from a character domain perspective. *Journal of Theoretical & Philosophical Psychology*. Advance Online, *41*, 155–173. https://doi.org/10.1037/teo0000161

Australian Institute of Health and Welfare. (2018). *A profile of Australia's veterans 2018*. *Cat. No. PHE 235*. AIHW. Retrieved from:. https://www.aihw.gov.au/getmedia/1b8bd886-7b49-4b9b-9163-152021a014df/aihw-phe-235.pdf.aspx?inline=true

Beks, T. (2016). Walking on eggshells: The lived experience of partners of veterans with PTSD. *Qualitative Report*, *21*, 645–660. https://doi.org/10.46743/2160-3715/2016.2269

Beks, T. A., & Cairns, S. L. (2018). Contexts precipitating help-seeking among partners of veterans with posttraumatic stress disorder: A qualitative exploration. *Traumatology*, *24*, 313–323. https://doi.org/10.1037/trm0000159

Bernard, H. R., & Ryan, G. W. (2010). *Analyzing qualitative data: Systematic approaches*. Sage.

Beyond Blue Ltd. (2018). Answering the call national survey, National Mental Health and Wellbeing Study of Police and Emergency Services – Final report. Retrieved from: https://www.beyondblue.org.au/docs/default-source/resources/bl1898-pes-full-report_final.pdf

Beyond Blue (2020). Good practice framework for mental health and wellbeing in first responder organisations. Retrieved from: https://www.headsup.org.au/docs/default-source/resources/good-practice-guide-first-responders_bl1675_acc_std.pdf?sfvrsn=e4b02c4d_8.

Bryant, R., Lawrence-Wood, E. R., Baur, J., McFarlane, A., Hodson, S., Sadler, N., Benassi, H., Howell, S., Abraham, M., Iannos, M., Hansen, C., Searle, A., & Van Hoof, M. (2019). Mental health changes over time: A longitudinal perspective: Mental health and wellbeing transition study. Department of Veterans' Affairs. Retrieved from: https://www.dva.gov.au/sites/default/files/mental-health-changes-over-time-a-longitudinal-perspective-report.pdf

Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annual Review of Psychology*, *59*, 301–328. https://doi.org/10.1146/annurev.psych.58.110405.085650

Coleman, S. J., Stevelink, S. A. M., Hatch, S. L., Denny, J. A., & Greenberg, N. (2017). Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: a systematic review and thematic synthesis of qualitative literature. *Psychological Medicine*, *47*(11), 1880–1892. https://doi.org/10.1017/S0033291717000356

Collier, L. (2016). Growth after trauma. *Monitor on Psychology*, *47*, 48. Retrieved from: https://www.apa.org/monitor/2016/11/growth-trauma

Cresswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Sage.

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology*, *17*, 8–13. https://doi.org/10.1177/1534765610395615

Ellingson, L. L. (2017). *Embodiment in qualitative research*. Routledge.

Fogarty, A., Steel, Z., Ward, P. B., Boydell, K. M., McKeon, G., & Rosenbaum, S. (2021). Trauma and mental health awareness in emergency service workers: A qualitative evaluation of the behind the seen education workshops. *International Journal of Environmental Research & Public Health*, *18*, 4418–4433. https://doi.org/10.3390/ijerph18094418

Forbes, D., Van Hooff, M., Lawrence-Wood, E., Sadler, N., Hodson, S., Benassi, H., Hansen, C., Avery, J., Varker, T., O'Donnell, M., Phelps, A., Frederickson, J., Sharp, M., Searle, A., & McFarlane, A. (2018). Pathways to care, mental health and wellbeing study. Retrieved from: https://www.dva.gov.au/sites/default/files/twrp_pathways.pdf

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress*, *32*, 350–362. https://doi.org/10.1002/jts.22362

Hom, M. A., Stanley, I. H., Schneider, M. E., & Joiner, T. E., Jr. (2017). A systematic review of help-seeking and mental health service utilization among military service members. *Clinical Psychology Review*, *53*, 59–78. https://doi.org/10.1016/j.cpr.2017.01.008

Jacob, C. M., Baird, J., Barker, M., Cooper, C., & Hanson, M. (2017). The importance of a life course approach to health: Chronic disease risk from preconception through adolescence and adulthood. White Paper, World Health Organization, 1–41. https://www.who.int/life-course/publications/life-course-approach-to-health.pdf

Jamieson, N., Maple, M., Ratnarajah, D., & Usher, K. (2020). Military moral injury: A conceptual analysis. *Internal Journal of Mental Health Nursing*, *29*, 1049–1066. https://doi.org/10.1111/inm.12792

Jones, S., Agud, K., & McSweeney, J. (2020). Barriers and facilitators to seeking mental health care among first responders: "Removing the darkness". *Journal of the American Psychiatric Nurses Association, [serial online]*, *26*, 43–54. https://doi.org/10.1177/1078390319871997

Keeling, M., Borah, E. V., Kintzle, S., Kleykamp, M., & Robertson, H. C. (2019). Military spouses transition too! A call to action to address spouses' military to civilian transition. *Journal of Family Social Work*, *23*, 3–19. https://doi.org/10.1080/10522158.2019.1652219

Kerr, M., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory*. Norton.

Kishon, R., Geronazzo-Alman, L., Teichman, M., Teichman, Y., Cheslack-Postava, K., Fan, B., Duarte, C. S., Wicks, J., Musa, G. J., Djalovski, A., Tadmor, B., Moreno, D. R., Cycowicz, Y., Amsel, L., Bresnahan, M., & Hoven, C. W. (2020). Parental occupational exposure is associated with their children's psychopathology: A study of families of Israeli first responders. *Journal of Occupational & Environmental Medicine*, *62*, 904–915. https://doi.org/10.1097/JOM.0000000000001971

Klarić, M., Franciskoviċ, T., Pernar, M., Nembić Moro, I., Milićević, R., Cerni Obrdalj, E., & Salcin Satriano, A. (2020). Caregiver burden and burnout in partners of war veterans with posttraumatic stress disorder. *Collegium Antropologicum*, *34*(suppl 1), 15–21.

Kulesza, M., Pedersen, E., Corrigan, P., & Marshall, G. (2015). Help-seeking stigma and mental health treatment seeking among young adult veterans. *Mil itaryBehavoral Health*, *3*(4), 230–239. https://doi.org/10.1080/21635781.2015.1055866

Lawn, S., Kaambwa, B., Oster, C., Stevenson, J., & Venning, A. (2021). *The Department of Veterans' affairs wellbeing and support program: Final evaluation report*. January 2021. Flinders University. Retrieved from: www.nationalcommissionerdvsp.gov.au

Lawn, S., Willis, E., Roberts, L., Couzner, L., Mohammadi, L., & Goble, E. (2019). Ambulance employees association – Scoping literature reviews drawing on qualitative literature to address the physical, psychological, psychobiological, and psychosocial health of operational ambulance staff and interventions to address the impact of workplace stressors. Flinders University. Retrieved from: https://www.aeasa.com.au/wp-content/uploads/2019/06/Ambulance-Union-Literature-Review-Report-Final-May-2019.pdf

Lawrence, D., Kyron, M., Rikkers, W., Bartlett, J., Hafekost, K., Goodsell, B., & Cuuneen, R. (2018). Answering the call: National Survey of the mental health and wellbeing of police and emergency services. Retrieved from: Final report. https://www.beyondblue.org.au/docs/default-source/resources/bl1898-pes-full-report_final.pdf

Lentz, L. M., Smith-MacDonald, L., Malloy, D., Careton, R. N., & Bremault-Phillips, S. (2021). Compromised conscience: A scoping review of moral injury among firefighters, paramedics and police officers. *Frontiers in Psychology*, *12*, 639781. https://doi.org/10.3389/fpsyg.2021.639781

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*, 695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Mansfield, A. J., Schaper, K. M., Yanagida, A. M., & Rosen, C. S. (2014). One day at a time: The experiences of partners of veterans with posttraumatic stress disorder. *Professional Psychology: Research & Practice*, *45*, 488–495. https://doi.org/10.1037/a0038422

McKeon, G., Wells, R., Steel, Z., Moseley, V., & Rosenbaum, S. (2020). Self-reported physical and mental health of informal caregivers of emergency service workers. *Journal of Loss & Trauma*, *26*(6), 505–518. https://doi.org/10.1080/15325024.2020.1845020

Meis, L. A., Barry, R. A., Kehle, S. M., Erbes, C. R., & Polusny, M. A. (2010). Relationship adjustment, PTSD symptoms, and treatment utilisation among coupled National Guard soldiers deployed to Iraq. *Journal of Family Psychology*, *24*, 560–567. https://doi.org/10.1037/a0020925

Murphy, D., & Busuttil, W. (2015). PTSD, stigma and barriers to help-seeking within the UK Armed Forces. *Journal of the Royal Army Medical Corps*, *161*(4), 322–326. https://doi.org/10.1136/jramc-2014-000344

Murphy, D., Palmer, E., Hill, K., Ashwick, R., & Busuttil, W. (2017). Living alongside military PTSD: A qualitative study of female partners' experiences with UKveterans. *Journal of Military & Veteran Family Health*, *3*, 52–61. https://doi.org/10.3138/jmvfh.4011

Nash, W. P., & Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical Child and Family Psychology Review*, *16*, 365–375.

Oster, C., Lawn, S., & Waddell, E. (2019). Delivering services to the families of veterans of current conflicts: A rapid review of outcomes for veterans. *Journal of Military Veteran and Family Health*, *5*, 159–175. https://doi.org/10.3138/jmvfh.2018-0011

Papazoglou, K., Blumberg, D.M., Chiongbian, V.B., Tuttle B.M., Kamkar K., Chopko B., Milliard B., Aukhojee P., Koskelainen M. (2020). The role of moral injury in PTSD among law enforcement officers: A brief report. *Frontiers in Psychology*, *11*(Article310):1-6. https://doi.org/10.3389/fpsyg.2020.00310

Papazoglou, K., & Chppko, B. (2017). The role of moral suffering (moral distress and moral injury) in police compassion fatigue and PTSD: An unexplored topic. *Frontiers in Psychology*, *8*(Article 1999), 1–5. https://doi.org/10.3389/fpsyg.2017.01999

Petrie, K., Milligan-Saville, J., Gayed, A., Deady, M., Phelps, A., Dell, L., Forbes, D., Bryant, R. A., Calvo, R. A., Glozier, N., & Harvey, S. B. (2018). Prevalence of PTSD and common mental disorders amongst ambulance personnel: A systematic review and meta-analysis. *Social Psychiatry & Psychiatric Epidemiology*, *53*, 897–909. https://doi.org/10.1007/s00127-018-1539-5

Pukay-Martin, N. D., Macdonald, A., Fredman, S. J., & Monson, C. M. (2016). Couple therapy for PTSD. *Current Treatment Options in Psychiatry*, *3*, 37–47. https://doi.org/10.1007/s40501-016-0070-0

QSR International Pty Ltd. (2018). NVivo qualitative data analysis software. *Version*, *12*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Rafferty, L. A., Wessely, S., Stevelink, S. A. M., & Greenberg, N. (2020). The journey to professional mental health support: A qualitative exploration of the barriers and facilitators impacting military veterans' engagement with mental health treatment. *European Journal of Psychotraumatology*, *10*(1), 1700613. https://doi.org/10.1080/20008198.2019.1700613

Ramchand, R., Tanielian, T., Fisher, M. P., Vaughan, C. A., Trail, T. E., Batka, C., Voorhies, P., Robbins, M. W., Robinson, E., & Ghosh-Dastidar, B. (2014). Hidden heroes: America's military caregivers, RAND Corporation. Retrieved from: https://www.rand.org/pubs/research_reports/RR499.htm

Randles, R., & Finnegan, A. (2022). Veteran help-seeking behaviour for mental health issues: A systematic review. *BMJ Military Health*, *168*(1), 99–104. https://doi.org/10.1136/bmjmilitary-2021-001903

Renshaw, K. D., Allen, E. S., Rhoades, G. K., Blais, R. K., Markman, H. J., & Stanley, S. M. (2011). Distress in spouses of service members with symptoms of combat-related PTSD: Secondary traumatic stress or general psychological distress? *Journal of Family Psychology*, *25*(4), 461–469.

Richardson, L. K., Frueh, B. C., & Acierno, R. (2010). Prevalence estimates of combat-related post-traumatic stress disorder: Critical review. *Australian & New Zealand Journal of Psychiatry*, *44*(1), 4–19. https://doi.org/10.3109/00048670903393597

Rikkers, W., & Lawrence, D. (2021). Mental health help-seeking experiences and service use among Australian first responders. *Australian Journal of Psychology*, *73*, 125–133. https://doi.org/10.1080/00049530.2021.1882271

Shay, J. (1991). Learning about combat stress from Homer's Iliad. *Journal of Traumatic Stress*, *4*, 561–579. https://doi.org/10.1002/jts.2490040409

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology*, *31*, 182–191. https://doi.org/10.1037/a0036090

Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. *American Psychologist*, *69*, 575–587. https://doi.org/10.1037/a0037564

Tamraker, T., Langtry, J., Shevlin, M., Reid, T., & Murphy, J. (2020). Profiling and predicting help-seeking behaviour among trauma-exposed UKfirefighters. *European Journal of Psychotraumatology*, *11*, 1721144. https://doi.org/10.1080/20008198.2020.1721144

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal of Quality in Health Care*, *19*, 349–357. https://doi.org/10.1093/intqhc/mzm042

Van Hooff, M., Lawrence-Wood, E., Sadler, N., Hodson, S., Benassi, H., Daraganova, G., Forbes, D., Sim, M., Smart, D., Kelsall, H., Burns, J., Bryant, R., Abraham, M., Baur, J., Iannos, M., Searle, A., Ighani, H., Avery, J., Hansen, C., … McFarlane, A. (2019). Transition and wellbeing research Programme key findings report. Retrieved from: https://www.dva.gov.au/documents-andpublications/transition-and-wellbeing-researchprogramme-key-findings

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. State University of New York Press.

Vig, K. D., Mason, J. E., Carleton, R. N., Asmundson, G. J. G., Anderson, G. S., & Groll, D. (2020). Mental health and social support among public safety personnel. *Occupational Medicine*, *70*, 427–433. https://doi.org/10.1093/occmed/kqaa129

Waddell, E., Lawn, S., Roberts, L., Henderson, J., Venning, A., & Redpath, P. (2020). 'Why do you stay?': The lived experience of partners of Australian veterans and first responders with posttraumatic stress disorder. *Health & Social Care in the Community*, *28*, 1734–1742. https://doi.org/10.1111/hsc.12998

Waddell, E., Pulvirenti, M., & Lawn, S. (2016). The lived experience of caring for an Australian m ilitary veteran with posttraumatic stress disorder. *Qualitative Health Research*, *26*, 1603–1613. https://doi.org/10.1177/1049732315601398

Wadham, B. (2013). Brotherhood: Homosociality, totality and military subjectivity. *Australian Feminist Studies*, *28*, 2121–2235. https://doi.org/10.1080/08164649.2013.792440

Wild, J., El-Shama, S., & Degli Esposti, M. (2020). The effectiveness of interventions aimed at improving well-being and resilience to stress in first responders: A systematic review. *European Psychologist*, *25*, 252–271. https://doi.org/10.1027/1016-9040/a000402

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

How to cite this article: Lawn, S., Waddell, E., Rikkers, W., Roberts, L., Beks, T., Lawrence, D., Rioseco, P., Sharp, T., Wadham, B., Daraganova, G., & Van Hooff, M. (2022). Families' experiences of supporting Australian veterans and emergency service first responders (ESFRs) to seek help for mental health problems. *Health & Social Care in the Community*, *30*, e4522–e4534. https://doi.org/10.1111/hsc.13856