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**In Search of Healing Narratives Amongst Warriors:  
Exploring the Lived Experience of New Zealand Defence Force Service  
Members Seeking Mental Health Support**

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## Abstract

Narratives of war and of warriors exist throughout recorded human history and society's support for soldiers in distress reflects the cultural paradigm of the period. Contemporary approaches to supporting military mental health focus on barriers to care and psychotherapy outcomes; however, little is known about the user experiences of personnel as they navigate military healthcare systems. This research project explored the narrative accounts of 21 active duty New Zealand Defence Force (NZDF) personnel who had accessed mental health support in order to understand their experiences of accessing care. Participants described their mental health recovery using a better-than-before narrative structure aligned with the hero's journey, which involved challenges crossing the help seeking threshold and concluded with positive personal transformation. Stories of holistic recovery adopted Māori well-being heuristics to narrate the interconnection of relationships and health behaviours that supported participant healing. Participant accounts of seeking support also reflected paradoxical narratives, as the NZDF mental health system both helped and hindered personnel during their period of distress. Many of the cultural aspects of the NZDF were described as strengths but also as barriers that prevented personnel from connecting to care that was effective and meaningful to them. Narratives in this research contribute important perspectives on military mental healthcare that both celebrate the NZDF mental health system and offer opportunities to develop practices that better support personnel to navigate the many values conflicts and dilemmas they experience during their military service.

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### ***Dedications***

He toa taumata rau. Courage has many resting places.

To the brave men and women of Te Ope Katua O Aotearoa, especially those prepared to live the value of courage and share your stories. This research would not have been possible without your voices. Mauri ora.

Dedicated also in remembrance of the military service of both sides of my family, Anglo-Saxon and Viking. To my grandfather, Major (retired) Ingemann O. Frandsen of the Royal Danish Army; and to my great uncle Private Sam G. Elmer 1st/9th Glasgow Highlanders Light Infantry, who died 22 May 1917, age 23. Remembered with honour at Sunken Road Cemetery, Boisieux-St Marc, France.

To all those within the New Zealand military and veteran community who are currently suffering alone in silence. May this research contribute in some small way to informing how we can better support you when you need us.

To all my fallen mates, and of course, to Stevo. Never forgotten.

Na koutou i tangi, na tatau katoa. When you suffer we all suffer.

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The views and opinions expressed in this thesis are those of the author and do not necessarily represent the official policy or position of the NZDF.

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## Glossaries

### *Military Terms and Abbreviations*

ADF	Australian Defence Force
AFDA	Armed Forces Discipline Act 1979
CAF	Canadian Armed Forces
CAPT	Captain (Army)
CDF	Chief of Defence Force of the NZDF
CPL	Corporal
DFO(T)	Defence Force Order (Temporary) issued by CDF
DM (69)	Defence Manual of Armed Forces Law
Five Eyes	New Zealand, Australia, Canada, United States, and United Kingdom. Sometimes referred to as allied militaries
LCPL	Lance Corporal
LT	Lieutenant
MAJ	Major
MO	Medical Officer, Doctor
NZDF	New Zealand Defence Force
PTE	Private
PTS	Post-traumatic stress; any effect of traumatic stress exposure
PTSD	Post-traumatic stress disorder; PTS meeting diagnostic thresholds
RF	Regular Force
RNZAF	Royal New Zealand Air Force
RNZN	Royal New Zealand Navy
SGT	Sergeant
SSGT	Staff Sergeant
WO1	Warrant Officer Class One
(E)	Equivalent rank across the three services

***Te Reo Māori***

Hui	Meeting, fostering social gathering and dialogue
Kapa haka	Performance of traditional cultural displays
Karakia	Traditional form of Māori prayer
Kaupapa	Topic, initiative, discussion
Kawenata	Covenant, social contract
Kōrero	Speak, talk, narrate, discuss, story
Korowai	Traditional cloak worn by chiefs
Mahi	Work, occupation
Mana	Status, respect
Manaakitanga	Demonstrating hospitality and care
Mārae	Ancestral meeting house
Ngāti Tūmatauenga	Tribe of the god of war, i.e., New Zealand Army
Powhiri	Welcome ceremony
Purakau	Story, cultural or historical narrative
Rongomātāne	The god of peace
Taha hinengaro	Mental health
Taha tinana	Physical health
Taha wairua	Spiritual health
Taha whanau	Social and family health
Tane toa	Strong man, masculinity. Title of a masculinity project in NZDF
Tangata whenua	Indigenous; literally ‘people of the land’
Tapu	Sacred
Tautoko	Support
Te Ao Māori	Māori worldview
Te Ope Katua O Aotearoa	Personnel of the main defensive stockade of New Zealand, i.e., NZDF
Te Tauaarangi o Aotearoa	Warriors of the Sky of New Zealand, i.e., RNZAF
Te Taua Moana o Aotearoa	Warriors of the Sea of New Zealand, i.e., RNZN
Te Tiriti O Waitangi	Treaty of Waitangi

Te Whare Tapa Wha	The house of four walls; Māori model of holistic well-being
Tikanga	Protocol, customs
Tohunga	Expert healer
Turangawaewae	Ancestral place of belonging
Whakanoa	To make safe, a ceremony to move from <i>tapu</i> (sacred) to <i>noa</i> (ordinary)
Whakapapa	Connection to forebears, or ancestral lineage, genealogy
Whakatauki	Proverb
Whānau	Family, community
Whanaungatanga	Establish a genuine and trusting relationship; create a connection (often used in the active form, <i>whakawhanaungatanga</i> )

## **Chapter 1: Introduction**

This introductory chapter sets the scene for the thesis, outlines the aim of the research, and provides a synopsis of the chapters to follow. The research context is described by giving an overview of the New Zealand Defence Force (NZDF) and specifically the NZDF mental health system. Finally, the personal orientation of the researcher and author is described as an insider to the community in the current project. The opening of the chapter explores how telling stories about warriors is a very old tradition and one that this thesis aimed to contribute to.

### **Warrior Stories**

Humans have been using story to narrate the experience of warriors since antiquity and the impact on soldiers of exposure to combat and war can be found in the oldest written records. Historic references to soldiers suffering from trauma and loss can be found as far back as 2000 B.C. in Sumerian records following sacking of the city of Ur (Kucmin et al., 2016). Indications of posttraumatic stress symptomology including nightmares and flashbacks appear in the writings of Herodotus and Homer (Abdul-Hamid & Hughes, 2014). More recent accounts describe “cannonball wind syndrome” during the Napoleonic Wars, “soldier’s heart” during the U.S. Civil War, “shell shock” in World War One and “combat stress” in World War Two (Kucmin et al., 2016, p. 278; Van der Kolk, 2014, pp. 221-227). Similarly, a society’s reaction to traumatised warriors has followed the culture of the day. War trauma has been explained as weakness of will in the case of shell shock or malingering and a lack of “first grade fighting material” in the case of combat stress (Van der Kolk, 2014, p. 225). Warriors come from their respective cultures, and how they are supported for mental distress is reflective of societal norms and cultures (Guina et al., 2017).

In contemporary literature, modern military service is generally accepted as being a stressful occupation similar to first-responder professions such as fire fighters, paramedics and police (Goodwin et al., 2014). However, the operational context of the modern military makes it unique as service can include delivering military effects across the full spectrum of the conflict continuum (NZDF, 2017). Operational deployments in particular can be associated with the increased experience of mental health distress (Fikretoglu et al., 2022; Thompson et al., 2016) and how a society treats its returning warriors has evolved over time. For instance, it was not until well into the post-Vietnam era that advocacy groups were successful in lobbying for the inclusion of Posttraumatic Stress Disorder (PTSD) into the Diagnostic and Statistical Manual (DSM) in 1980 (Van der Kolk, 2014). The term posttraumatic stress (PTS) is now used in contemporary

scholarship to refer to the full range of responses to traumatic stress, both sub-clinical reactions as well as those meeting diagnostic thresholds for the disorder (i.e., PTSD; Fisher & Schell, 2013), and this distinction is adopted in this thesis also.

The last 20 years of modern history have seen considerable focus on the physical and psychological consequences of the protracted wars in the Middle East, and this heightened social awareness of the need to support veterans has been termed a “resilience renaissance” within the military health and well-being community (Britt et al., 2013, p. 13). The *NZDF Defence Doctrine* (2017) acknowledged the inherent “friction, uncertainty...violence and destruction” of engaging in aspects of military operations (p. x) and there is increasing acknowledgement of the moral obligation to provide support to military members: “Our elder veterans served us when they were fresh and resilient; our obligation to them is to ensure that their gift does not end in needless suffering and suicide” (Castro & Kintzle, 2014, p. 5). In New Zealand, over 90% of the public surveyed agreed that NZDF has a *kawenata* (social covenant) to recognise the impact of service and to provide support to its service members (Veterans' Advisory Board, 2020).

## **Research Aim**

The aim of this thesis was to explore how NZDF personnel described their experiences of help seeking within the NZDF mental health system. In order to ensure that appropriate care to military members is provided, it is essential that both barriers to support and good areas of practice are understood, and that the cultural factors around mental health recovery in the NZDF context are appreciated. The aim of this thesis was addressed using a narrative psychology approach in order to explore the mental health stories told by current serving personnel.

## **Overview of Chapters**

This thesis takes the form of thesis with publications and given the format there is some repetition between chapters which has been minimised as far as possible. *Te Reo Māori* (the Māori language) is used throughout and terms are italicised with English translation in brackets the first time they appear. Glossaries of NZDF and te Reo terms are provide on pages vii-ix. This opening chapter, Chapter 1, sets the research context by providing an overview of the NZDF and characteristics that make it a unique bicultural military. The NZDF mental health system is described, including the NZDF mental health strategy, before examining key models of well-being that inform NZDF’s orientation to mental health care. Chapter 2 provides a literature review on what is known about military mental health; risk and protective factors, rates and types of mental distress, treatment-seeking rates and treatment outcomes. Both international and NZDF-

specific literature is examined. The military mental health and treatment outcome literatures are acknowledged to be vast areas and an overview is provided to the extent that it supports the current research orientation. Chapter 3 builds on the previous literature reviewed by considering military mental health help seeking as a complex social phenomenon intimately embedded within and influenced by aspects of military culture. The influence of stigma as a barrier to help seeking is explored by considering the recruit socialisation process and the resilience culture within the military. Common military values are discussed as being central to the “stigmatising predicament” (Britt, 2000, p. 1601) service members experience when considering whether or not to seek support for their mental distress. Social identity threat, masculine norms, and what it means to be part of the warrior community within a modern society are discussed. Despite frequent overlap between relevant concepts in Chapters 2 and 3 (e.g., rates of help seeking and cultural barriers to care) efforts are made to disentangle these literatures where possible.

The following two chapters describe how the research was conducted. Chapter 4 outlines the methodology which includes the ethical principles and critical realist position adopted. The analytical approach of narrative psychology is described, as well as what is known about narrative research within military settings. The research method describes the recruitment of participants, conduct of the interviews, and analysis. Chapter 5 adopts a reflexive first-person perspective and discusses how the interview process facilitated the development of participant narratives.

The next three chapters describe the results of the thesis. Chapter 6 presents journal article one which has been published in *The Journal of Military, Veteran, and Family Health*. This article outlines the overall process of mental health recovery told by participants, which follows the arc of a hero’s journey narrative structure. Chapter 7 presents in-depth narrative accounts around barriers to accessing care and what prevented meaningful care once enrolled in the mental health system. Chapter 8 presents journal article two which has been published in *Military Psychology*. This article outlines narratives of what supported holistic mental health recovery as described by participants through the lens of Māori well-being concepts.

The final two chapters present discussion and reflections from the results chapters. Chapter 9 summarises the findings across the three results chapters and discusses the clinical and organisational implications. Discussion focuses on how to improve mental healthcare for NZDF personnel, including how to navigate the clash of values inherent in military service, improving access to care, recommendations for therapists working with military personnel and how to better align organisational messaging with NZDF values. Chapter 10 then concludes this thesis with a summarised table of research and organisational recommendations before closing with final

reflections on conducting the research as a military insider with the opportunities and challenges this presented.

### **NZDF Context**

The NZDF comprises 15,000 regular, civilian, and reserve force members. The regular force (RF) consists of 9,000 uniformed personnel across three services of Army, Navy, and Air Force (NZDF, 2022). The NZDF workforce is 25% female with 17.7% of NZDF personnel identifying as Māori, slightly higher than 17.3% of the national population (Statistics New Zealand, 2023). This demography varies by services and trade specialisation, with higher Māori representation within the Army and within non-commissioned ranks across the three services (NZDF, 2022). The term veteran in New Zealand has several meanings depending on the context, most notably as defined under the Veterans' Support Act 2014. Under this legislation veterans include those who have served in the NZDF *and* who have qualifying operational service. Controversially, it is possible under this definition to have been a uniformed member of the NZDF for many years, but not meet the legislative definition of a veteran (and therefore not qualify for Veterans' Affairs support upon exiting the NZDF; Patterson, 2018). This thesis, however, treats the term veteran in its broadest application and includes any service member who has deployed on any operation, as well as any retired or ex-military service member.

Like other modern militaries, NZDF must be prepared to engage in a variety of complex and dissimilar roles along the conflict spectrum; from civil defence and domestic support duties, humanitarian and disaster relief, to peacekeeping, counterinsurgency, to full scale warfighting at the combat end of the spectrum (Kaspersen, 2021; NZDF, 2017). NZDF's military doctrine reflects a philosophy of being prepared to conduct warfighting operations, which then enables it to effectively operate in de-escalated and benign environments such as in peace, stability, and security operations when required (NZDF, 2017). In 2024 NZDF had between 200–250 personnel deployed overseas, in addition to personnel engaged in a variety of domestic support operations (NZDF, 2024). Notably 1200 personnel over 2021–22 were engaged in Operation Protect, the all-of-Government response to Covid-19 including support to managed isolation and quarantine facilities. Substantial commitments in contemporary history include operations in East Timor, the Solomon Islands, support to the NATO mission in Afghanistan and Iraq, in addition to considerable contributions to stability and regional activities in Asia, the South Pacific, and Antarctica. The New Zealand geostrategic environment is acknowledged to be deteriorating, with both greater competition in the Indo-Pacific and climate change impacts likely to see greater NZDF involvement in the future, and therefore pressure on NZDF personnel (New Zealand

Ministry of Defence, 2021). During the writing of this thesis over 2022–2024 conflict erupted in both Ukraine and Israel/ Palestine, underscoring the volatility of the contemporary geopolitical landscape that will inevitably impact on the expectations and demands placed on NZDF and its personnel.

Military service members inhabit socially constructed roles which are influenced by historic and contemporary norms, cultures, individual, and societal factors (Kaspersen, 2021). *Te Ope Kātua O Aotearoa* (the te Reo name for the NZDF) literally means “the main defensive stockade of New Zealand” and is used to describe NZDF as the main warrior force for the people of New Zealand (NZDF, 2023a). The three services are also known in te Reo as *Te Taua Moana* (warriors of the sea; Royal New Zealand Navy), *Ngāti Tūmataunga* (tribe of the god of war; New Zealand Army), and *Te Tauaarangi* (warriors of the sky; Royal New Zealand Air Force) (NZDF, 2023a). Service members reside within concentric layers of culture and context each exerting their influence; from a dominant western values orientation, to the *Aotearoa* New Zealand bicultural context, to the influence of military and masculinised culture, and finally to the unique blend of subcultures within the three services and trade specialisations (Schnittker, 2022). It is a reflection of the strength and influence of the military identity that ex-NZDF members often consider themselves veterans first and members of New Zealand society second (Cardow et al., 2021).

### ***NZDF Bicultural Orientation***

New Zealand has been described as “a nation seeking to establish bicultural co-equal partnership between Māori *tangata whenua* (Indigenous) and non-Māori” (Hohaia, 2016. p. 47). *Te Tiriti o Waitangi* (The Treaty of Waitangi) is the foundational document in New Zealand that sets out the *tikanga* (protocol) and relationship basis between Māori and the Crown. The principles of Te Tiriti guide modern policy and were established through The Treaty of Waitangi Act 1975 and Government legislation and commentary during the 1980s. These principles include protection of Māori interests, the provision for participation of Māori in decision-making that affects their interests, and partnership in all matters that concern Māori (New Zealand Psychologists Board, 2012). These principles are intended to guide the orientation to health service delivery within New Zealand, for example by designing collaborative and culturally appropriate interventions that affect Māori consumers of health services. These principles also reflect a central tenet within the Māori world of *whakawhanaungātanga*—of establishing relationships and working collaboratively with others (Durie, 1985).

The NZDF is a unique fusion of the British European military tradition with the Māori warrior culture (Bargh & Whanau, 2017; Hohaia, 2016; NZDF, 2023a). The NZDF prides itself

on a “best of both worlds” narrative (New Zealand Army, 2020, p. 14) that recognises the importance of Māori integration into the three services and the important historic contribution Māori soldiers have made to conflicts New Zealand has participated in since the First World War (Walker, 2012). In particular the New Zealand Army is unique in that it transformed itself in 1994 by adopting the Māori tribal name Ngāti Tūmataua. This has been noted to take the military brothers-in-arms paradigm and imbue it with an even deeper cultural significance. When soldiers enlist in the New Zealand Army they are instilled with a sense of becoming part of the same *iwi* (tribe) (Hohaia, 2016; NZDF, 2023a). The *NZDF Bicultural Policy* provides guidance for the use of tikanga and sets out how the NZDF is to achieve a bicultural status that recognises Māori cultural interests, and the special place Māori culture has within the New Zealand military (NZDF, 2016). NZDF’s bicultural orientation actively harnesses synergies between Māori culture and military culture (Scoppio, 2018) and NZDF is recognised as an institutional leader with respect to its level of integration of Māori education opportunities for its service members (Hohaia, 2016). *Te Ao Māori* (the Māori worldview) and traditions are very much integrated into NZDF’s way of operating. Examples include the establishment of each service’s *Mārae* or *Tūrangawaewae* (meeting house) on camps and bases, integrating tikanga into ceremonial occasions (e.g., *kappa haka* and *pōwhiri* [welcoming ceremonies] and the wearing of *korowai* [cloaks] by NZDF leaders), *noho marae* (overnight stays) for new recruits to be welcomed onto their service *Mārae*, as well as te Reo and cultural training being widely offered and accessible (NZDF, 2023a). This fusion of Māori culture within NZDF is recognised to enhance operational effectiveness, for example by predisposing NZDF service personnel to diplomacy and cultural sensitivity, and by integrating Indigenous war fighting strategies and skills—all significant assets for NZDF personnel when operating in deployed environments (Bargh & Whanau, 2017; Hohaia, 2016; Scoppio, 2018).

#### *NZDF is Different in Important Ways to Other Militaries*

NZDF shares many characteristics with other Five Eyes militaries<sup>1</sup>. For example all five nations employ volunteer forces, share a common European cultural heritage, language, and have a history of working closely together<sup>2</sup> (Fikretoglu et al., 2022). Yet despite many commonalities between New Zealand and its military partners and allies, it is essential to appreciate how attitudes

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<sup>1</sup> Five Eyes militaries include New Zealand, Australia, United Kingdom, United States, and Canada.

<sup>2</sup> The Five Eyes also share an interest in military mental health research. The Technical Cooperation Programme (TTCP) of the Five Eyes nations is highly engaged in collaborative mental health research (TTCP, 2019).

towards mental health and help seeking might vary across cultures and sub-populations (Gould et al., 2010). It is especially important to note that as a biculturally-orientated force, relying exclusively on international research on military mental health may be problematic, or at best incomplete, when considering the NZDF cultural environment. Indeed, NZDF is described as not being a conventional military because of its integration with te Ao Māori (NZDF, 2023a). In addition to bicultural considerations, NZDF personnel are comprised of a number of other cultural factors that may impact the understanding of their experiences in a mental health context. For example, New Zealand forces are more egalitarian than other militaries (e.g., British forces), with less difference in privilege, more communication, and more social contact between different ranks (Deans, 2007; Veterans' Affairs New Zealand, 2022). Dyball et al. (2022) also highlight variations across even closely allied nations as to how service members are deployed, deployment lengths, and personnel management policies. This awareness of differences when comparing NZDF with even seemingly similar allied forces is necessary to appreciate the many cultural dynamics involved when NZDF service members seek support for mental health distress.

### ***NZDF Mental Health System***

NZDF provides mental health support nested within both the military organisation and the wider New Zealand healthcare system. The overall New Zealand mental health system is an interconnected network of providers which includes the NZDF Health Directorate (Government Inquiry into Mental Health and Addiction, 2018). The Health and Safety at Work Act 2015 requires all organisations to eliminate or minimise risks to health and safety, including mental health, so far as reasonably practicable. In light of this heightened legislative focus on employer responsibilities, NZDF has placed increased emphasis on help seeking, resilience, and well-being promotion in recent years (Bennett, 2017; Hom et al., 2020). The *NZDF Defence Health Strategy* set out the direction for a “better, stronger, healthier NZDF” in order to support NZDF’s defence and security and obligations to New Zealand (NZDF, 2018, p. 1). This strategy acknowledged the changing and demanding health needs of service members and the operational reality that personnel may be placed in situations that expose them to stressors and hazards that are unique when compared to the civilian context. The strategy also recognised the “deepening significance” of mental health, including spiritual and social health and commits to broadening the NZDF healthcare capability to be contemporary and “well-rounded” (NZDF, 2018, p. 9). Similarly, the *NZDF Mental Health Strategy* recognised that the mental health of personnel is vital for the achievement of the NZDF mission (NZDF, 2014). It recognised a duty-of-care to NZDF members and encouraged programmes that facilitate early help seeking behaviours, including the provision

of quality mental health care when needed. This strategy recognised the importance of providing a system that is trusted by service members, which is widely recognised as an important factor for removing barriers to accessing care (Williamson et al., 2019). In addition, the NZDF Chief Mental Health Officer (CMHO) provides reassurance to the Chief of Defence Force (CDF) that current mental health pathways of care, including interventions, are valid, safe, and defensible.

The community of health providers within the NZDF includes a mix of uniformed and civilian specialists. Uniformed support professions include general scope (organisational) psychologists, chaplains, and medical officers. Civilian support staff include social workers, sexual assault and prevention advisors (SAPRAs), complex care co-ordinators, and defence community support specialists. Given the wide variety of entry points into accessing mental health care within NZDF, there is scope for inconsistency in care across providers, interventions, and perceived ease of access (Nicholson et al., 2023). In addition, mental health information can be disjointed and not shared consistently by well-being support providers and leaders. In terms of specialist clinical intervention, NZDF currently employs contracted clinical mental health services, either through civilian contractors or via referral to external psychology clinics. At the time of writing in early 2024, NZDF is at the beginning stages of employing a uniformed clinical psychologist capability. Service members can self-refer to seek mental health support, or—given the nature of the military discipline system—can be directed to seek support (i.e., be ordered to attend health appointments) via a command referral (Nicholson et al., 2023). In summary and of particular relevance to the current thesis, the possible experiences of accessing mental health support within NZDF is wide and varied, and the experience of traversing this system is poorly understood.

### *Te Ao Māori Conceptualisation of Health*

The NZDF approach to mental health is integrated with Māori models of holistic well-being (NZDF, 2018; Nicholson et al., 2023) and the most important model for this research is *Te Whare Tapa Wha* (TWTW [the house with four walls]; Durie, 1985). In New Zealand, a renaissance of embracing Māori culture began during the 1970s which constituted a growing awareness of and return to holistic health practices. This movement included a more *whānau* (family and community) centred health orientation (O'Hagan et al., 2012). Māori conceptualisations of health have been increasingly incorporated into New Zealand health services since the 1980s (Durie, 2011) with the simplicity of TWTW making it widely applied throughout New Zealand (McNeill, 2009). TWTW is a metaphor to describe the interconnection of four *taha* (walls) or domains of health, and its adoption by NZDF recognises that service member well-

being is shaped by complex interactions between physical health (*taha tinana*), spiritual health (*taha wairua*), mental health (*taha hinengaro*), and social and family health (*taha whānau*; Durie, 1994; Nicholson et al., 2023). TWTW is used in NZDF workplace well-being surveys to assess workforce health (Bennett, 2019; Hom et al., 2020) and is promoted as a key heuristic for personnel well-being in training materials (e.g., New Zealand Defence Force, 2023b).

Through the adoption of Māori health models NZDF has become an organisation that is primed to be receptive to Indigenous knowledge systems (Hohaia, 2016). Research with NZDF chaplains has found that a general acceptance towards spirituality within NZDF was largely attributable to the importance of wairua in Māori culture (Hill et al., 2016). The opening *whakatauki* (proverb) of this thesis, *na koutou i tangi, na tatau katoa* (“when you suffer we all suffer”; Alsop & Kupenga, 2016, p. 68), is representative of a Māori worldview which prioritises collectivist concerns over individual concerns. Māori well-being is considered incomplete without the inclusion of connection to ancestral land (*tūrangawaewae*), to the wider family unit, and to ancestors (*whakapapa*; Mark & Lyons, 2010). The NZDF approach to well-being through a holistic Indigenous perspective allows for a broadened understanding of how service demands can affect personnel. For instance, being separated from ancestral land and Mārae may contribute to a different deployment experience for Māori compared to non-Māori service members, and indeed Māori and Pacifica personnel have been found to score in higher risk groups on mental health screening on return from deployment when compared to other members of the NZDF (Grimm, 2016). Rich examples of integrating Māori well-being protocols with deployment experiences can be found in the tikanga of *whakanoa*, where upon returning from conflict a cleansing ceremony is performed in order to lift the cloak of war (O’Hagan et al., 2012; Reynolds & Smith, 2009; Smith, 1975). Integration of Māori cultural worldviews in addition to western models enhances service member well-being, pride, and reinforces the best-of-both-worlds narrative in NZDF culture (Hohaia, 2016).

### **Personal Orientation of the Researcher**

This section adopts a first person perspective on the orientation to the thesis. My motivation for this research stemmed from a commitment to work for change within the NZDF mental health system and to advocate for service members’ mental health needs from a position of scholar activism (Hodgetts et al., 2021). My military career also provided me with a solid foundation of cultural appreciation to inform the investigation. I had served over 21 years of active duty at the time of writing (in 2024) with an additional 6 years as a reservist, across two separate careers; initially as an Iroquois helicopter pilot and flying instructor, followed by

retraining and service as a military psychologist. My deployment history included three flying tours to East Timor and the Solomon Islands, and a ground tour embedded in a New Zealand Army patrol as a civilian liaison officer in the remote subdistricts of Bamiyan, Afghanistan. I considered my history to be an asset to this type of investigation, which is at root an extremely intimate exchange with interview participants about deeply personal experiences. My two periods of active service were separated by a Master's degree in Psychology and working for the Mental Health Foundation of New Zealand.

My research interest fundamentally derived from my experience that military service can be hard work. It can involve considerable stress and risk of harm, and the personal toll can involve mental distress and grief at the death of colleagues. Two overlapping observations informed my curiosity around the way mental health help seeking is often communicated. The first I witnessed while at the Mental Health Foundation during 2014–2015, where despite spending millions of donation capital on national mental health promotions the suicide rate in New Zealand continued to climb. Words from the famous baseball film *Field of Dreams* struck me as representative of this strategy, “if you build it [they] will come” (Robinson, 1989, 00:04:25)—if we just earnestly provide more information then people will automatically get help. It seemed to me this approach overlooked complex psychological barriers to help seeking and left me wondering whether information campaigns alone would be enough to solve the problems of treatment avoidance in many military personnel. The second observation was around the way that help seeking was often framed in overly simplistic language, as a well-intended call to action to just raise your hand or to just speak up (e.g., Schlichthorst et al., 2018; Walsh & Foster, 2021). At best this appeared to me to be incomplete and potentially even ineffective within the military community—I personally have never found it easy to ask for help, and my transition home from Afghanistan was a real mental health challenge even with all the NZDF well-being support on offer. At worst I wondered if the just-speak-up messaging might be somehow counterproductive by ignoring real-world potential penalties of help seeking, especially in the military where there is always the risk of losing one's career due to medical discharge. This also led me to consider whether many well-intentioned help seeking campaigns may actually lead to backfire effects by entrenching fear and the avoidance of help seeking altogether. These observations and the desire to understand this important and complex area formed my orientation to the research in the hope that the findings would contribute to informing how we care for those who give so much to the NZDF and to New Zealand.

## **Chapter 2: Military Mental Health**

This chapter lays the foundation for the research to follow by providing an overview of mental health in military and veteran populations. An initial understanding is established by adopting a clinical perspective on the risks, triggers, and protective factors for mental health distress in military personnel. Following this the rates of types of mental distress across NZDF and allied militaries are reviewed, before examining the current evidence around the treatment of mental distress in military populations. This chapter concludes with a focus on facilitating posttraumatic growth in military personnel.

### **Through a Clinical Lens**

Understanding military mental health can be conceptualised through a clinical formulation lens which describes how predisposing risk factors interact with precipitating triggers and stressful circumstances to produce mental distress (Monroe & Simons, 1991). Formulation allows for a multi-perspective lens that considers a variety of factors that contribute to distress and recovery and also to resilience (i.e., protective factors) (Weerasekera, 1993). The following areas therefore review what is known about predisposing, precipitating, and protective factors associated with mental health issues in military personnel before turning to examine the literature on rates of the most common types of mental distress in the military.

### ***Predisposing Factors***

Predisposing risks for mental distress typically relate to childhood or key developmental factors that may confer a predisposition to the later development of mental health issues (British Psychological Society, 2011). It is acknowledged that in militaries generally and within New Zealand specifically, some number of recruits are attracted to service life as a way of escaping their difficult life circumstances (Veterans' Affairs New Zealand, 2022). The segment of New Zealand society that NZDF attracts its recruitment population from may itself provide predisposing risks for later development of mental health distress under stressful circumstances. For instance, in a large representative study of U.K. military personnel, anxiety and depression ranged from 14% in those with no reported childhood adversity to 25% in those with two or more reported childhood adversity experiences, higher than in the general U.K. population (Goodwin et al., 2014). In a study of 4,292 U.K. veterans, Burdett et al. (2021) found that childhood adversity was associated with poorer post-service mental health and PTSD scores irrespective of service experiences. Similarly, in New Zealand, Richardson et al. (2020) found that in a study of 1,817 current and ex-serving NZDF personnel that they had a significant number of adverse childhood

physical (35%) and/or sexual abuse experiences (16%). Those NZDF military service members drawn from high trauma exposed populations or sub-demographics may contribute a significant systemic predisposing factor towards distress when exposed to triggering events later in their military careers. This is especially relevant when considering the propensity to engage in help seeking behaviours, as early trauma experiences can have a detrimental effect on the ability to form trusting relationships, including with care providers (Van der Kolk, 2006, 2014). In the *NZDF Health and Wellbeing Survey* (described in more detail later in this chapter) just under half of all RF respondents (46%) reported they had experienced a traumatic event in their lifetime and 27% of the RF said that trauma had been a result of time in service with the NZDF (Bennett, 2019). Both preservice and service-specific trauma exposure provide risk factors for the later development of mental health distress in NZDF personnel.

### ***Precipitating Factors***

Military service can expose personnel to a variety of stressors in both operational (i.e., deployment) and in-garrison environments (Campbell & Nobel, 2009). Combat trauma exposure in particular is recognised as a common mental health risk for service members (Westphal & Convoy, 2015). Combat stress has been found to show a dose-response relationship between combat experiences (e.g., attacks or ambushes, seeing human remains, killing enemy combatants, knowing someone who was killed) and the incidence of PTSD (Hoge et al., 2004; McLean et al., 2013). For instance a linear relationship was found between number of firefights experienced and PTSD in soldiers and Marines who had been deployed to Iraq (4.5% for no firefights to 19.3% for more than five firefights; Hoge et al., 2004). Additionally in this same study, becoming wounded or injured was associated with a three-to-four fold increased risk of developing PTSD, highlighting the significant mental health risk of combat deployments.

More recent attention has also been paid to the variety of day-to-day stressors beyond the warzone that arise from the demands of a military-based lifestyle (Mobbs & Bonanno, 2018). These are multiple and could include some or all of the following: Chronic workplace stressors (e.g., long duty hours), lack of agency due to restrictions and constraints on freedoms associated with military discipline (Bartone, 2006), underutilisation of specialist skills in some operational contexts (e.g., peacekeeping, civil response such as managed isolation quarantine [MIQ] duty), stressful leadership styles, work in locations geographically distant from family and usual support networks, and the emotional role strain associated with military roles (Bartone et al., 1998; Campbell & Nobel, 2009; Hill et al., 2016). Military-specific stressors can also include the upheaval of moving home and family every two to three years as part of the posting-cycle,

changing job-roles from training to operational, living with work colleagues in barracks, military sexual trauma, as well as realistic training involving live ordnance or dangerous equipment (Goodwin et al., 2014). These in-garrison stressors can all lead to difficult mental health issues that are not specifically deployment or combat precipitated (Forbes et al., 2019). NZDF research has found that facing a variety of psychosocial issues, not exclusive to military occupational stressors, can increase the chances of experiencing mental health distress. Self-reported loneliness, poor sleep, lack of job satisfaction, increased self-reported stress, conflict with others, and financial stress have all been found to increase the odds of suicide risk in NZDF personnel (Bennett, 2017; Stuart & Bennett, 2017). Non-deployment stressors are part of the day-to-day life of service members and as time spent in uniform accumulates, often so too can the cumulative wear-and-tear on military personnel (Forbes et al., 2019; Westphal & Convoy, 2015).

Salient also for this study is the stress associated with the risk of medical release from service. Involuntary separation from the military has been found to be an important risk factor for subsequent poor mental health in veterans. In a large study examining Australian suicide statistics over 1997–2020, ex-Australian Defence Force (ADF) males were overall found to be 27% more likely to die by suicide compared to the general Australian population. Female veterans were found to be twice as likely to die by suicide (Australian Institute of Health and Welfare, 2022). Involuntary medical release from service was associated with the highest rate of suicide, three times higher than for voluntary separation. Similarly in the U.K. military, medical discharge from service has been associated with the worst post-service outcomes when compared to voluntary leaving and end of contract, especially for unemployment, poor mental health, and for PTSD (Burdett et al., 2021). As will be discussed in more detail later in the thesis, the risk of being discharged from the military for a mental health issue can be a significant stressor for many personnel.

### ***Protective Factors***

Despite the many stressors military personnel are exposed to there are also considerable protective factors associated with service. Military personnel are generally healthier than the general population due to several reasons including that many health and mental health conditions are screened out on recruitment (McLaughlin et al., 2008). Training and social support factors, as well as access to free medical care and mental health services contribute to these protective factors (Kang & Bullman, 1996) and the “healthy soldier effect” has been coined to describe how mortality rates for military personnel tend to be lower than for comparable segments of civilian society (McLaughlin et al., 2008, p. 928). Bruhn et al. (2022) examined a large U.S. dataset of

157,415 male soldiers between 2005 and 2015 spanning the wars in Iraq and Afghanistan and found that while mortality risk in U.S. soldiers increased from combat exposure specifically, it did not increase from non-combat service. In New Zealand research, deployment experience, sleep and social support have been associated with better health in ex- and current-serving NZDF personnel ( $N = 1767$ ; 1009 still serving) (McBride et al., 2022). In NZDF workforce surveys (discussed more under mental health rates), overall NZDF personnel have been found to have moderately or mostly healthy exercise, diet and sleeping practices. There are few differences between civilian and uniformed groups, and between deployed and non-deployed personnel in most areas. Moderate exercise, regular sleep patterns, social support, leadership and team cohesion have all been found to be protective factors for overall health in NZDF personnel (Bennett, 2019).

The literature on training for hardiness has received considerable research attention in military contexts in order to identify what supports resilience during adversity and swift recovery from trauma exposure (Bates et al., 2010; Hammermeister et al., 2010). Hardiness denotes a resilient attitude derived from cultivating a sense of meaning towards life's challenges, a high sense of personal agency, and openness to changes (Bartone, 2006, p. 137). Relatedly, resilience is the ability to withstand challenges and recover, adapt, and grow under difficult circumstances (Bates et al., 2010). NZDF continues to provide training in many resilience areas, such as how to utilise key sports psychology and other therapeutic skills (e.g., self-talk, cognitive reframing, mindfulness) throughout a service member's career, and particularly for those roles that pose elevated risk for mental health issues. Service itself is also protective—in the Australian Institute of Health and Welfare (2022) study the suicide rate for current serving ADF males was 49% lower compared to the general Australian population, demonstrating the protective benefit that service life can confer.

Several New Zealand-based studies point to the importance of developing psychological flexibility as a protective factor for NZDF personnel and veterans. Similar to hardiness, psychological flexibility is the ability to adapt to changes in circumstances and is specifically targeted in interventions such as Acceptance and Commitment Therapy (ACT). ACT uses acceptance and mindfulness skills as mechanisms for developing psychological flexibility (Harris, 2006). In a sample of retired and active duty NZDF personnel, participants who scored higher on a measure of psychological flexibility exhibited reduced odds of PTS (Richardson et al., 2020). One month following a 1-week ACT-based course for NZDF personnel with alcohol and drug issues service members were found to show better emotion management, reduced substance use

and lowered aggression (Harvey et al., 2017). Feedback from participants recommended a proactive approach to making ACT available to NZDF service members, and the wider literature is supportive of ACT as one of the treatments for PTS in the NZDF (Harvey et al. 2017; Richardson et al., 2020). The protective factors for military personnel are therefore considerable and are always evolving. However, despite these efforts to train and support resilience, a significant number of personnel experience clinical levels of distress as a result of their service, which this review now turns to examine.

### **Rates of Mental Distress in Military Personnel**

A career in the military can be challenging (Castro & Kintzle, 2014) and many people in the profession suffer the consequences of mental health distress. A large majority of research, media, and political attention has focused on the impacts of PTSD following the Iraq and Afghanistan wars (Forbes et al., 2019; Goodwin et al., 2014). In one meta-analysis of PTSD research in veterans, over 3,500 possible studies associated with military-based PTSD were identified since 1980 (Maglione et al., 2021). This focus is not without good reason as PTSD can be a debilitating and chronic condition that afflicts huge numbers of veterans globally. In the United States alone, of the 2 million veterans of the Iraq and Afghanistan wars, around 20% require support for mental distress associated with PTSD (Steenkamp & Litz, 2013). However, it is also important to recognise that the majority of military personnel exposed to trauma *do not* go on to develop PTSD (Westphal & Bonanno, 2007). As a testimony to the strength of the many protective factors reviewed in this chapter, despite exposure to extreme circumstances and chronic stressors, most military personnel show a resilient recovery profile (Bonanno, 2021a; Bonanno, 2004a). Even in veterans with a high lifetime exposure to trauma, two-thirds nevertheless show low levels of psychological distress (Isaacs et al., 2017).

A significant amount of research on health and well-being in allied militaries shows that depression, anxiety, PTSD, and substance abuse are the dominant forms of mental distress experienced by military personnel, with significant comorbidity between these conditions (Goodwin et al., 2014; Thompson et al., 2016). Research has also in recent years moved away from a focus on PTSD as the “primary” form of military mental distress to include a broadened awareness of the impacts of stress, depression and anxiety in military personnel (Fikretoglu et al., 2022; Goodwin et al., 2014). Moral injury in particular has attracted attention since the Vietnam War with the recognition that it is a distinct form of trauma from PTSD (Litz et al., 2009). Whereas PTSD includes symptomology associated with fear-based learning, moral injury has psychosocial or spiritual features including a sense of betrayal arising from the experience of a

moral transgression (Phelps et al., 2022; Koenig et al., 2019). As militaries screen for mental illness on application to join (including in NZDF; Iremonger et al., 2015) the incidence of many types of mental illness are far less prevalent in the military population (e.g., schizophrenia, bipolar disorder) (Acosta et al., 2018). The *Health Related Behaviours Survey* ( $N = 17,166$ ; Meadows et al., 2021), the U.S. military's flagship health and well-being survey, found that across all services 16.4% of personnel met criteria for serious psychological distress as measured by the Kessler K6 psychological distress scale (Kessler et al., 2003). A lower proportion of active duty personnel met criteria for probable PTSD (10.4%) than in studies earlier in the Iraq and Afghanistan conflicts (13-18%; Hoge et al., 2004), a possible reflection of improvements in behavioural health services and the changing nature of the role of the U.S. military in these conflicts. Just under 10% of U.S. active duty personnel were current heavy drinkers, with rates of PTSD, psychological distress and problematic drinking all higher than the U.S. national average (Meadows et al., 2021).

The ADF similarly has considerable data on the well-being of its personnel with the *Pathways to Care Report* the most comprehensive mental health study ever conducted on the Australian veteran and RF community (Forbes et al., 2018). Of the 8,480 RF respondents 14.4% met criteria for having a probable 30-day disorder as per cut-offs on the PTSD checklist (Weathers et al., 2018) or on the Kessler K10 (Kessler et al., 2002). Of those ADF RF surveyed, 52% reported having experienced concerns about their mental health at some point in their lifetime and the most common reasons for help seeking were depression, anxiety, relationship problems, and anger (Forbes et al., 2018, p. vi). The Canadian Armed Forces (CAF) has similarly conducted considerable research into understanding the well-being needs of their military and veteran population over the last 10 years. In a comprehensive summary of epidemiology studies of veterans and RF since the Korean War, 16.5% of the current RF were found to have a past-year mental disorder (Thompson et al., 2016). The most common mental health conditions in CAF personnel were depression (8.0%), PTSD (5.3%), generalised anxiety (4.7%), followed by alcohol abuse or dependence (4.5%; p. 75). Mental health rates were worse in the current generation of Canadian veterans compared to earlier eras—particularly past-year depression—and rates in the CAF RF were higher than in the general Canadian population. Similar trends of higher rates of mental health concerns in currently serving personnel compared to civilians have been found in the U.K.. The King's Centre for Military Health Research (KCMHR) cohort study is a representative study of the U.K. military across three time points (2004-06, 2007-09, and 2014-2016) in comparison to a representative sample of the U.K. civilian population (Burdett et al., 2021). Data from the second time point showed that serving military personnel were twice as

likely to report presence of a common mental disorder (CMD; anxiety and depression) compared to civilians. This risk was higher in female members, with a quarter of females in the military meeting criteria for probable depression or anxiety (Goodwin et al., 2014, p. 4). Data from the latest wave of this KCMHR study ( $N = 4292$ ) found that 7.8% had probable PTSD, 23.5% likely met criteria for a CMD, with 11.8% likely meeting threshold for alcohol misuse. This wave notably consisted of a high proportion of cohort members who had transitioned from service, which nevertheless indicates the significant burden of mental health distress experienced by the U.K. veteran population (Burdett et al., 2021).

### ***NZDF Mental Health Rates***

Rates of mental distress in the military and veteran community within New Zealand are not as well documented or publicised compared to other Five Eyes nations (Veterans' Affairs New Zealand, 2022). Nevertheless, indications of mental health distress in the NZDF can be found in several areas: NZDF workforce surveys and research on suicide risk; academic research on rates of PTS; rates of mental distress leading to medical discharge from service; and New Zealand veterans research. The *NZDF Health and Wellbeing Survey* has been administered across two waves (2016, 2019). Data from the 2016 wave ( $N = 4512$ ) indicated that agreement with suicidal ideation items (i.e., 6 items from the Mini-International Neuropsychiatric Interview; Sheehan et al., 1998) was higher compared to the general New Zealand population (7.1% in NZDF compared to 3.2%). However, despite this the NZDF suicide rate was lower than the general New Zealand average over 2008-2012 (12 compared to 14.9 per 100,000; Stuart & Bennett, 2017). In another study, NZDF personnel were found to have low prevalence of suicide mortality when compared to a number of other occupation groups (e.g., doctors, farmers, hunters, police) over the period 1973-2004 (Skegg et al., 2010). Findings from the 2019 wave of the *NZDF Health and Wellbeing Survey* ( $N = 4100$ ; 33% response rate) indicated around one quarter (26%) of those surveyed screened as having an elevated level of psychological distress and nearly two thirds of respondents (64%) reported one or more life stressors had been a problem (“quite a lot” / “to a great degree”) over the previous four weeks. The five most commonly reported concerns were workload, concern about others, job satisfaction, finances, and sleep (Bennett, 2019). Workforce well-being checks were also conducted in response to Covid-19 lockdowns in three waves over May and August 2020 and April 2021. Survey data in 2021 ( $N = 3839$ ) showed that approximately 1 in 4 RF and civilian personnel reported they were struggling with their mental and emotional well-being. Top challenges at the time for both RF and civilians were job satisfaction, workload, and difficulties sleeping, with 23% of participants reporting that their

financial circumstances had been adversely impacted within the previous 12 months (Bennett et al., 2022).

In an epidemiology study of reasons for medical discharge from service in the NZDF over 2006–2013, 19.5% of all medical releases were found to be due to mental illness and behavioural disorders (Iremonger et al., 2015). The most common mental illnesses leading to medical release were anxiety and depressive disorders (9.2% of medical discharges) and PTSD was found to lead to medical release in only 0.5% of discharge cases in this study. However, this is somewhat at odds with an investigation of PTS conducted in a mixed RF and veteran NZDF population ( $N = 1817$ ; 56% current serving) where overall 30% of participants reported experiencing probable PTS and 10% were identified as likely to have clinically diagnosable PTSD (Richardson et al., 2020). Older age, male gender, higher reported distress, and exposure to trauma were all significantly associated with increased likelihood of PTS symptoms. Additionally, Māori were more likely to be at risk of clinically significant PTS compared to New Zealand European members and veterans. The rates of probable PTSD in this study were similar to earlier research on rates of PTSD in Vietnam War veterans (also 10%; MacDonald et al., 1997). New Zealand veterans and currently serving personnel have been found to exhibit poorer physical health compared to the general New Zealand population (e.g., mobility, pain or discomfort). However, in one study there was no statistical difference in anxiety or depression when compared to the general New Zealand population (McBride et al. 2022). New Zealand Vietnam veterans have also been found to have higher rates of hospitalisation for alcohol related mental disorders compared to the general population, either due to comorbidity with PTSD or due to drinking habits picked up during time in service (Cox et al., 2015; Harvey et al., 2017). The medical issues veterans most frequently claim support for through Veterans' Affairs New Zealand are hearing, depression, PTSD, orthopaedic, and skin conditions (Veterans' Affairs New Zealand, 2022).

#### *Mental Health Rates Discussion*

Despite the considerable international literature on the rates of mental distress across the Five Eyes, the field is nevertheless hampered by a huge variation in research methodologies making direct comparisons across nations challenging. Nevertheless, reasons for medical discharge from the NZDF are predominately depression and anxiety which aligns with the Australian, Canadian and U.K. militaries. Rates of PTSD in the New Zealand veteran population suggest an incidence of around 10% consistent across the Vietnam and contemporary generations of veterans. However the low rates of medical discharge for PTSD in NZDF personnel (just 0.5%) suggested that either PTSD is not recognised while still serving (a hidden problem), or that there

is a delayed presentation of this in the New Zealand veteran community (a latent problem) which is common in military populations (Bonde et al., 2022). A combination of both hidden distress and latent full onset is also possible and warrants further investigation. Our allies show higher mental health rates for veterans when compared to their national populations, but in New Zealand only one study (McBride et al. 2022) has compared this so far and found no difference in veteran rates of anxiety and depression with the general population. While the most recently available survey data indicate around 25% of NZDF personnel are experiencing mental distress (Bennett et al., 2022), representative sample research in NZDF using the same scales and cut-offs as our partners would be needed in order to ascertain accurate benchmarking.

While important and necessary, these findings alone may be insufficient to fully contextualise the potentially large subsection of the military community that may experience sub-clinical and comorbid symptoms that do not meet full diagnostic thresholds (Huppert, 2009). For instance, sub-threshold PTSD rates in U.S. military samples has been found to range anywhere between 2.3% to 22.3% depending on which definitional criteria is used across the literature (Bergman et al., 2017). While many military members continue to be able to serve and do their jobs within the confines of the structure of the military system, they may do so even as they experience significant psychological pain—functioning, but suffering (Adler & Castro, 2013; Castro & Kintzle, 2014). There is clearly a large need for contextualised mental health support and treatment options for military personnel, which the following section now turns to review.

### **Military Mental Health Treatment**

This section focuses on what is known about the rates of using military mental health services and the outcomes of mental health treatment. Barriers and facilitators that contribute to these rates and outcomes are discussed in depth in Chapter 3. The section concludes with a focus on posttraumatic growth outcomes in veterans.

#### ***Rates of Accessing Care***

Despite a focus on improving military mental health care over the last two decades, a significant proportion of service members do not access care when needed (Fikretoglu et al., 2022). For instance, across studies in allied nations, of those personnel with a probable mental health disorder approximately 25% continue to not receive any support or access any help (Fikretoglu et al., 2022). In the U.S. *Health Related Behaviours Survey*, 25.5% of active duty personnel reported using any mental health service with 7% reporting an unmet need for mental health treatment in the past year (Meadows et al., 2021). In the ADF *Pathways to Care Report*

24.4% of current serving RF personnel had never sought help despite being concerned about their mental health (Forbes et al., 2018, p. 63). Of the ADF RF personnel with a probable mental health disorder 82% had sought care; however, only 37% sought care within three months of first being concerned and 18% waited three or more years before getting help. In the Canadian military, rates of accessing mental health services have improved 7.2% over a 10 year period, an 84% relative increase (Fikretoglu et al., 2018). Interestingly, help seeking rates in the U.S. military, CAF, and ADF have all been noted to be higher than help seeking rates in their respective national populations (Fikretoglu et al., 2018; Forbes et al., 2018; Meadows et al., 2021). As discussed earlier, a significant protective factor for military personnel is free access to healthcare and indeed across allied nations the closing gap between need and treatment is attributed to the significant investments in mental health services in recent decades (Fikretoglu et al., 2022). For instance, in CAF improvements have been attributed to the extensive renewal of the Canadian military mental health system, a doubling of the number of mental health clinicians, and the establishment of a Directorate of Mental Health to coordinate regular screening and the delivery of mental health literacy and resilience training.

Compared to overseas research, the rates of accessing mental healthcare within NZDF is less well understood (Iremonger et al., 2015; NZDF, 2014). It is estimated that approximately 5% of RF members seek mental health support through primary care health services annually (Stuart & Bennett, 2017). In the *NZDF Health and Wellbeing Survey*, 24% of NZDF service personnel indicated they would not seek support internally for a mental health concern, with 7% saying they would not seek support at all due to a preference for managing issues alone and concern about career impacts (Bennett, 2019). A qualitative study in U.S. military personnel who sought treatment external to the military system found that reasons for why private (civilian) support was sought included: a lack of trust in the military system, enlistment regret, military sexual trauma experiences, the perception of being deceived by recruitment or leadership, values conflicts (e.g., guilt around deployment), preexisting mental health conditions, and family or financial distress (Waitzkin et al., 2018). These factors can all lead to a sentiment of rejecting the considerable support that military health systems offer, as expressed by one U.S. Air Force study participant interviewed by Lefeber and Solorzano (2019): “I have recommended seeking help outside of a base, rather than on a base, so that everybody is not able to stick their nose into your business” (p. 9). Accessing support services external to military healthcare can often mean that personnel are waiting until significantly distressed before receiving care—nearly half the clients in the Waitzkin et al. (2018) study expressed suicidal ideation at intake of civilian accessed mental health services.

Being in the position of having to decide whether or not to access support, whether to trust the military system, or to pursue help externally, can all significantly contribute to the distress that service personnel experience.

### ***Treatment Outcomes***

Until relatively recently very few studies had focused on factors associated with treatment outcomes, adequacy of care, timeliness, and maintenance of treatment gains in military personnel (Fikretoglu et al., 2022). The majority of military mental health research has focused on PTSD treatment with few studies focusing exclusively on the treatment of common mental health conditions such as depression and anxiety in military samples (Thompson et al., 2016). Current treatments specifically for military and veterans with PTSD as recommended by the U.S. Department of Veterans' Affairs (U.S. VA) and APA include Cognitive Behaviour Therapy (CBT), Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) as well as Eye Movement Desensitisation Reprocessing (EMDR) (APA, 2017; U.S. VA, 2023). Despite a huge amount of research attention, military personnel and veterans have in general been found to benefit less from psychotherapy for PTSD than non-military populations (Haagen et al., 2015; Straud et al., 2019). In a review of randomised control trials, Steenkamp and Litz (2013) found that while PE and CPT were superior to waitlist or psychodynamic supportive counselling, and despite treatments providing improvements, most veterans (around 60%) retained their PTSD diagnosis at treatment completion. Similarly in a more recent meta-analysis of therapy outcomes for PTSD treatment (28 studies), remission rates were found to be lower for veterans (50%) than for civilians (65%) (Straud et al., 2019). An additional concern with the currently recommended therapies for military personnel is the high rate of therapy dropout. Therapies that focus on trauma symptoms such as CPT and PE have been found to have higher dropout rates among veteran and military populations when compared to non-trauma focused approaches (Edwards-Stewart et al., 2021). A curvilinear relationship has also been found between PTSD severity and treatment outcomes, with low severity (under engagement in treatment) and high severity (overwhelming distress) showing poorer outcomes compared with moderate pretreatment distress (Haagen et al., 2015). An important consideration in the treatment of trauma-exposed military personnel is therefore the careful navigation of the therapeutic window, where a psychological midpoint is maintained that is neither unengaging or too overwhelming (Haagen et al., 2015).

Improvements in the co-ordination of mental health care systems are also required to reach those in need as there are huge variations in treatment timeliness and satisfaction with services across the literature (Forbes et al., 2018). For instance, a large scale review of evidenced-based

therapy use in veterans in the U.S. VA system over 15 years examined therapy use, drop-outs, and completion outcomes. Of the 308,556 Iraq and Afghanistan veterans who were identified as having PTSD, 22.8% of veterans initiated therapy, and only 9.1% of veterans completed treatment (Maguen et al., 2019). Additionally, the time to completion of treatment was on average three years after the initial visit. Similarly, in a large review of quality of care for U.S. military personnel with PTSD and depression, fewer than 50% of patients ( $N = 38,828$ ) received the recommended standard of care on examination of medical records (Hepner et al., 2018). Thirty six percent of PTSD patients and 25% of depression patients received adequate care following diagnosis in the first 8 weeks (operationalised as either 4 psychotherapy or 2 medication visits). Improvements around treatment follow-up was particularly recommended as a low proportion of depressed patients exhibiting suicide risk were found to receive adequate follow-up care. The reasons for these pervasively poor treatment outcomes for military personnel and veterans are likely due to a variety of factors, such as the complexity of military-based PTSD intertwined often with moral injury, as well as due to military cultural factors (Steenkamp et al., 2020). Nevertheless, these outcomes have led many researchers to question whether the currently available manualised therapies should continue to be prioritised as the first line treatments for military mental health conditions, and whether alternative approaches that encourage a more tailored and holistic recovery approach might be needed (Hepner et al., 2018; Steenkamp et al., 2020).

### *Posttraumatic Growth*

The literature on military mental health treatment has increasingly focused on how to facilitate posttraumatic growth following trauma exposure, in addition to the traditional approach of aiming to reduce PTSD symptoms (Mark et al., 2018; Tedeschi & McNally, 2011). Posttraumatic growth was first coined by Tedeschi and Calhoun (1995) and has been described as the experience of positive changes resulting from the struggle with major life crises. Importantly, growth following trauma is not inevitable but can occur through the process of disruption to core beliefs and the resulting engagement in meaning-making (Calhoun et al., 2010). Unlike currently recommended approaches that focus on manualised therapies for PTSD treatment, clinical approaches to facilitating posttraumatic growth in veterans involve an integration of several orientations, such as cognitive-behavioural, narrative, existential, and interpersonal therapies (Tedeschi & Moore, 2021). One programme for veterans that adopts this approach using residential and online follow-up components has been found to support mental health

improvements across a range of metrics including PTSD, posttraumatic growth, and psychological flexibility (Moore et al., 2021).

In a qualitative synthesis of nine studies on posttraumatic growth in military personnel, commonly identified themes included a newfound appreciation for life, the development of a more nuanced perspective, a new sense of purpose, and experiencing an improvement in compassion, empathy, and sensitivity towards the feelings of others (Habib et al., 2018). In a systematic quantitative review on posttraumatic growth in military samples, the most commonly reported statistically significant association was between ethnicity and posttraumatic growth, with higher posttraumatic growth occurring for members of ethnic minority groups (Mark et al., 2018). One possible explanation for this finding is a greater emphasis on spirituality among ethnic minorities, and prior research has identified that religion or spirituality can be a protective factor for people following trauma exposure as a potential avenue through which to find meaning and supporting a readiness to face existential issues (Shaw et al., 2005). Intrinsic religiosity was also identified as the strongest correlate of posttraumatic growth in a nationally representative study of U.S. veterans (Kang et al., 2023). Spiritually-inclusive models such as TWTW and the general acceptance of wairua within the bicultural orientation of the NZDF may therefore be important psychologically protective factors for NZDF personnel (Hill et al., 2016). Both posttraumatic growth reviews in military samples also identified the important role of social relationships in recovery from trauma, both in terms of accessing support, but also in the development of appreciation and gratitude for relationships as a result of the posttraumatic growth (Habib et al., 2018; Mark et al., 2018).

Symptoms of PTSD have been found to frequently co-occur with posttraumatic following trauma exposure (Tedeschi & McNally, 2011) indicating that both distress and growth can occur concurrently (Calhoun et al., 2010). A curvilinear relationship between PTSD symptoms and posttraumatic has been found in some meta-analyses (e.g., Shakespeare-Finch & Lurie-Beck, 2014) and in a nationally representative survey of U.S. veterans (Kang et al., 2023). These studies show that an increase in PTSD symptomology was associated with an increase in posttraumatic growth, but beyond a critical point severe distress is associated with less growth. Both combat-related stress and healthcare-related stress exposure have also been found to exhibit the same inverted-U dose-response relationship in U.S. Air Force medical personnel one month following deployment (McLean et al., 2013). Time course has been found to be an important variable in posttraumatic growth as trauma survivors can often lack the language to be able to process and make meaning out of their experiences in the near-distance of a crisis—“if you’re still in it, it’s

hard to talk about it” (Van der Kolk, 2014, p. 382). In one meta-analysis of benefit-finding following trauma, more positive outcomes (i.e., less depression and more positive affect) were more likely when the time since the traumatic event was greater than two years (Helgeson et al., 2006). This underscores the importance of ensuring that support for veterans continues long after they have completed their official military duties.

### ***Conclusion***

Military personnel have many protective factors which support their resilience to the variety of stressors and challenges in their roles, but even the strongest have inevitable limits. Commonly occurring mental health distress in military personnel includes PTSD, anxiety, depression, and problematic alcohol use, and in addition to known mental health rates there is a potentially large proportion of the military community that experience these comorbidities at sub-diagnostic, but nevertheless clinically significant levels. While rates of mental distress in allied militaries are higher than their national civilian populations, the rates of accessing mental health services are better than their civilian averages, which is likely due to considerable investment in improving access to services. In New Zealand, one study has found no difference in rates of mental distress between veterans and civilians, and the NZDF suicide rate is lower than the national average. The gap is considered to be closing between those who need help and those who access mental health services, but a significant proportion of personnel either do not get timely support or refuse military healthcare and seek it elsewhere. Also, despite acknowledgements that intervention outcomes have generally improved over the last decade, the most commonly recommended therapies today still leave many “treated” veterans with ongoing distress and impairment. Orientations that encourage posttraumatic growth may offer alternative approaches to supporting military personnel and veterans, but while examples exist they are not widespread. Overall the review of military mental health reveals considerable complexity, including protective factors and risks, as well as higher rates of accessing care than civilians but poorer outcomes. The next chapter turns to consider military culture and the factors influencing help seeking in more detail.

## **Chapter 3: Cultural Factors**

This chapter explores the impact of military culture on help seeking. Military culture is discussed by considering the need to train for the violence of war, the recruit socialisation processes, resilience training, masculine gender roles, as well as contemporary soldier role expectations. Discussion focuses on the mixed-messaging and inherent contradictions between healthcare and military worldviews that personnel must navigate when seeking mental health support.

### **The Complexity of Treatment Seeking**

Well before the resurgent interest in military mental health, help seeking was known to comprise competing motivations of simultaneously wanting to approach treatment (i.e., to alleviate distress) and avoid treatment (i.e., treatment fears) (Kushner & Sher, 1991). Barriers to accessing care in military studies are typically divided into structural (e.g., policy, logistical) and attitudinal (e.g., stigma, internalised) barriers (Acosta et al., 2014; Britt, 2000; Britt et al., 2008). In a recent synthesis of barriers and facilitators to care questions in military settings, significant tensions were found between fundamentally opposite attitudes, for example; “I would be seen as weak” versus “friends...would be supportive”; and “treatment doesn’t work” versus “it is possible for people with mental health problems to recover” (Acosta et al., 2018, p. xvii). For military personnel, each step along the mental health journey involves not only considerable complexity but is influenced by implicit cultural perspectives (Westphal & Convoy, 2015). Even when deciding to seek support, treatment fearfulness can become stronger as one moves closer to engaging in care and as concerns such as career consequences become more salient (Paige & Mansell, 2013). The bind that military members face has been famously termed “Catch-22”, where knowing one needs help is acceptable, but actually seeking support renders one unfit for duty (Heller, 1961; Lefeber & Solorzano, 2019). The complexity of interacting issues sets up a “stigmatising predicament” for military personnel, where those who seek help also risk becoming stigmatised because of it (Britt, 2000, p. 1601). Being torn between competing attitudes and cultures is at the heart of many of the dilemmas that military personnel face (Atuel & Castro, 2018; Castro et al., 2015).

### **Military Culture**

Traditional military culture has variously been described as a hero culture (Frisk, 2018, 2019), warrior culture (Bryan & Morrow, 2011; Pressfield, 2011), and the combat masculine-warrior paradigm (Dunivin, 1994). As discussed in Chapter 1, the NZDF warfighting ethos establishes the need to be prepared to engage in violence and destruction in the national interest

(NZDF, 2017). Military culture is arguably highly adaptive under conditions of war and violence: “War requires [people] to willingly undergo an extremely painful, unpleasant experience, and to hang in there over time despite every instinct to flee” (Goldstein, 2001, p. 266). The qualities needed to survive battlefields—which are unmerciful towards weakness—are bravery, discipline, and the ability to overcome one’s own biological instincts of fear and grief. The human *will to fight* and to drive through adversity is acknowledged to be one of the most decisive factors in war and must be deliberately cultivated in military cultures in order to improve the chances of survival and winning (Lander et al., 2019).

Joining the military involves an intense socialisation process and indoctrination into a particular worldview that can have profound effects on recruit identity formation (Arkin & Dobrofsky, 1978; Peat & Perrmann-Graham, 2023). Culture and the transmission of cultural values includes “a pattern of shared basic assumptions learned by a group...which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel. (Schein & Schein, 2016, p. 6). Through communal living, marching, shared hardship, ritual and reward, becoming a member of the military is a transformational process that instils a new identity quite removed from civilian cultures (Arkin & Dobrofsky, 1978). Socialisation through initiation and onboarding processes teach the importance of cultural artifacts, espoused values, shared mental models and basic underlying assumptions (Schein & Schein, 2016). In this way the military identity has been described as a distinct form of ethnicity or quasi-ethnic identity with its own unique customs, language, and traditions (Daley, 2013; Lancaster & Hart, 2015). As previously noted, NZDF instils the recruit socialisation process with a particularly deep cultural significance by welcoming recruits onto service Mārae and into the tribes of the NZDF (Hohaia, 2016; NZDF, 2023a). In New Zealand veterans research, becoming a soldier is described as an irreversible and lifelong change, of becoming more than just an employee; “it is an identity, and a family” (Cardow et al., 2021, p. 14). The military socialisation process can be seen to work powerfully across even very different countries and contexts: U.S. service members have been found to share more traits in common with other nations’ military personnel than with their own U.S. civilians (Matthews et al., 2006). Similarly, ex-NZDF members have described themselves as veterans first and New Zealand citizens second (Cardow et al., 2021). These social forces of structure, rules and reinforcement—including shaming and punishment (Adler & Castro, 2013)—all powerfully contribute to the cultural mechanisms that define the military cultural experience (Mobbs & Bonanno, 2018).

### *Collectivism and Self-Sacrifice*

In military cultures, courage and sacrifice are espoused as ultimate goods that provide a meaning framework that can overcome even the fear of death (Frisk, 2019). Military cultures are well known to indoctrinate a service-before-self orientation in order to prioritise mission success and readiness for adversity (Coleman et al., 2017) and recruits are instructed early in their careers (on day one) to rely on their teammates and to sacrifice for them (Weiss & Coll, 2011). By instilling standards of discipline the military culture constrains behaviours and in so doing removes autonomy and individual choice from soldiers (Harvey et al., 2017). Among the worst offences in the team-centric military context is to be labelled “not a team player” and the mixed-messaging around seeking mental health support for oneself, while always putting others first, understandably creates internal conflict (Riggs & Mallonee, 2017, p. 35).

The worldview of te Ao Māori is also widely accepted as collectivistically orientated, where health comes from relationships rather than within the individual (Durie, 1994). Within this perspective, it is the collective orientation that is of primary importance: “The individual whose first thoughts are for himself, his personal ambitions or his own body, is considered unhealthy” (Durie, 1985, p. 484). NZDF values also include strong collectivistically orientated themes, for example under *Comradeship* (Tū Tira); “working together as a team, being inclusive, recognising we are stronger together” (NZDF, 2023c). Even more explicitly, guidance for New Zealand Army leaders makes it clear that in order to “live up to the Army’s expectations” one must display a “willingness to sacrifice oneself for the mission, unit, or comrade” (New Zealand Army, 2020, p. 50). The primacy of mission-first culture was noted starkly by one participant in a U.S. qualitative study on soldier recommendations for improving military mental health systems:

The mission has to come first, no matter what. No matter what it is, no matter how simple or how complex it is, you know, it’s got to be first and, you know, kind of go, go, go, and take up the slack for other people whether I have to or not and just kind of put my issues on the back burner. (Cheung et al., 2016, p. 106)

Relegating one’s issues to the backburner clearly aligns with prioritising collective over individual interests, including help seeking. Indeed, it has been suggested that the evolution of the warrior ethos was intended to serve the collective interest and to override the self-preservation instinct (Pressfield, 2011). The war journalist and author Sebastian Junger who was embedded in a Marine combat unit in Afghanistan for a year has called his experience of the bond that forms between members of the military under life-threatening circumstances as “extremely intoxicating” (Attia,

2022, 01:02:15). This primal group bonding is clearly at odds and in conflict with help seeking as an individualistic self-preservation behaviour.

### ***The Dark Side of Resilience Training***

The military as an institution has been described as promoting a resilience affirming culture throughout the layers of its organisation (Bryan & Morrow, 2011). Militaries place a lot of importance on individuals taking responsibility for their own coping by emphasising resilience values via language and slogans (e.g., embrace the suck), and by providing recognition and reward for displays of overcoming adversity (Adler, 2013). This strongly socialises for an emotional self-reliance tendency to endure hardship without complaint (Weiss & Coll, 2011). Additionally, military training is recognised to instil in members an idealised view of their abilities and the meaning of injury (Feczer & Bjorklund, 2009), which can convey the cultural narrative that if an individual struggles to overcome (even quite profound) stressors, then they must have a character defect or something wrong with them and their own personal abilities (Adler, 2013). NZDF values also signal strong resilience expectations, for instance the value of *Courage* (Tū Kaha) is described as “having the strength—moral and physical—to do what is right, even in the face of adversity. It is stepping up when things get hard”; and *Commitment* (Tū Tika) is described as “persevering even when the going gets tough” (NZDF, 2023d). While aspirational and positive in many ways, this overt focus on resilience—without nuance—can produce a “dark side” of military culture with significant negative impact on the inclination to seek help for experiences of distress (Britt et al., 2013, p. 15). In New Zealand, the military community including the wider veteran population is recognised as having a maladaptively stoic disposition, which is associated with a reluctance to seek support when needed (Austin et al., 2020; Veterans' Affairs New Zealand, 2022). In NZDF research, soldiers have described their understanding of the dichotomy of resilience or failure as “you're either ‘on’ or you're a sack [of shit]” (Kohere, 2022, p. 93). In this way military cultures can fail to acknowledge the reality of an individual’s limits to resilience, can fail to acknowledge the darker sides of trauma, and can fail to acknowledge that military service can often involve profound personal sacrifice (Adler, 2013).

The fear of being seen as weak and of being ostracised by peers has been found to be a significant barrier to accessing care in military cultures (Weiss & Coll, 2011). Seeking help can even lead to bullying or worse—one qualitative study identified veiled threats directed at team members who were seeking help for mental distress, such as comments from teammates indicating that those soldiers would suffer a “training accident” (Waitzkin et al., 2018, p. 237). Similarly, Lefeber and Solorzano (2019) point to the performance pressures of having to live up to

cultures that insist on relentless achievement, for example the New Zealand Army's vision to be world class and "the best of the best" (New Zealand Army, 2020, p. 11). The values around teamwork, excellence, and service before self are deeply entrenched in military cultures, and the fear of "letting the team down" is a very common barrier to seeking support (Pury et al., 2013, p. 35).

### *Issues of Masculinity*

Joining the military involves socialisation into a hyper-masculine culture (Ashley & Brown, 2015; Veterans' Affairs New Zealand, 2022). While the military has been described as an institution comprised mainly of men and with a culture shaped by men (Dunivin, 1994), it is embedded within a western paradigm which has also emphasised masculine gender role scripts around achievement, independent problem-solving, providing and protecting, maintaining mastery and self-control (Neilson et al., 2020; Seager, 2019). The military bootcamp is argued to be one of the last remnants of the traditional masculine rite of passage and aspects of masculinised gender identity is how societies have historically prepared men to fight to defend the tribe during times of war (Goldstein, 2001, p. 265). In the recent *Tāne Toa* project on masculinity attitudes within NZDF, qualitative focus group participants noted many societal expectations of stereotypical male behaviours, such as expectations on men of being "breadwinners", strong, independent, assertive, to not cry, and to not express strong emotions (Poulter, 2021, p. 15). Participants reported perceived expectations from both within and external to NZDF that men in the military needed to exhibit traditional masculine qualities—to "be prepared to defend Aotearoa's interests...at a moment's notice" (Poulter, 2021, p. 16). In a qualitative U.S. Air Force study participants also noted the pervasive culture of masculinity in their day-to-day work: "The squadron is full of type-A personalities, a bunch of pilots... You're surrounded by warriors, and at a minimum, you're going to maintain that outward appearance and that dominant, Alpha male presence, period" (Lefebber & Solorzano, 2019, p. 6).

Masculinised cultures constrain behaviour and truncate what is an acceptable emotional range, which eventually leads many military personnel to become disconnected from their biological emotions (Goldstein, 2001). Conformity to traditional masculine norms has been shown to be associated with poorer mental health outcomes and is inversely associated with mental health help seeking across populations (Wong et al., 2017). In New Zealand for example, the male suicide rate is close to three times that of females (14.9 per 100,000 for males, 5.5 per 100,000 for females in 2020/21; Health New Zealand, 2023). In their review of traditional masculine values and PTSD outcomes, Neilson et al. (2020) found the endorsement of emotional inexpression (e.g.,

stoicism, toughness) was consistently associated across the literature with worse PTSD symptoms. Members of masculinised cultures often cite feeling a deep lack of permission to be authentic and to reveal the complexity of their inner conflicting emotions which can lead to a shutting down of emotional expression and the avoidance of emotional expression from others (Norman, 2023). Indeed, in order to conform to stereotypes military personnel can often hide their emotions behind a façade, or “put up a wall” to project toughness and control while avoiding revealing their true inner experience (Prochaska & Norcross, 2018, p. 335). In hypermasculine cultures, expressing emotional distress or help seeking can result in a loss of social capital—social standing amongst peers or the community—which is itself a profound disincentive to access care (Abraham et al., 2017).

### ***A Good Death***

Nowhere are espoused military values more clearly on display than in the commemoration and obituaries of fallen soldiers (Coker, 2007; Monnet, 2016). The way military casualties are framed as “a good death” epitomises the highest forms of military culture and serves to strengthen the social coherence of military values (Frisk, 2018). Modernist values have shed the belief in a “for King and country” national heroism of earlier historical conflicts (Frisk, 2019; Frisk, 2018, p. 900) and scepticism since the Vietnam War has ushered-in an era of post-heroism in military culture, partly due to the public sentiment of casualty aversion (Frisk, 2018). The “old lie” that dying for one's country is *dulce et decorum* (sweet and just) (Monnet, 2016, p. 405) has been replaced, and military death justification (legitimisation) in recent conflicts has been found to invoke sentiments of individual professionalism, contributions towards humanitarian efforts, and an altruistic orientation towards helping the world's needy (Frisk, 2019). Kaspersen (2021) argued the modern role of soldier has also shifted substantially due to a mix of historical, societal, and institutional expectations. Where once the role expectations of service members fitted with the classic warrior archetype (disciplined, patriotic, violent, masculine), this has now differentiated into several sub-categories to include: the nation defender, the law-enforcer, the state-builder, the humanitarian, and the ideological soldier (Kaspersen, 2021). Western societal values have increasingly placed importance on military members adopting more cosmopolitan values and humanitarian orientations—the ideals of “doing good beyond borders” (Kaspersen, 2021, p. 15). For instance, military obituaries of Danish soldiers in Afghanistan were found to call on modern civic ideals by constructing the fallen as “responsible risk assessors” who were prepared to “knowingly risk their life in the service of a job they loved” (Frisk, 2018, p. 908). Fatalities were framed via an achievement-orientated ethic that emphasised individual agency, choice, and

striving for personal meaning in a professional military career. Death in service was an indicator of a fully lived life in alignment with contemporary societal values. Similar language portraying an honourable death is used in current NZDF training material to describe various accounts of posthumous awards for bravery, “paying the ultimate price”, being “remembered with honour and respect”, including a stirring example of one soldier in a contemporary war who “could have easily saved just himself, but instead chose to risk his life and then drive himself virtually to collapse” (New Zealand Army, 2020, pp. 28-30). The way military communities remember the fallen as exemplars and role-models leaves little doubt as to what is valued in military culture, even today (Monnet, 2016). While the specific language may have changed, the tradition of military self-sacrifice as the highest ideal of warriorship endures (Coker, 2007; Frisk, 2018).

### **Stigma**

Stigma in the military is very closely associated with the social penalty of seeking help (Pury et al., 2013). As the review of military culture makes clear, the worldview that values strength and group cohesion for survival is fundamentally opposed to anything dysfunctional or self-serving (Lefebber & Solorzano, 2019; Riggs & Mallonee, 2017). A commonly used definition of stigma is “an attribute that is deeply discrediting” that acts to reduce an individual “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 12). A comprehensive review of stigma definitions in military contexts identified concepts such as “loss of status”, “being disgraced”, “otherness” and “separation” (Acosta et al., 2014, p. 115). Stigmatised individuals are often perceived to have a character flaw that evoke judgements in themselves and others that they have brought their current distress and problems on themselves (Britt et al., 2020). While stigma around treatment seeking in military contexts is considered to have improved in recent years (Britt et al., 2020) it is still one of the most commonly cited barriers to care (Riggs & Mallonee, 2017) and is a durable and notoriously difficult social phenomenon to change (Schnittker, 2022).

Stigma acts as a constant “threat in the air” that one could risk becoming devalued, marginalised, or discriminated against (Steele et al., 2002, p. 417). Whereas internalised stigma is holding prejudiced attitudes towards oneself (e.g., I am weak), individuals do not need to hold stigmatising attitudes themselves to experience a sense of threat to their group belongingness or social identity (Major & O’Brien, 2005). Merely knowing that stigmatising attitudes exist is enough to activate the stress and anxiety associated with social identity threat (Major & Schmader, 2017). Any situational cues that make a sense of identity threat salient can lead to nonvolitional responses such as anxiety and avoidance (Major & O’Brien, 2005) and can lead to

counter-stereotypical behaviours as a defence (Steele et al., 2002). In their review of PTSD outcomes in military personnel, Neilson et al. (2020) identified that after a perceived loss of control following trauma exposure, veterans felt compelled to act in compensatory hypermasculine ways, such as engaging in risky sexual behaviour and aggressive activities, also endorsing sentiments such as “man up” (p. 588). In an experience sampling study of female officer cadets, on days where cadets reported more feelings of identity threat they also had more concerns about their belonging in the military and distanced themselves from other females (Veldman et al., 2021). Social environments where threat and consequences are high, such as in the military, often lead to impression management, social avoidance and isolation, impairments in relationships, and negative impacts on self-identity. The vigilance and effort required to navigate threats to one’s identity can therefore be stressful and exhausting (Major & Schmader, 2017).

Differences in subcultures and subpopulations within the military may also influence an individual’s willingness to overcome stigma barriers to seek support. Stronger identification with aspects of military identity was found to impact on internalised self-stigma which mediated the relationship to suicide risk in a sample of U.S. veterans ( $N = 1495$ ; Cacace et al., 2022). Status hierarchies between combat and noncombat trades can also contribute to increased social pressure to conform to the masculine and warrior cultural expectations in combat-focused roles (Ashley and Brown, 2015). NZDF junior enlisted ranks have been found to endorse more stigma survey items that indicated lower intentions to seek help compared to senior enlisted and officers, and female personnel have been found to have higher intentions to seek help compared to males (Boyd, 2017), consistent with the help seeking literature around masculinised attitudes (e.g., Addis & Mahalik, 2003). In the more recent NZDF Tāne Toa masculinity research, senior enlisted personnel were noted to be particularly supportive of mental health help seeking, and junior ranks in this study expressed more progressive attitudes around “talking about your emotions” (Poulter, 2021, p. 16). Higher scores on measures of stigma have been found to be associated with higher psychological distress in NZDF personnel (Hom et al., 2020) and negative attitudes towards help seeking has also been found to increase the odds-ratio of reported suicide risk (Bennett, 2017).

### ***Stigmatising Attitudes Increase During Mental Distress***

A common finding across military mental health studies points to the increase in concern around stigmatising attitudes with increasing mental distress (Fikretoglu et al., 2022). For example, active-duty and veteran service members in the U.K. who met criteria for probable mental health conditions (anxiety, depression, alcohol misuse) and/or PTSD were also more likely to agree with items relating to superiors blaming them for their problems, to being seen as weak

by those who were important to them, and to being concerned about what friends and family might think (Williamson et al., 2019). Those meeting criteria for probable PTSD were also significantly more likely to endorse items such as “mental health care doesn’t work” and “my bosses discourage the use of mental health services” (p. 4). One study also found a similar pattern across all the Five Eyes militaries, where service members who met cut-off thresholds on mental health screens were also more likely to endorse items relating to stigma (“my unit leadership might treat me differently”; “I would be perceived as weak”) (Gould et al., 2010, p. 153)<sup>3</sup>. The ADF *Pathways to Care* research also found higher endorsement of stigma items in both veterans and current RF who met criteria for probable 30-day disorder with the most endorsed stigma related item being “people would have less confidence in me” followed by “people would treat me differently” (Forbes et al., 2018, p. 246). In a U.K. military sample self-stigma and label avoidance were both associated with denial of symptoms and the avoidance of mental health support services (Ben-Zeev et al., 2012). The overall pattern is that service members who are struggling with their mental health are also likely to be wrestling with the consequences of getting help (Hom et al., 2020). This presents a terrible paradox for military personnel, because as mental distress increases, so too does concern about being judged, internalised self-stigma, and the inclination to avoid help seeking. Mental health stigma is a vicious cycle that compounds mental health problems for military personnel.

### ***Making Stigma Worse***

Despite best intentions, attempts to increase help seeking behaviour by reducing stigma have proven challenging and may potentially create backfire effects (Schnittker, 2022). Most military mental health campaign strategies aim to convince personnel to adopt new beliefs (e.g., it's not weak to seek help; Bryan & Morrow, 2011, p.17) and employ education efforts to challenge stereotypes about mental illness and offer facts in the hope of changing people’s minds (Ben-Zeev et al., 2012). However, unless very carefully implemented, antistigma campaigns can make stigma worse. For example, by making stigmatising attitudes more salient and memorable, campaigns can inadvertently prime and reinforce those very same ideas—known as the familiarity backfire effect (Dobson & Rose, 2022). Studies on retrieval fluency highlight how making stereotypes more easily remembered can increase the sense of trust in those attitudes (Häfner &

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<sup>3</sup> In this study New Zealand was the only nation not to follow the trend, where those who did not meet mental health cut-offs endorsed more stigmatising attitudes, possibly due to low sample size or difference in mission type (i.e., peacekeeping, versus combat for the other nations).

Stapel, 2009). The salience of stigma can be maintained by even very subtle environmental and situational cues, which prime, reinforce, and make “magnetic” the remembering of stigmatising attitudes (Schnittker, 2022, p. 368). In addition, preexisting beliefs can be shown to continue (and become strengthened) even after people are presented with contradictory information, known as belief perseverance (More, 2020). Ironically and problematically for the military, backfire effects are more likely to occur when individuals are motivated to defend their belief system and are strongly associated with their identity (Nyhan & Reifler, 2010; Swire-Thompson et al., 2020), and as the review of military culture attests to, attitudes and identities acquired when in the military can last a lifetime.

### **Military Culture Discussion**

Many aspects of military culture are necessary and adaptive under the extreme circumstances of war. A culture dominated by an orientation towards preparing soldiers for conflict will prioritise masculinised qualities such as autonomy and control, as well as valuing group loyalty over sensitivity to what’s best for the individual (Weiss & Coll, 2011). However, these strengths on the battlefield when adopted uncritically and overplayed can flip and become vulnerabilities to service members when they require mental health support (Veterans’ Affairs New Zealand, 2022; Westphal & Convoy, 2015) as examples in Table 1 illustrate.

**Table 1**

*Military Culture Strengths and Vulnerabilities*

<b>Strength</b>	<b>Trait</b>	<b>Vulnerability</b>
Placing the welfare of others above one’s own	Selflessness	Not seeking help because personal well-being is not a priority
Commitment to the team	Loyalty	Unwillingness to seek support for individual needs
Toughness and the ability to endure hardships	Stoicism	Not acknowledging significant distress and suffering
Becoming the most effective professional possible	Excellence	Feeling ashamed of perceived imperfections and hiding any sign of perceived weakness
Determination to problem-solve and find solutions	Resourcefulness	Unwillingness to concede limits of personal abilities and to ask for help
Commitment to operational service	Operational focus	Reluctance to risk deployability
Identity, brotherhood, tribe membership as highest ideals	Belonging	Avoidance of any risk to tribe membership

*Note.* Table adapted from “Military Culture Implications for Mental Health and Nursing Care” by R. Westphal and S. Convoy, 2015, *Online Journal of Issues in Nursing*, 20(1), p. 4. (<https://doi.org/10.3912/ojin.vol20no01man04>). Copyright 2015 by American Nurses Association. Adapted with permission.

While the highest of military ideals may have moved on from a nationalistic sense of duty, the service-before-self imperative lives on in the modern military ethos and casts considerable influence over what is culturally valued and disparaged. The threat of losing social belonging is a powerful deterrent to help seeking, and as personnel become more distressed they also become more concerned about becoming stigmatised. The next section turns to examine the healthcare worldview that may contribute towards treatment aversion when contrasted against military culture.

### ***Clash of Cultures***

A clash of cultures exists between the military and mental health orientations (Bryan & Morrow, 2011). As the review of military culture makes clear, seeking help is fundamentally opposed to the warrior ethos that emphasises self-sacrifice and the ability to endure hardship and adversity (Forbes et al., 2019). In stark contrast, clinical orientations value talking about emotions and vulnerabilities in individualised treatment, and implied by traditional mental health messaging is the idea that service members should seek help for themselves and thereby reject their social group, culture, and their identity of self-reliance (Bryan & Morrow, 2011). Shields (2016) highlights how the very nature of many of the diagnostic criteria used (e.g., in PTSD) are directly counter to military masculinised norms, as shown in Table 2.

**Table 2**

#### *Military Norms and PTSD Symptomology*

<b>Military norms</b>	<b>PTSD symptomology</b>
Mastery over environment	Victim of witnessed or experienced trauma
Mastery over thoughts	Re-experiencing of trauma and intrusive thoughts
Mastery over emotions	Numbness, emotional hijacking or negative mood
Mastery over body	Physiological hyper or hypo arousal
Powerful and agentic	Distressed, impaired, and reliant on treatment

*Note.* Table adapted from “Military Masculinity, Movies, and the DSM: Narratives of Institutionally (En)Gendered trauma” by D. Shields, 2016, *Psychology of Men and Masculinity*, 17(1), p. 69. (<https://doi.org/10.1037/a0039218>). Copyright 2015 by American Psychological Association. Adapted with permission.

The way trauma symptomology is described from the clinical worldview sounds like failure and weakness to the military mindset (Shields, 2016). Military personnel train for and often seek-out opportunities to deploy and test their skills, even in combat where the challenges are anticipated; however, clinical language uses terms like “trauma exposure” that suggests unwanted or unexpected “risk factors” that should be avoided to stay safe (Adler & Castro, 2013; Bryan & Morrow, 2011). Even once the hurdles to enrolling in treatment are overcome, common therapy language (e.g., how does that make you feel?) and therapeutic attempts at empathy can be interpreted as emasculating, “coddling”, and signals that imply weakness (Shields et al., 2017, p. 221). Skills valuable for therapeutic progress such as emotional disclosure are opposed to the traditional military culture of emotional stoicism, and not automatically verbally sharing emotions can be subtly conveyed to military personnel as inherently problematic and “a wilful and unnecessary barrier to help seeking” (Seager, 2019, p. 240). The culturally derived quality of emotional suppression and compartmentalisation proves dysfunctional outside of the warfighting context (Weiss & Coll, 2011)—the conundrum that “good soldiers do not necessarily make good patients” (Forbes et al., 2019, p. 100). Understandably, many personnel reject mental healthcare that is perceived to be directly at odds with how they have been socialised since the moment they joined the military (Bryan & Morrow, 2011) and this clash of cultures contributes to drop out and many of the poor outcomes seen in the military treatment studies that were reviewed earlier in this thesis (Straud et al., 2019; Neilson et al., 2020).

### ***Disincentives to Access Military Healthcare***

Cultural misalignment is not the only impediment to help seeking within military healthcare—there are significant occupational incentives to not disclose mental health issues in the military context (Castro & Kintzle, 2014). The unfortunate irony is that the structure and rules of the military healthcare model can themselves be significant barriers to utilising the help on offer (Bryan & Morrow, 2011). Specifically, the dual agency model of military healthcare that seeks to balance responsibilities to both the service member and to the organisation can create problems of trust around confidentiality and the career impact of accessing help (Johnson et al., 2010; Waitzkin et al., 2018). The military requires a high level of physical and mental health in order for members to carry out aspects of their roles, for example safe access to weapons or to be in command of hazardous equipment (e.g., vehicles, aircraft) (Iremonger et al., 2015). Consequently, having a diagnosed mental health condition can be a direct threat to remaining operational and in uniform. As has been found in both NZDF and ADF research, the most endorsed reason for not accessing care is “it would stop me deploying” followed closely by “it

would harm my career” (Boyd, 2017; Forbes et al., 2018). Other research points to the complexity of pressures to remain employed by the military, for instance one U.S. Air Force qualitative research participant noted the perceived career ending impacts of help seeking:

“It’s not weakness, it’s just really just basics of, ‘Well, I’m ending my career if I do this.’ It’s not who gives a shit if someone thinks I’m weak or not, that’s irrelative, it’s career ending... When they’ve got a wife and kid that’s hard to swallow” (Lefebber & Solorzano, 2019, p. 6)

The fear many military personnel have that they would lose their job if they came forward with a condition that would impair their ability to deploy or perform operational duties is not unfounded (Castro & Kintzle, 2014; Forbes et al., 2019). Many service members are familiar with cases where colleagues have had their careers affected or disrupted due to mental health medical grading changes (Riggs & Mallonee, 2017). No organisation, it has been argued, can offer complete reassurance of continued employment in every possible mental health circumstance (Gould et al., 2010). For instance, NZDF exists to provide military options to the New Zealand Government and its organisational primacy is to deliver military effects under likely difficult circumstances (New Zealand Ministry of Defence, 2021). Indeed, “combat readiness is at the heart of what the NZDF does as an organisation” (NZDF, 2023c, p. 10). Despite a duty of care in recognition of the risks of military service, the NZDF is not obligated to provide employment opportunities in the event of mental illness—“discharge and release from service is an inevitable and necessary part of business” (Iremonger et al., 2015, p. 82).

The mixed-messaging of military mental health slogans with the actual experiences of some personnel can lead to widespread cynicism and a lack of trust in healthcare systems (Cheung et al., 2016). Experiencing contradictions between messaging and actual policy is described by some military qualitative research participants as making mental health stigma worse:

When good people are put through the wringer for seeking the treatment that just increases the stigma and it makes people want to not recommend it and not do it themselves...you can’t persist and say, ‘Hey we’re here to help you, we care about you, you’re a member of our family’ if you will but then turn around and completely disregard everything you just said. (Lefebber & Solorzano, 2019, p. 6)

When service members believe that healthcare comes with “no strings attached” they can often be left feeling betrayed by the organisation when there are nevertheless significant costs to receiving that care (Lefebber & Solorzano, 2019, p. 18).

The reality is there may very well be consequences for personnel that come forward to get help and despite medical release being rare, the impact of medical discharge can be high. One systematic review of 61 studies in the U.S. military found that help seeking was indeed associated with the higher likelihood of medical discharge, and that 20% of personnel who had sought help felt that their careers had been harmed as a result (Heyman et al., 2022). As discussed earlier in the thesis, medical release in NZDF due to a mental health issue occurs in only 0.1% of personnel who leave active duty service—just 80 personnel over 7 years (2006–2013, 19.9% of all medical releases; Iremonger et al., 2015, p. 86). However, the psychosocial consequences for those involuntarily discharged can be especially harmful (Pedlar et al., 2019), as the review of risk factors in Chapter 2 identified. ADF research has found higher suicide rates amongst those discharged for mental health reasons (Australian Institute of Health and Welfare, 2022) and U.K. research has found poorer psychosocial outcomes among U.K. veterans medically discharged (Burdett et al., 2021). In addition, the loss of identity and belonging that arises from post-service transition can be made worse by involuntary separation (Weiss & Coll, 2011; Castro & Kintzle, 2014). Help seeking promotion efforts that encourage members to “raise your hand” or “just reach out” are therefore asking a great deal of military personnel who are mentally distressed. The threat of medical discharge presents personnel with another paradox, as the most needed time for accessing care also coincides with the risk of job loss, fear of identity loss, and threat to social belonging (Forbes et al., 2019). While the rates of medical release might be low, the potential consequences can be intolerably high, leading many personnel to not want to take that risk.

## **Conclusion**

This chapter review points to many of the dilemmas at the centre of military mental health help seeking. At its essence, the military needs to have personnel capable of warfare and therefore has a socialisation process that seeks to instil an identity and culture of self-sacrifice. Weakness and abandoning the collective are risks to the military mission and are stigmatised, resulting in numerous psychological barriers to seeking help for mental health distress. Social norms are inherently challenging to go against, and militaries display and reward their cultural values of toughness and self-sacrifice in prominent ways throughout the organisation. As mental health worsens, the potential threats and costs of help seeking become even more salient—there are real, life-altering, career risks from receiving a mental illness diagnosis within the military.

The review of military mental health literature in Chapter 2 and help seeking complexity in this chapter both serve to highlight particular gaps in understanding around how NZDF service members navigate the many barriers to help seeking when deciding to access support. The review

also highlights how little is known about the actual user experience of the NZDF mental health system, from seeking help to treatment completion, and these gaps are the subject of the current thesis. The next chapter brings these areas together and describes the methodological considerations of the current research including the research aim and key questions.

## Chapter 4: Methodology

The primary research question in this thesis was; how do NZDF service members describe their experience of utilising the military mental health system? The review of military mental health and help seeking complexity in Chapters 2 and 3 identified the importance of understanding how service members come to access care and what factors contribute to positive treatment outcomes. The availability of support systems does not guarantee that those most in need will engage with support, similarly the use of support services does not automatically confer positive outcomes. Investigating the user experience of engaging with current systems is essential to understand if effective care is being provided for NZDF personnel experiencing mental health distress during the course of their service.

Several areas were of particular interest in this study. The first was the overall trajectory and story-arc of how participants described their mental health experience. While there is research exploring the onset of distress and treatment outcomes, there is a dearth of literature that connects these start and end points, that is—the experience of military personnel as they traverse the various complexities of engaging with and being supported by military healthcare. Results from this area are the focus of journal article one, which is Chapter 6. The second area of interest involved how paradoxical approach factors (e.g., the desire to relieve distress) and avoidance factors (e.g., the fear of career implications) resolved into help seeking behaviour for NZDF personnel, which is the focus in Chapter 7. Finally, all of the influences that supported mental health recovery were of interest in this research, as the literature on treatment outcomes in military populations has tended to place primacy on therapy as the active ingredient while backgrounding the potential importance of other factors. The results describing this area of focus are presented in journal article two in Chapter 8.

### **Ethical Considerations**

#### ***Relational Ethics in Military Mental Health Research***

This research foregrounds the importance of relational ethics as a guiding principle, which seeks to “strive to leave communities, participants, and [our]selves better off at the end of the research” (Ellis, 2007, p. 25). Relational ethics asks how and why knowledge is being produced in the first place, and who stands to benefit from this knowledge (Ellis, 2007; Hodgetts et al., 2021). This research set out to serve multiple stakeholders; military personnel who are also mental health care users within NZDF, the NZDF as an organisation and employer, and the author who occupies multiple positions as a psychologist, service member, clinical doctoral student and researcher.

Relational ethics is closely aligned with the te Ao Māori principle of manaakitanga that recognises duty of care and respect for those with whom one is in relationship with, in this case research participants and the wider NZDF community. Relational ethics and manaakitanga extend to working towards deficits in social systems that may be underserving vulnerable groups (Hodgetts et al., 2021). A hierarchical organisation such as NZDF has clear power structures, rules, and explicit and implicit cultural norms that limit individual agency, whereas in mental health consumer and recovery movements a core principle is that *tangata whaiora* (consumers of mental health services) should be the ones who define what living well with mental distress means for them (Moeke-Maxwell et al., 2008; O’Hagan, 2001). This research therefore sought to amplify the impact of participant narratives around what mental health recovery in NZDF looks like. In addition, bringing in “insiders” local knowledge and perspectives to inform future policy recommendations is a way of legitimising lived experience and honouring user stories (Lefebvre & Solorzano, 2019, p. 18). Importantly for this study, *He Ara Oranga*—the report published by the Government Inquiry into Mental Health and Addiction (2018)—identified the need for a greater range of choice of mental health treatments and identified New Zealand veterans as an important subpopulation with specific needs that are frequently underserved by existing healthcare and systems. This research therefore sought to leverage existing power structures available to the researcher, such as official reporting channels and academic publishing, in addition to utilising social capital such as reputational influence within the NZDF healthcare system (Hopner & Liu, 2021).

### *Dual Agency Ethics*

In the current project it was important to carefully manage the ethical tension of the dual agency nature of uniformed psychologists being members of two professional groups—the profession of psychology and the profession of arms (Johnson, 2008; Kennedy & Johnson, 2009; Rockwood, 2012). NZDF personnel, including psychologists, come under the Armed Forces Discipline Act 1971 which establishes the Manual of Armed Forces Law as the legal authority for the maintenance of military rules and discipline. If during the interviews an active-duty service member were to disclose a degraded ability to carry out their job safely, or a violation of an established law (e.g., illegal substance use) the interests of the individual, the organisation, and the research would all collide (Nicholson et al., 2023) with the possibility that those breaches would need to be formally referred for investigation. To resolve this ethical dilemma, and as an additional organisational level of manaakitanga, an NZDF order was put in place specifically for this research to protect participants from being subject to disciplinary action should any historic

duty-breaches be divulged. A temporary Defence Force Order (DFO[T] 04/2022, dated 16 May 2022) was approved by the NZDF Chief of Defence Force (CDF) to exempt the need for the researcher (and military supervisor) to report any historic offending, and to place primacy on the confidentiality of the interviews to help participants feel safe to speak freely about their experiences (see Appendix A for a copy of the order).

### ***Confidentiality***

Participants had the voluntary nature of the research explained in the information sheet and underscored at every stage of the research, especially at the start of interview. Service members who the researcher had previously seen as clients were ineligible for this study to mitigate any conflict of interest. In addition, it was explained to participants that the interview constituted research and was not intended as therapy. Participants did not receive compensation for participating. The DFO(T) was explained in detail at the start of the interview and it was made clear that CDF had absolved the researcher from the obligation to report any historic offending that may have been declared during the interviews that would come under the Manual of Armed Forces Law. The need to report any current risk of harm to participants or others, or any current threats to the NZDF's ability to operate, remained in place and was clearly communicated to the participants. Given the small community nature of NZDF, it was emphasised to participants that confidentiality would be preserved in all written outputs by not providing information in a format that could lead to identities being deduced (e.g., the participant was a 25 year old, female, Māori, Navy, Lieutenant). This research was approved by Massey University Human Ethics Board (NOR 22/28 dated 15 June 2022) and the NZDF Organisational Research Ethics Board (5000 PB/5/3 dated 27 June 2022) (for a copy of the participant information sheet and consent form see Appendix B).

### **Critical Realism**

#### ***Mental Health Research and Narratives***

This research adopted a critical realist philosophy (Bhaskar, 1975/ 2008) which supported the narrative psychology analytical approach. Critical realism has been argued to offer the best philosophy of science for mental health research (Pilgrim, 2015, 2018). Critical realism encourages the exploration of illness and impairment as emerging from causal factors in open and complex systems (Bhaskar & Danermark, 2006; Haigh et al., 2019). In social science and health research, critical realism adopts the position of enquiring how nonphysical entities, such as ideas or institutions, come to affect outcomes such as accessing care (Haigh et al., 2019). As a

philosophy of science, critical realism includes a double inclusiveness of ontological realist and epistemological constructionist positions (Bergin et al., 2008; Pilgrim, 2018) which allows for realist explanations of biological causes of mental illness, as well as social constructionist interpretations of experiences such as through narratives (Bhaskar & Danermark, 2006).

Viewed through the critical realist lens, narratives emerge as social artefacts from particular historical contexts and institutional influences, and examining narratives can increase our understanding about how these systems and structures come to influence individuals (Riessman, 2008). A useful way to think about narratives is as the intermediary between ontological reality and the individual's constructed experience. Narratives are subjective constructions that have objective implications (Adler et al., 2017), and variations in the way people story their experiences have been linked to better mental health and overall quality of life (Adler et al., 2015). Narratives can contain both realist factual content, akin to a historical biography, in addition to interpretative stories with more of a constructionist epistemology that is inherently socially influenced (Alleyne, 2015; Stalker, 2009). Narratives also inform how the storytellers themselves assign causality—for example, how do military personnel described why they became unwell, and what contributed toward their recovery? In this way narratives can be a “portal” into how people understand their experiences (Hiles et al., 2017, p. 157).

### **Narrative Analysis**

Constructing narratives is one of the primary ways in which humans make sense of the world and assign meaning to events (Alleyne, 2015; Murray, 2000)—“humans are natural storytellers” (Rogers et al., 2023, p. 770). Narratives can be found in myths, fables, and legends since the dawn of humankind, and narrative analysis has its roots in the Aristotelean writings on Greek tragedies which examined drama via plot devices (i.e., beginning, middle, end) and events that were meant to stir an audience response (e.g., something going wrong; Riessman, 2008). Stories come naturally to most people through the social mechanism of relating to one another via storytelling, through hearing stories in the available culture (e.g., books, plays, movies) and in day-to-day interactions where narrative structures are conveyed (e.g., when describing one's day; Wong & Breheny, 2018). In mental health research narrative analysis is well suited to the exploration of how people make sense of and bring order to the disruption that illness produces in their lives (Murray, 2000). Narratives often tell us something about the taken-for-granted assumptions people have about how they understand the social world to work—they tell us about the rules of social life (Murray, 2018; Wong & Breheny, 2018). A story can function across several levels at the same time (Wong & Breheny, 2018) such as the personal level of identity and

history (Kirkpatrick, 2008; Murray, 2000) and the social level of culturally dominant stories (Frank, 2004; Murray, 2000). The power of culturally dominant narratives around “how things should be” and “what characters are allowed to do” is the invisible water we are swimming in (Wong & Breheny, 2018, p. 252), which can exert considerable influence on how stigma and discrimination are experienced by those with mental illness and distress (Kirkpatrick, 2008).

Becoming unwell initiates a process of cognitively reorganising and restorying the self (Radley, 1994) and core narratives are often sourced from within the culture and dominant discourses that we are exposed to (Wilson, 2011). Experiencing illness can be very disruptive to the day-to-day lived experience of the sick person (Bury, 1982) and humans have been argued to need to tell stories about their illness experiences (Frank, 2004)—“story telling seems to be a natural reaction to illness. People bleed stories” (Broyard, 1992, p. 20). In *The Wounded Storyteller*, Frank (1995) described the three types of narrative templates that society makes available to those with illness; the restitution, chaos, and quest narratives (Frank, 1995, 2004). The restitution narrative has as its plot the expectation of a transitory illness and a return to health (Wiillig, 2013)—a restoration to the life people had before the illness; “yesterday I was healthy, today I am sick, but tomorrow I will be healthy again” (Frank, 1995, p. 77). The chaos narrative in contrast is an antinarrative that does not have a clear resolution or sense of hope for healing. It is the “pit of narrative wreckage” where it is essential that a caring witness be able to tolerate the chaos without prematurely urging the patient to adopt a restitution narrative (Frank, 1995, p. 110). The final narrative is the quest, which follows “humanity’s oldest structure” of the call, descent, suffering, and return with a reward (Frank, 2004, p.86). This narrative is based on Joseph Campbell's (1949/2004) book *The Hero's Journey* and focuses on the positives that the illness has brought, such as wisdom or a positive transformation (Wiillig, 2013).

Narrative analysis can involve focusing on different elements of the participant story, the overall structure, looking at different levels, or a combination (Riessman, 2008). The current research focused on understanding the coherence of the overall arc of participant stories (Mishler, 1995) as well as the sense of meaning and agency embedded in how participants described their experiences. Transformational narrative arcs are an important aspect of posttraumatic growth (Tedeschi & McNally, 2011) and have been associated with mental health improvements during therapy (Adler et al., 2013, 2015). Importantly, the quest narrative structure affords most agency to the recovered story-teller; in chaos stories the self is consumed by suffering and restitution narratives are often about a triumph of intervention (i.e., it was the drugs that fixed me) (Frank, 1995). Veterans who wrote about their experiences using themes of growth and agency have been

found to have lower scores of posttraumatic stress, depression, and anxiety symptoms (Tappenden et al., 2022). Following injury veterans have been found to initially story themselves via a chaos narrative of being lost, of derailment, and of identity wreckage, and then during their recovery used a quest narrative of hope, of new identity exploration, healing, and connecting to new relationships (Carless, 2014). Narratives of moral injury experiences in U.S. Afghanistan veterans identified not only the impact and context of the morally injurious events, but also the process of personal transformation in the subsequent search for meaning and purpose, and the importance of connecting with others during their healing journey (Held et al., 2019). Similarly, taking control of the recovery process has been described as a critical change that facilitated healing in veterans that involved moving from a passive recipient of care, to an agent engaged in a “battle” and the “hard work” of therapy and healing (Shields et al., 2017, p. 222).

Also of interest in this research are counter-stories that may challenge official narratives that exist within institutions (Murray, 2000) or offer a political critique of power structures or exploitative practices (Riessman, 2008). Challenging the dominant narrative was instrumental in the transformation of the U.S. VA hospital philosophy, which required clinicians to let go of their traditional roles of experts in favour of seeing veterans as partners with shared expertise (Cohen et al., 2012). Similarly, New Zealand veterans research has not shied away from offering uncomfortable critiques of the dominant paradigm. In oral histories of New Zealand veterans from the First and Second World Wars and Vietnam, coping with service experiences was frequently described as a lifelong process that continued into old age (Hopner, 2014; Reynolds & Smith, 2009). Interviews with Māori Vietnam veterans, their spouses and adult children, identified the intergenerational consequences of service, such as through the exposure to toxins and psychological injuries (Reynolds & Smith, 2009). Several New Zealand studies have also acknowledged the tension between organisational and individual level narratives that can occur through NZDF service. New Zealand Army soldiers were found to experience a lack of empowerment and meaningful autonomy over their own health and well-being decisions in qualitative interviews, for instance when experiencing pressure to return to normal duties despite carrying injuries (Kohere, 2022). Harding (2008) analysed the clash in narratives between Royal New Zealand Air Force personnel who were deployed as part of the 1991 Iraq War, and the media (and government) discourse of the mission as one of peacekeeping by a peaceful nation. Similarly, interviews with NZDF nursing officers identified the clash in cultural values of the military as a combat force and nursing in New Zealand society as a trade of compassion (Sheard, 2021). This undervaluing of NZDF nurses within the hegemonic and hierarchical power structures of the

military and medicine led to nurses feeling as if their work was invisible, like “outsiders in a world where value lies with those who reside closest to the weapons” (p. 265). Understanding participant counter-stories is an essential aspect of relational ethics and manaakitanga in this study and follows in the tradition of giving voice to the lived experiences of NZDF personnel.

### **Methodological Considerations**

As this thesis is presented with publications the description of the research method is provided in the manuscripts in Chapters 6 and 8. This section provides an opportunity to discuss additional considerations around sample size, recruitment, interview procedure, and analysis that is unconstrained by publication wordcount. Content repeated in the publications is minimised as far as possible.

#### ***Sample Size***

Guidance on number of participants in this qualitative research was taken from Dey (1999) as well as Braun and Clarke (2021) who advocate for providing an estimate on an initial sample range and then data gathering until theoretical sufficiency. Indicative qualitative research within NZDF shows organisationally significant insights from sample sizes between 5–12 participants (e.g., Hill et al., 2016; Kohere, 2022). Comparable qualitative research in the U.S. military shows significant insights from interviews with 7–8 participants (e.g., Held et al., 2019; Lefebber & Solorzano, 2019). The initial sample range in the current research was therefore set at 5–12 participants with deliberate flexibility built into the process to review this during data collection.

Theoretical sufficiency suggests that data collection stops when the researcher has reached a sufficient or adequate depth of understanding (Dey, 1999). The generalisability of qualitative research is different to that based on quantitative statistical-probabilistic principles (Smith, 2018). This study aimed to add depth of understanding to how service members face challenging decision points in their mental health journeys, contributing to naturalistic generalisability and transferability—helping other NZDF service members to recognise the same narratives in their own lives and to potentially adopt the same lessons as identified in the participant interviews (Carminati, 2018; Smith, 2018). The final sample was based on richness of accounts, ability of participant narratives to inform analysis and recommendations, as well as recruitment momentum during the iterative data gathering and analysis process. Recruitment therefore ceased in this study at 21 participants as recruitment momentum slow-down coincided with sufficient richness of the usable data.

## ***Recruitment***

Eligible participants were current RF NZDF members who had accessed support for mental health concerns and who had been referred to external mental health providers. Those still undergoing psychological treatment were ineligible, that is participants must have concluded their referral sessions and were no longer in therapy. NZDF civilians and reservists were not the focus and were not included in this study. As the study was exploratory, variation in the sample was desirable and intended to be broadly representative. Therefore, a mix across three services, genders (male/female/other minority) and ethnicities (New Zealand European/ Māori/ other minority) was considered vital to this thesis. A mix of officer/ non-commissioned officer as well as different trades (i.e., operational and support) was desired but was secondary to services, genders and ethnicities.

Participants were recruited via email outreach through existing NZDF support providers which included psychologists, chaplains, social workers, medical officers, sexual assault and prevention advisors, and defence community support specialists (see Appendix C for a copy of the email invitation). These networks were well known to the author and existing relationships with some providers allowed for the establishment of trust in the researcher's intentions. Support providers were asked to consider referring prior clients to the study if they fit the recruitment criteria. The recruitment invitation aimed to acknowledge the voluntary nature of the research and the service member's own agency and held as valuable the existing trust that had been established during earlier contact with the NZDF mental health system. The recruiting process was therefore considered to be an expression of *whanaungatanga* and extended the offer of respectfully listening to each member's experiences. It was stressed that all views on the NZDF mental health system were sought, particularly views that might inform how the current system could be improved to support personnel achieving better care and outcomes. The participant information sheet and consent form were attached to the email invitation.

On receiving email contact from potential participants, a time was arranged in which to conduct a brief phone call. This served to initiate rapport building, answer any questions, and confirm eligibility including that potential participants were not currently engaged in mental health treatment. On confirmation of eligibility, an interview time and location was arranged with the researcher communicating a willingness and flexibility to travel in order to facilitate in-person interviews which were preferred (only one interview needed to be conducted via Zoom due to Covid-19 disruptions). Participants were encouraged to select an interview location where they would feel most comfortable to speak openly about their experiences. Interview settings included

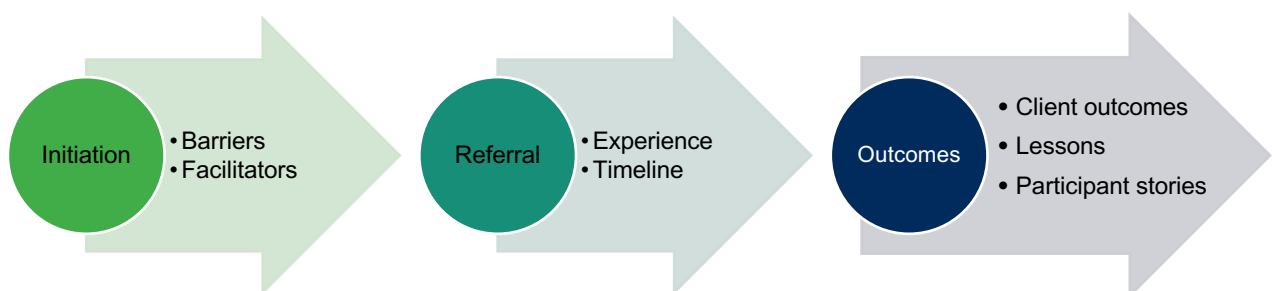
offices in NZDF well-being provider locations and private residences. One participant was interviewed in a public library office space convenient for both the participant and researcher. Participants were invited to meet with the researcher both dressed in civilian clothing in order to feel more comfortable, to convey less formality, and to emphasise the role of the researcher as a curious investigator over that of (and less invoking of) the role of a uniformed NZDF psychologist. Contact with the primary supervisor via text message prior to and after concluding each interview served as a safety process should additional support have been required.

### ***Interview Procedure***

Interviews were conducted over June 2022–February 2023 and ranged over 60–150 minutes each. Interviews were conducted using an informal and semi-structured conversational format. Following explanation of the confidentiality parameters the interviews opened with initial rapport building which aimed to establish trust in the researcher. Participants were provided the opportunity to ask any questions, following which audio recording started using an Olympus VN-733PC audio recorder. The opening question aimed to encourage a narrative account and rich description: “Can you please tell me the story of you seeking help through the NZDF mental health system?” A general guide to the interview questions was utilised (see Appendix D). Periodically participants were encouraged to provide more detail to their descriptions, for example: “Could you help me understand why you chose to talk to the social worker and not another well-being provider?” Figure 1 conceptualises the stages of help seeking in the NZDF which helped to provide an orientation for the current research, where initiation into the mental healthcare system led to an external referral process when clinical psychologist services were required. The simplicity of this model belies the many turns participant narratives took during their recounting; however, this flow of events supported the interview process and underscored areas to probe for further details.

**Figure 1**

*Stages of Engaging with the NZDF Mental Healthcare System*



Participants were frequently affirmed for sharing their mental health experiences openly and bravely, as well as for the insights and perspectives they offered. The final interview question was “what would your advice be to an earlier version of yourself at the start of this journey?” As the interview drew to a close the interviewer reflected on several experiences and perspectives the participant had shared and thanked the participant for their courage in sharing their story. The interview was closed with a karakia if participants wished and participants were reminded of how to access support resources if needed. Later in the thesis, a detailed reflection on the creation of the narratives during the interviews is outlined.

### *Transcription*

Audio recordings were transcribed using the inbuilt function in Microsoft Word (Office 365) and analysed using NVivo12 for Mac. Recordings were listened to several times as part of the familiarisation process and the transcripts checked for accuracy. Transcripts were cleaned to remove repeated words and ellipses used to denote where sentences were smoothed by removing clipped-speech, sentence false-starts, or re-phrasing. For example, a sentence such as “I I was like, um I wasn’t, not not like, I didn’t necessarily like, like, need to talk to anyone right away” was transcribed as “I didn’t necessarily need to talk to anyone right away”. Omitted words were inserted using square brackets to provide context, for example, “When I was posted to, so I went and met my new boss” was transcribed as “When I was posted to [my new unit]...”. All identifying features such as names, places, ranks, trades, genders, and units remain in the original transcripts, but are presented in written material in square brackets substituted for appropriate nouns, for example, “[the social worker] saved my life if I’m being honest” in the instance of a social worker’s name being used directly.

As is true with all transcription, various markers of context and significance can become obscured or washed out in the transition from spoken live to audio recorded and are therefore reliant on the author’s rendition and description (Riessman, 1990, 2008). Linguistic markers of culture, such as certain words and phrasing of contextual significance within the NZDF military culture, are pointed out where appropriate. Participant cadence, tone, volume, and pacing that aid understanding are described when additional explanation of transcript segments are presented. This is particularly important for linguistic devices that provide emphasis and drama, subtlety, and sarcasm (Riessman, 2008). Added emotional emphasis or clarity is added in square brackets, especially when emphasising phonetic sounds, for example: “And I was like whaaaa!” [makes dramatic sound to indicate stress].

## *Analysis*

Narrative analysis was used as set out by Riessman (2008), Hiles et al. (2017), and Stephens and Breheny (2013). Data was coded according to both how the story was told, and the sequence of events being related. Analysis was across multiple levels of meaning, including; personal stories (especially around identity, belonging, barriers, facilitators, and agency) and culturally available narratives (Stephens & Breheny, 2013). Analysis focused on variations of healing narratives (e.g., healthy, sick/chaos, recovered) following identity or narrative rupture due to mental health distress (Frank, 1995; Orsini & Scala, 2006). Also, a focus was on the influence of social-cultural narratives particularly from within the NZDF on individual help seeking and mental health experiences (Murray, 2000).

Transcription and coding allowed for the deep immersion into the participant accounts, and use of NVivo software allowed for transcript highlighting and collating of transcript sections. As increasing familiarity with transcript structures and participant accounts continued, commonalities and differences began to be interpreted. When identifying individual personal stories, characters were identified (e.g., a social worker, a manager) as well as any recognisable plot using beginning, middle, and end (e.g., I didn't believe I had a problem, then I became unwell, then I got support, now I am better than I was before). When identifying broader socio-cultural stories, the central character was often "the NZDF" as an institution with social power and dominant cultural influence. Initially, messy draft narrative titles were used to collate similar transcript sections, for example:

Sense of injustice; you (NZDF leadership) weren't there for me when I really needed you during the worst/ hardest time of my life (but I have always been there for the NZDF people who need me). When I needed help most, I was alone.

Breach of social contract.

The process was iterative and not linear, and as more interviews were completed a sense of recognition of common stories was refined and the noticing of subtle differences in sub-plots began to be acquired. During the analysis process considerable time was spent on reflexivity both in self-reflection and in supervision. A thorough discussion of reflexivity is provided later in the thesis, which provides reflections on the interviews and how I contributed to the creation of the narratives.

## **Chapter 5: Interview Reflections**

This chapter reflects on the interview and narrative co-construction process before presenting the results chapters, and as such adopts the first person perspective. Conducting a narrative analysis involves making many different decisions about how much to foreground the co-creation of the interview as an encounter between two people (Mishler, 1995). Reflexivity relates to how the researcher locates themselves in the interview by making explicit their influence, rather than pretending they are not there (Riessman, 2008). Honest transparency of the researcher's influence on the shaping of the narrative is an essential feature of good quality narrative analysis (Murray, 2003; McAllum et al., 2019). The analysis approach can prioritise a conversation between two people, or it can prioritise the experiences of one person. In the results chapters that follow, my role as the interviewer is set into the background and the focus is deliberately placed on the participants' accounts so that the influence of the narratives is given as much authority as possible. The focus on reflexivity here in this chapter provides for a discussion around the interview process as a co-created dialogue between two people, and on how my insider status contributed to the creation of the narratives. Lessons from the interviews are also drawn that relate to my practice as an aspiring clinical psychologist.

### **Co-creating Stories**

#### ***Trust Facilitated Revealing***

Narratives are not told in a vacuum, they are told to a listener and within a context (Murray & Sargeant, 2012). I endeavoured to be reflective during the interview phase of this research on how I was participating in the creation of the narratives and was aware there were two jointly active participants in each encounter (Mishler, 1995). While I did not want to influence the participant in any particular direction, I also felt it was important to be present as a whole person. In particular, my insider status as a fellow NZDF member arose naturally and frequently and allowed for many opportunities to discuss topics in depth given our shared understanding of the NZDF. Studies on the New Zealand veterans' community have acknowledged the value of research being conducted by "one of their own" from within the tribe (Cardow et al., 2021, p. 5). Insider perspectives are known to offer several advantages: They can produce rich accounts due to the shared knowledge of meaning and context between researcher and participant; insiders may more easily develop rapport with participants given their shared experiences; and richer and more complex understandings may be achieved as a result (Hayfield & Huxley, 2015).

Every effort was made to ensure participants felt safe and supported during the interviews. All interviews were commenced and concluded with an offer of a karakia led by the researcher or by the participant, or any other way that felt appropriate for the participant. The DFO(T) (see Appendix A) arrangements were made clear at the start of interviews and may have made a difference to how much participants were prepared to share in this study. However, even after the introductory confidentiality parameters had been discussed, there were several occasions where the dual agency dilemma nevertheless appeared to surface, as some participants were hesitant to reveal too much early on. Some participants initially shared some seemingly safe biographical history, gauged my response, then perhaps deemed that I had shown sufficient care and that trust had been established, before proceeding with more detailed, sensitive, personally revealing—and therefore risky—information. Some participants needed additional reassurance during the interview that what they were about to reveal would remain confidential. Sharing my insider’s understanding of the small-community nature of service life in the NZDF built trust, especially by being empathetic to participant concerns around the possibility that peers or colleagues could potentially come to know the identity behind the published stories. At every step of the interview process I was attuned to supporting my interviewees’ need to feel safe and protected around what they shared, and that their participation would not come back to harm them in any way.

### *Grappling with Difficult Issues*

While my military cultural competence was a potential strength (e.g., Westphal & Convoy, 2015), I was also aware that one of the possible downsides of insider research is arriving with too many assumptions about shared understandings. There were many occasions while hearing participants’ accounts of receiving poor or problematic help from well-being providers that I was confronted with the likelihood that I may have been guilty of doing something similar in my past practice:

Participant L Even psychs aren't very good at dealing with people saying that [i.e., thinking about suicide]. They all get a bit weird. Like even the psych here in [location] would get a bit weird when I'd say that, he'd be like, oh, and then he'd pull out the whole you know, 'but if you did, I'd be in trouble and I would go and you know there'd be a big review into me' and [noticing the interviewer's facial reaction]— yeah, he did say that! I'm like oh that's helpful, cool, good to know where you sit on that [laughs, sarcasm].

Interviewer: What impact did that have hearing that?

Participant L Well it just makes you kind of keep quiet about things. You know it's like. Anytime that a psych or an MO says, 'hey look, if you talk about self-harm or harming yourself or harming others I have to report it' you go, 'oh well I'm not going to tell you the whole truth then'—why would I tell you the truth when it could be potentially risky for me?

I learned many valuable insights into what it is like to sit facing me in therapeutic sessions with NZDF personnel that I was keenly motivated to share with my wider support provider colleagues. Practice implications such as being uncomfortable with service person distress or giving off the impression of being too busy and therefore inattentive to the suffering beneath participants stories struck home for me, and I felt these were particularly important lessons to recognise and be able to share in future presentations and workshops.

There were also many times during the interviews where I felt like the participant had just touched on something that was paradigm shifting for me, even though it was difficult to feel confident at the time that I had fully grasped what participants were actually describing. In these moments I did my best to use non-verbal attending behaviour (e.g., leaning forward, nodding) and reflective listening skills (e.g., summarising; Sommers-Flanagan & Sommers-Flanagan, 2017) to communicate my understanding of the narrative they had just told, and then outlined a question that often initiated a very insightful next section of story or subplot. This was in a sense like giving up control of the flow of conversation and may have empowered participants to step into their own natural style of storying themselves and their experiences, leading to rich descriptions. I was conscious of allowing the participant's account to take whatever shape they wanted, without my influence of it needing to conform to any particular arc. This required some self-control and restraint on my part when seemingly off-topic detours appeared to meander and take a long time. This approach frequently paid off by signalling to the participant that I had the patience and willingness to be with them in an unhurried way to witness and hear what was important to them. Often the questions that got participants most animated and engaged with the complexity of their help seeking was when we collectively sat in a shared sense of paradox, or of not knowing what the answer to certain barriers to care might be. There was often a tension between remaining silent and allowing the participant to wander wherever they wanted, and the need to probe deeper, or to circle back to an earlier point and ask the participant to clarify or explain further. An important part of the co-creation process was therefore embracing the inevitable tension between silence and asking questions (Sommers-Flanagan & Sommers-Flanagan, 2017).

### *Witnessing Stories of Suffering*

Narratives do not merely refer to past experiences but can also create important experiences for their speakers and audiences even in the very moment of interviewing (Riessman, 2008). Participants often benefit directly from discussing their experiences in qualitative research and while the interview was not intended as a therapeutic intervention, it did provide an opportunity for meaning-making which is a therapeutic activity (Frank, 1995; Radley, 1994). However, discussing mental health experiences can also be uncomfortable or distressing for interview participants. Several participants showed heightened emotions during the interviews, some became tearful as they recounted their distress, or agitated when they described the perceived lack of support they received from NZDF during their mental health struggles. The participant encounters were at times some of the most professionally intimate of my career to date, especially when participants shared their sense of struggle with mental health distress while still trying to serve and do their jobs. This was a very moving and humbling experience for me as the interviewer, as a military psychologist, and as a service person. There were numerous times when it no longer felt like I was actively interviewing at all, but rather simply witnessing a fellow uniformed person tell their stories of chaos and redemption (Frank, 1995). It was in those times that often the richest insights and revelations emerged. Therapeutic strategies such as taking breaks, holding space, offering witnessing silence and acknowledging the emotions associated with participant stories were sufficient to support participants during their story-telling (Morrison, 2014). Participants were reminded that the research was voluntary and that they were under no obligation to proceed with the interview at any stage under any circumstance. This was especially underscored during moments of heightened emotion.

Frequently when participants would draw a section of narrative to a close or pause after recounting a particularly harrowing ordeal like surviving a suicide attempt, or an experience of military sexual trauma, I would let out an exhale...pause...and embrace the shared silence before saying anything. This felt like a small but significant way to honour the enormity of the experience that the participant had just shared. There was often a mix of emotions in me which I attempted to communicate, along the lines of "I'm both happy to see that you're well, but I am so sorry that you had to go through that". It was hard to not both feel joyous and proud at the examples that were shared of good support that had been provided by NZDF, and somewhat ashamed and disappointed at the examples of neglect and harm at the hands of people inside NZDF. There were particular stories where I felt the participant had been so poorly treated by the organisation that I ended up feeling the need to offer an apology on behalf of the military

community that we were both part of. This was often wrapped up in wanting to communicate to the participant the value I saw in their courage to share their experience with me. Reflecting back to participants the value of sharing their story and the potential benefit to others by being involved in this research was often met by expressions of gratitude and seemed to be cathartic for some—as if their experience of suffering could be seen as worthwhile if it could contribute to helping someone else.

### ***Closing Insights***

Not only were stories of suffering humbling to witness, but there were many surprising insights that participants revealed—sometimes at the very conclusion of the interview—that were so totally unexpected yet vital for shaping the findings of this thesis:

Participant G: I think...I think Defence Force is on the right track. It's just getting those guys that are that low into planning, really. Planning for the future so they know there's gonna be something to look forward to or goals going forward and that. 'Cause like when you're lost in depression, you're just, like. You're lost. 'Fuck it. I got nothing to look forward to. Why?'

Interviewer: So you think Defence is on the right track?

Participant G: Yeah, yeah, I think they are. Yeah, yeah.

Interviewer: 'Cause you know, you kind of get a mix [of opinions] and I want to do like an honest job of sort of presenting back—these people said 'this'.

Participant G: Yeah 'cause some people expect too much. You know, and like, there's only so much Defence Force can do...So you gotta be realistic about it too what they can do for you, and they're probably doing a lot more than what other employers would do probably.

Participant thanks at the conclusion and reflections on the interview experience itself were often heart-warming, and participant acknowledgement of the value of the interview for them helped to close the time of shared connection:

Interviewer: Is there a particular way you'd like to close? I think sometimes it would be good to kind of book-end things, like some people like a karakia to close off the energy, but I'm also happy to just keep moving.

Participant D: Yeah, yeah, that would be cool. But before you do that. I would like to say the opportunity to thank you for doing the work you're doing. And whilst you know like I'm not blameless, I do not believe the organisation put its best foot forward

with me. And to have someone like yourself pick up that and go ‘yeah, I understand that and we’ll do what we can and it might not be perfect, but it’s something.’ OK. Right then, that gives me solace and makes you feel better.

Interviewer: Awesome, that’s cool.

Participant D: I appreciate it.

Interviewer: Well, thanks for saying that. Like I really believe in this work and I really believe in yeah, sort of being brave with saying ‘hey listen. This is what your community is telling you. This is what our people are describing. You know they’ve had the hardest time of their lives in here, and this is how we’ve either supported them or not supported them’. And not everyone is going to like that. But I think it’s important.

Some participants noted the closing of the session with a *karakia* in particular was uplifting and helped to *whakanoa* (clear the air and make safe) the heavy and intimate nature of the preceding interviews which they appreciated. Other participants took the opportunity to recognise and point out the wider organisational implications of the research and expressed a desire to see the impact reach the upper levels of policy decision making:

Participant W: No, I mean thank you for your time and for you know all the all the energy that you’re putting into this because, from the very little we know about each other, I know that it is a very important kaupapa for you. And in your position in Defence, I urge you to just take all the strength and all the *tautoko* because there’s a lot of people that you won’t come across that will absolutely need you to be doing what you are doing.

My position, my insider status, and my potential ability to influence change seemed to give some participants an additional sense of hope that their stories would reach the lives of others throughout the NZDF and impact them in a positive way.

### ***Conclusion***

In very many ways, witnessing the participant stories in these interviews has valuable crossover lessons for me in my clinical practice. Some of the biggest lessons for me were around the power of providing a safe container for the interaction, and the power of therapeutic silence to provide space for participants to explore their own stories in meaningful ways (Sommers-Flanagan & Sommers-Flanagan, 2017). Often the best thing for me to do to help facilitate the narrative creation process was to simply bear witness. Not being in a hurry to push participants

out of their chaos narratives into a more psychologically comfortable and perhaps familiar restitution narratives (Frank, 1995) was one of the central ingredients that allowed for the successful co-creation of the narratives in this study.

### **Overview of Results Chapters**

The following three chapters detail the results from participant interviews and analysis. Chapter 6 and the first published article details the overall structure and contour of participants' journeys; from origins of distress, to engaging in care, treatment, and recovery. Chapter 7 details the many barriers to becoming engaged in care, and how barriers remained present even in the therapeutic process once participants had become enrolled in the healthcare system. Chapter 8, the second published article, then explores what supported participant recovery and the interconnections between aspects of well-being that supported a holistic recovery.

## Chapter 6: Journal Article 1

This chapter has been published as: Grimm, C. J., de Terte, I., Hodgetts, D., & Kearney, S. (2024). Narratives of transformation and recovery in New Zealand Defence Force personnel accessing mental health support. *Journal of Military, Veteran, and Family Health*, 10(3). <https://doi.org/10.3138/jmvfh-2023-0086>

### Abstract

**Introduction:** Little is known about the user experiences of accessing mental healthcare among active-duty New Zealand Defence Force (NZDF) personnel. While research exists on barriers to care and treatment outcomes, there is a dearth of understanding of the experiences between these two areas of focus. This study describes the narratives of 21 active-duty personnel who sought mental health support within the NZDF healthcare system.

**Methods:** Participant accounts were generated through semi-structured interviews and analysed using a narrative approach. The focus of analysis was to provide a deeper understanding of how participants storied their experiences from the onset of mental distress to recovery, with a focus on the narrative structure of these experiences.

**Results:** Participant narratives often followed the progression of a quest narrative, mirroring the hero's journey, which encompassed background factors leading to distress, chaos and breakdown, serendipitous connection to support, recovery and redemption. Engaging with the healthcare system marked the beginning of personal transformation and posttraumatic growth. This transformation involved changing core beliefs and perspectives, leading to increased self-awareness and empathy, and ultimately contributing to growth as individuals and leaders within the NZDF.

**Discussion:** The study underscores the importance of understanding and facilitating posttraumatic growth in military personnel in both clinical and organisational contexts. In addition, the study highlights the need for mental health messaging and support within military institutions to align with existing cultural values and narratives. Overall, the study contributes to a deeper understanding of the complex journey of recovery and growth in military mental healthcare contexts.

### Lay Summary

The way that military personnel describe seeking support for their difficult mental health experiences can highlight what helped and what got in the way of their recovery. This study

examined the stories of accessing care told by New Zealand Defence Force (NZDF) military members to understand their unique perspective on mental health recovery. In total 21 military personnel were interviewed from the NZDF who had been treated for mental health concerns. The results show how personnel described their experiences of being supported through the NZDF mental health system, how hard it was to seek help, and how challenging the process was to get better. In general, participants described positive outcomes, where they felt supported to recover and become better versions of themselves through the process. Results highlight that growth from mental health struggles for NZDF military personnel is possible and can be supported. Discussion focuses on things leaders and organisations can do to ensure that military service members are encouraged to feel they are in control of their own recovery process.

## **Introduction**

Narratives can be found in myths and legends since the dawn of humankind (Riessman, 2008) and narratives of soldiers and war have appeared since antiquity (Kucmin et al., 2016). Constructing narratives is one of the primary ways in which humans make sense of the world and assign meaning to events (Murray, 2000) and the ways in which military personnel story themselves and their experiences are shaped by a variety of societal, institutional, and cultural values (Kaspersen, 2021). Until recently few studies had conducted narrative research in contemporary cohorts of military personnel (Tappenden et al., 2022; Crespo & Fernandez-Lansac, 2016). Understanding the narratives that service personnel commonly adopt is critically important because the types of stories people tell during periods of recovery from distress can have profound and long lasting impacts on their mental health (Adler et al., 2015) For instance, adult community patients whose narratives reflected an increase in personal agency over time have been found to show improvements in their mental health during therapy (Adler, 2012). Improvement in PTSD in trauma patients has been found to be associated with an increased ability to generate healthy, balanced trauma related beliefs (aka. accommodation) in both brief expressive writing and gold-standard PTSD therapies (Alpert et al., 2023). Similarly, themes of growth and agency were found to be associated with lower scores of posttraumatic stress, depression, and anxiety symptoms in U.S. veterans who wrote about stressful experiences during their military service (Tappenden et al., 2022). In narratives of moral injury experiences, Afghanistan veterans described a process of personal transformation in grappling with their experiences, as well as how difficult and important it was to open up and share with family, friends, and other veterans (Held et al., 2019). Similar narrative themes of taking control of the recovery process have been described by veterans in group therapy, where a critical perspective change involved moving from being a passive

recipient of care, to an agent engaged in a “battle” in the “hard work” of therapy and healing (Shields et al., 2017, p. 222).

Studies that have examined the New Zealand (NZ) active-duty or veteran perspective of seeking support for military experiences have identified the importance of culture, the impacts of service, as well as the barriers and facilitators around help seeking. Military service in New Zealand is unique because of the fusion between the British European military tradition with the Māori warrior culture (Hohaia, 2016). Many New Zealand veterans from both World Wars and Vietnam have described aspects of posttraumatic growth following their service, which included a sense of gratitude, an appreciation for life and for living in NZ, as well as a change in life priorities (Hopner, 2014). Interviews with Māori Vietnam veterans, which included their spouses and adult children, also identified the intergenerational consequences of service, such as through exposure to toxins, as well as physical and psychological injuries (Reynolds & Smith, 2009). Social connectedness is often of central importance to the help seeking and recovery experience in New Zealand Defence Force (NZDF) military personnel and veterans (Hopner, 2014; Reynolds & Smith, 2009). A recent study of the health and well-being experiences of Māori soldiers in the New Zealand Army found that participants sometimes felt a lack of empowerment and meaningful autonomy over their own health and well-being decisions, for example when experiencing pressure to return to normal duties despite carrying injuries (Kohere, 2022). Barriers to help seeking such as not being aware of support resources, a reluctance to seek support due to a stoic sense of independence, as well as the perceived ineffectiveness of support options were found to be common during interviews with New Zealand veterans during the Covid-19 lockdown period (Austin et al., 2020).

### ***Navigating Military Mental Healthcare Systems***

The patient perspective of seeking and obtaining mental healthcare among currently serving personnel is vital for understanding where barriers and opportunities for intervention exist (Fikretoglu et al., 2022; Adler et al., 2020). While approximately 5% of NZDF personnel seek mental health support annually (Stuart & Bennett, 2017) narratives of help seeking in this community are not as well documented compared to allied nations (Veterans' Affairs New Zealand, 2022). The aim in this study was therefore to investigate how NZDF service members recounted their journey through the NZDF mental health system and to address the gap in understanding of their experiences between initiating support seeking and treatment outcomes.

## **Methods**

### ***Participants***

Eligible participants were active-duty NZDF personnel who had accessed support for any mental health matter and had been referred to clinical psychologist or psychiatry services. Those still undergoing treatment were ineligible. Participants were recruited via email outreach through existing NZDF support providers; psychologists, chaplains, social workers, and medical officers. Participants were assigned a random alphabetical identifier and sample characteristics are presented in aggregate to protect participant identities. In total, 21 participants were interviewed: 9 Air Force, 7 Navy, and 5 Army. Years of service ranged from 2 to 29 years. There was a broad distribution of ranks which included five officers and 16 non-commissioned (enlisted) personnel. Age range was between 19 – 52 years. Seven participants identified as Māori, 2 identified as Pasifika, and 12 were New Zealand European (Pākehā). Eleven participants identified as cisgendered women, nine as cisgendered men, and one participant identified as a non-cisgendered person. Participants described a wide variety of lived experience of mental distress, including depression, anxiety, combat trauma, PTSD, and moral injury (more details are provided in Grimm et al., 2023).

### ***Ethical Considerations***

This research was approved by the Massey University Human Ethics Board and the NZDF Organisational Research Ethics Board. To facilitate frank participant accounts a special NZDF military order was instigated to protect the interviewer (who was also currently serving) from obligation to report any potential military offences that could have been declared during the interviews (e.g., duty violations). Participation was voluntary and participants received no remuneration for taking part.

### ***Interview Procedure and Data Collection***

Interviews were conducted using an informal and semi-structured conversational format. Interviews were in-person (one was conducted via Zoom due to Covid-19 disruptions) and varied over 60 – 150 minutes. The opening question aimed to encourage a narrative account and rich description: “Can you please tell the story of seeking help through the NZDF mental health system?” Periodically participants were encouraged to provide more detail to their descriptions, for example, “Why did you choose to talk to the chaplain and not to another well-being provider?” All interviews were conducted by the first author. A description of Māori cultural protocols adopted during the interviews is described in Grimm et al. (2023).

### *Narrative Analysis*

Participant accounts were analysed using narrative analysis (Riessman, 2008). A narrative approach to service personnel as storied beings is well suited to the exploration of how people make sense of and bring order to the disruption that illness produces in their lives (Radley, 1994). The focus in this study was on identifying illness narrative templates; restitution (i.e., yesterday I was healthy, today I am sick, but tomorrow I will be healthy again), chaos (anti-narratives of despair), and quest narratives (i.e., the hero's journey) (Campbell, 1949/2004; Frank, 1995). A similar analytical approach has been used to explore U.K. veteran recovery experiences from physical and psychological trauma (Carless, 2014). Audio recordings of interviews were transcribed and coded to identify aspects of narrative structure and sub-plots. Researcher reflexivity and reflection on the construction of the narratives occurred during frequent researcher supervision among the authors (Riessman, 2008).

### **Results**

Participant stories of accessing care through the NZDF mental health system frequently followed the contours of a quest narrative (Campbell, 1949/2004; Frank, 2004). A shared progression was described: From background and onset factors, to chaos and breakdown; serendipitous connection to support; recovery as an ongoing process; and concluding with re-connection to important relationships and redemption.

#### *Origins: Background Factors and Mental Distress Onset*

When discussing the circumstances around the onset of their mental health experiences, participants often described a combination of childhood factors as well as specific triggering events. Several participants disclosed experiences of abuse, including sexual abuse prior to enlistment. Many participants described how they could trace the impact of these events experienced in childhood on their subsequent mental illness onset while in uniform:

And in that moment it just triggered all these emotions. All this repressed stuff that came bubbling to the surface...I realised all this anxiety and depression and self-medication with alcohol has been as a consequence of what happened to you  
(Participant N).

Participants described how their mental distress was precipitated by a complicated intersection of military service and non-military life events. Stress from relationship conflict was commonly storied as a key variable in contributing to mental distress and a broad range of relationships were implicated such as with partners/spouses, family members (parents, children), leaders, managers,

and colleagues. Mental distress onset was often compounded by sleep disturbances due to duties (e.g., shift work), alcohol use, and intertwined with military factors such as being away from home on overseas exercises or deployments:

My ex-partner was saying that he thought I prioritised my work over him and not getting back to New Zealand to help him through some of the stuff he was going through (Participant T).

Started drinking a lot [on overseas duties] as well 'cause that's really bad like [military] culture... when my ex broke up with me I just had really bad anxiety and I didn't know what was going on with me and I just stopped sleeping straight away... So yeah, my emotional resilience just went out the window (Participant O).

Participants described this stage of their story in terms of disorientation and lacking a clear sense of direction. Many participants noted they lacked even the language to be able to convey to others what they were experiencing at that time:

So that's when I realised I was like struggling with something and I didn't know how to really handle it kind of thing... I just felt lost. I didn't know what I was doing, felt out of place. How do you even explain that? 'I don't know where I am' (Participant I).

Despite a growing recognition of their mental health problems, many participants described how committed they remained to managing their difficulties on their own. Several participants had not even recognised that support was an option to consider:

No, it didn't occur to me at all to get help honestly, like for me when I think about it, I was like I can get through this. I don't need help, I'm strong I can do it by myself... but I think it just got too much (Participant Q).

All participants described various ways of hiding their distress and many reflected on how well versed they had become at portraying a competent image: "Because that's what I've gotten good at for 20 some years man, you know, really good at just pretending, playing the part" (Participant K). Participants' narratives revealed a multifaceted relationship with their work duties as both a source of stress as well as a resource of structure and stability:

There was definitely like a period of quite a few months. I was pretty bad, I was real bad ... I would go to work, be real terrible and as soon as I like turn the corner and head into camp then boom that facade would come over and I'd just be on-point at work, nobody needed to know anything (Participant L).

The duration of managing distress alone varied from months and years to decades. During this period participants described using a variety of coping techniques including self-medicating, such as with alcohol, as well as using strict control of diet and exercise. Several participants described adverse impacts of their mental health distress on their duties, while others described “functioning while suffering” (Castro & Kintzle, 2014, p. 465).

Like I can tell you right now between 2003 and maybe 2012, 2013, a solid decade, I didn't even know I needed help, right? I just thought I was dealing with stuff and I was the man and everything was cool as. At the height of my depression, outwardly I'm projecting this like amazing I'm awesome... but the only thing I felt I could control in my life at that time was my diet and exercise. So, I was just like eating nothing and exercising a lot. So then I felt, you know, ‘Oh, look at me. I'm controlling a thing’ right? I wasn't happy at all (Participant R).

And it got so bad that I was literally sitting at my desk and at that point in time like I would have been the one in the room that was smiling the widest laughing the loudest. Yet driving to work thinking ‘oh what if I just turned my car this way?’ Not because I wanted to, but because my anxiety was so intense at that time and also again, probably drinking up to a bottle and half of wine at this point a night like every night (Participant N).

### ***Crossing the Threshold: Connecting to the Healthcare System***

Participants consistently described how it took considerable mental distress before they became ready to engage with support, or before their distress was finally either noticed or commented on by others. Mental distress included descriptions of self-harm, suicidal ideation and attempts:

I did need someone to tell me that you will get better. You will get through this. Because at that point I didn't think I would...I thought this was literally going to kill me. I just felt like I wasn't going to survive it to be honest (Participant A).

Participant storied this phase of their narrative as among the most difficult time of their lives and mirrored aspects of the hero's journey of entering the abyss—involving physical, emotional, and social suffering (Campbell, 1949/2004; Frank, 1995). Added to this distress, participants described in various ways how difficult and almost insurmountable crossing the help seeking threshold was: “It's just that first step is the hardest” (Participant E). Even when talking with support providers many participants described failing to connect to care that was helpful, or not realising they were not providing the cues necessary to communicate the severity of their

impairment and distress. In the hero's journey, crossing the threshold often can involve support from a key figure or helper (Campbell, 1949/2004). Participants described that having someone to help them get into the healthcare system was often essential—and also that this encounter was unplanned and frequently by chance:

I went to the gym, the padre (chaplain) just happened to be there, first thing he always says to me is 'How are you?' and I was like 'Oh my God' and just broke down and then that's when I found out that you know, I could get support and what my options were (Participant B).

It got to a point where I let a friend in and they were like, 'Look. You can't continue to go this way, I care about you, so if you don't go and seek support, I'm going to effectively tell on you', but it was like they were doing it from a place of care and compassion. And so at that point in time I was like, OK, fine, I need, I need to go and see someone (Participant F).

### ***Beginning the Journey Home: Transformation and Recovery***

Becoming engaged in the healthcare system was often described by participants as a key turning point in their narratives, marking the beginning of personal recovery and re-storying. This transformation process frequently involved descriptions of changing core beliefs and perspectives. Several participants described how they had changed their attitudes around mental health—from being something foreign that had never applied to them—to something with which they were now intimately familiar: "It's not until I went to my own dark place...I just didn't get it, you know? And now I get it" (Participant B). Some participants described their transformation as the most extreme version of a quest story (Frank, 1995) in terms of becoming someone else entirely:

I grew so much in those [therapy] appointments...It gave me a safe place to go and put everything that was stuck in my head and in my heart ... But you know now that I look back on it, I felt so broken that I just didn't know what to do but cry. And so when I was able to start talking about it, I was like, oh man, it's like a release... I feel like a completely different person (Participant D).

Engaging in therapy opened up new behavioural possibilities and participants described the various ways in which the recovery process resulted in them being better able to appreciate alternative narratives (Frank, 2018):

I definitely had a very kinda I guess fixed mindset, closed minded sort of mentality when I joined ... I would probably call people 'soft cocks' back in the day you

know, if they were struggling, ‘well take a concrete pill.’ You know, the classic line. But yeah, definitely I can see there's usually a bit more to it now... everyone’s got a story, everyone’s got a history (Participant J).

Participants also described their iterative, at times messy and inconsistent, recovery timeline, with several participants narrating regressions and periods of slow or no progress. For example, one participant described a sporadic relationship with accessing support: “But I'll still get low. And just deal with it. The road after that is just back to work as usual... To be honest, I’ve probably had a good six years on or off counselling” (Participant D). One participant described the recovery back to fulltime duties as a series of slow progressive steps:

I wouldn't say that I wasn't in a very good headspace to come back to work in the first place, but I kind of had to ... just trying to get me back and into a routine of coming back to work...then I would extend, increase my work hours and then I would go to four days a week, half days and five days a week. You know and then start increasing the time you know finish at two or finished at three and it took me a whole year to get back up to full time work (Participant B).

### ***Reconnection and Re-storying***

Part of the recovery process often involved reconnection back to important people or communities within the NZDF. Some participants described re-storying themselves back to the organisation in a way that reconnected them with a sense of worthiness and positive contribution back to their community:

We ended up in the base theatre with all [of my trade]... So, I spoke for myself and just kind of again said ‘Look, this is where I went [to get mental health support]. This is why and holy shit, despite what happened, I wouldn't ever change it, I'm so glad I did what I did’. And then after that people came up to me and congratulated me, or said ‘hey thanks you know I've had this issue, what do you think about that?’ The learnings I've had I felt like in an appropriate way, I hope to try and share with people (Participant D).

Others reconnected with important central characters in their narrative of trauma, for example family members or the spouses of deceased comrades:

You know, and [my best friend’s widow] reiterating to me to my face that it wasn't my fault, you know. That was good, but I wouldn't have got there if I hadn't started the counselling... before I'd started this counselling process it would just

not have come up. You wouldn't have got through the steel veneer that I had up at all times (Participant R).

Elements of posttraumatic growth were evident in participant reflections on how far they had progressed in their recoveries. The growth described often involved opening-up to new ways of being in relationship to themselves and to significant others. Importantly, participant stories reflected the positive contribution that their mental health recovery had—not just for themselves—but also for their closest relationships and extending to their duties within the NZDF.

I think I've grown more in the last couple of years than I did in the 10 years previous. Definitely know myself better than I ever have... on my way to be a bit more authentic I think after all this. My experience has definitely helped me as a leader armed with a few more tools, more empathy, more compassion (Participant J).

I will never be the man I was before the [traumatic event], but I'm a better man now than I was. And my wife says it quite often, that she's getting her husband back piece-by-piece. Without a shadow of a doubt, the help I've got has been a force multiplier in me basically being alive (Participant R).

## **Discussion**

This study examined the narratives of 21 active duty NZDF personnel who had accessed mental health support through the military mental healthcare system. Participant narratives frequently followed a better-than-before story arc where growth and change in core beliefs redeemed earlier periods of chaos and struggle. The structure of the stories in this study show remarkable similarity to research in allied militaries, such as the difficulty of dropping the “mask of competence” (Shields & Westwood, 2019, p. 425), feeling lost with one’s distress (Carless, 2014), a crisis catalysing an inflection point of change, and the gradual process of recovery (Palmer et al., 2016). The narratives of social reconnection and change in personal priorities described by service members in this study align with the qualitative synthesis of posttraumatic growth themes in military samples (Habib et al., 2018) and also with stories told by earlier generations of New Zealand veterans (Hopner, 2014; Reynolds & Smith, 2009). While the idea that trauma can lead to transformation is rooted in ancient philosophical traditions and religions (Tedeschi & Calhoun, 1995) the importance of narratives in the development of posttraumatic growth in military and veterans has become much more salient with recent conflicts (Tedeschi & McNally, 2011). Participants in this study retold their experiences by adopting the quest

narrative—“humanity’s oldest structure”—of the call to change, rejecting the call, suffering and transformation, followed by the renewal of relationships based on a new understanding (Frank, 2004, p. 86). Importantly, of the wounded storyteller templates, the quest narrative structure affords most agency to the recovered story-teller, as chaos stories are consumed with unredeemed suffering and restitution narratives often centre the triumph of an intervention (i.e., it was the medication that fixed me) (Frank, 1995). The adoption of this template is informative, as narratives of agency and growth are associated with positive mental health outcomes in both civilians and veterans (Adler, 2012; Tappenden et al., 2022).

### ***Clinical and Organisational Implications***

Given the hero’s journey storytelling structure appears to be associated with benefits to military personnel, it is important to consider how it may be encouraged in both clinical and organisational contexts. Several areas have been identified as clinically relevant when seeking to facilitate and support posttraumatic growth in military and veterans in therapeutic approaches: Psychoeducation around trauma and posttraumatic growth, emotion regulation skill-building, the facilitation of meaningful self-disclosure, narrative development, and living in accordance with new values often in service to others (Tedeschi & McNally, 2011). Additionally, clinical approaches to posttraumatic growth can often involve an integration of approaches, such as using cognitive-behavioural, narrative, existential, and interpersonal therapies (Tedeschi & Moore, 2021). One programme for veterans that adopts this approach using residential and online follow-up components has been found to support mental health improvements across a range of metrics (e.g., PTSD, posttraumatic growth, psychological flexibility) (Moore et al., 2021). Central to this programme—and critical to the recovery of participants in the current study also—is *expert companionship*; the presence of a supporter or clinician who appreciates the paradox and ambiguity of trauma recovery, and the often messy process that can take months or years (Tedeschi et al., 2015).

In addition to therapeutic considerations, there are organisational implications from this study and others that highlight the importance of “spreading good stories” (Frank, 2004, p. 82). Culturally available narratives of trauma, coping, and growth can provide templates which can aid or hinder posttraumatic growth in the aftermath of a crisis (Calhoun et al., 2010). Other authors have advocated that mental health messaging be framed to military audiences in ways that fit their already existing culture and values (Shields et al., 2017). For example, instead of viewing combat as potentially traumatic, this and other types of military service can instead be approached as some of the most challenging and life-changing of experiences that hold the potential for

significant personal growth (Bryan & Morrow, 2011). How leaders talk about this also matters, as specific leadership behaviours that influence how subordinates create meaning from hardship have been found to moderate the impact of combat stress on mental health in U.S. soldiers (Wood et al., 2020). Role-modelling narratives is also an important cultural transmission of available recovery journeys (Cain, 1991), as participants in this study demonstrated by sharing their recovery stories back to their colleagues and peers. The Invictus Games Foundation is an organisational-level example of supporting posttraumatic growth through sport for wounded, injured, and sick servicemen and women (Invictus Games Foundation, 2023). The Games have adopted the *Invictus* poem (meaning unconquered in Latin) by William Ernest Henley as their core narrative of overcoming adversity and frequently reinforce the lines, “I am the master of my fate; I am the captain of my soul” (English et al., 2021; Henley, 1891/2016, p. 57). Interestingly, here again agency features powerfully in key messaging to veterans and their communities. Altogether, the current research, as well as other examples and literatures, all highlight the importance of finding ways to cultivate an attitude of empowerment when supporting military personnel in their mental health recovery.

Despite the possibility of growth following trauma, it is not inevitable nor linear—it is the process of disruption to core beliefs and the resulting struggle with meaning-making that may result in posttraumatic growth (Calhoun et al., 2010). Participants in the current study frequently framed their recovery in ways that were considerably more nuanced than simply progressing through the NZDF mental healthcare system. While quest narratives have redemptive features, they are rooted in suffering, and they may nevertheless risk romanticising the mess of those that experience significant illness and injury. They can also risk deprecating those that do not live up to the “phoenix rising from the ashes” level of personal transformation (Frank, 1995, p. 135). Many participants in this study storied their distress as a protracted period of struggling alone and it took considerable time before their level of distress crossed thresholds significant enough to either seek support or be noticed by even those closest to them—aligning with literature on recovery in military personnel as being a dynamic, complex and iterative process (Acosta et al., 2018; Morgan & Desmarais, 2017). This poses considerable challenges to military healthcare systems that are tasked with either the expedient return of service members to full duty, or their removal from service through medical discharge (Iremonger et al., 2015).

### **Strengths and Limitations**

This study was qualitative and exploratory and therefore is not representative of all NZDF mental health experiences. Ongoing NZDF workforce research will be needed to confirm

statistical generalisability to the wider population. While there was broad representation of ranks in this study there was a lack of senior ranks and attitudes towards help seeking have been found to vary along this dimension (Gould et al., 2010). For instance, in NZDF research junior ranks endorsed more stigma barrier survey items that indicated lower intentions to seek help compared to senior enlisted and officers. Senior officers were found to most frequently endorse items associated with help seeking intentions (Boyd, 2017) and future research will be needed to establish if the recovery narratives found in this study extend to senior members of the NZDF.

There were no identified gender differences in narratives in this research, despite previous NZDF survey research identifying statistically higher help seeking intentions in female service members compared to males (Boyd, 2017). The gender composition of the participants in this study itself is possibly representative of a higher inclination to come forward and discuss mental health topics within NZDF— over half of participants but only 20% of the current serving NZDF regular force are women. Nevertheless, in this study the description of hiding distress was common to all participants irrespective of gender. All genders were represented in suicidal distress, and cisgendered males, females, and non-cisgendered individuals all described the challenge of crossing the help seeking threshold. Future research should seek to identify how differences in gendered help seeking intentions may translate into different rates of accessing care in NZDF personnel.

## **Conclusion**

This study identified stories of utilising the NZDF mental healthcare system from precipitating events to outcomes. The process of recovery was described as conferring many benefits for active-duty participants, however, the journey to being better-than-before was more complicated than simply accessing clinical services. The narrative arc of the participant accounts in this study have lessons for how mental health is discussed within military institutions, particularly around how service members can be empowered to reclaim a sense of agency within military mental health cultures, and how leaders can promote resources for meaning-making during times of struggle and hardship. The quest narrative fundamentally involves transformation and positive personal change and is a natural complement to the current generation of modern-day warriors.

## Chapter 7: Barriers to Care

This chapter presents results from participant narratives around the barriers they experienced connecting to care. The NZDF mental health system was often described as a paradox of both supporting and discouraging help-seeking. Participant narratives pointed to the universal experience of hiding mental distress and fearing the consequences of the help that was needed. Barriers to care narratives also highlighted how organisational policies and difficulties navigating healthcare processes prevented many from connecting to effective support. Participants' experiences of threatened social identity and of a sense of conditional belonging were central to why many were reluctant to seek help. The implications from this chapter, as well from the two published articles, are synthesised and discussed in Chapter 9 including implications for NZDF and well-being providers.

### Fighting Alone

#### *Internalised Barriers*

A universally told story by participants in this study involved hiding mental health struggles and trying to manage their distress alone: “The reason why I haven't been able to get the support I needed is 'cause of myself. It's not anybody else. It's me. They're reaching out with their hand and I'm not reaching back” (Participant O). Fighting alone with distress was pointed out by many participants to be irrespective of, and in direct juxtaposition to, the considerable amount of support on offer from the NZDF and from particular well-being providers:

It's kind of hard because like soldiers are stubborn and just think ‘oh nah, I'm all good’ when really they're not, but they won't do anything to help themselves...It's like psychs are doing everything they can, like advertising, coming around like talking to everyone like on courses and things like that. Everyone just sits back [crosses arms and leans away] and just hides away (Participant D).

Hiding away was a common form of avoidance and self-protection for many participants, either to protect their identity, their job, or to protect themselves from further distress. Several participants spoke to how well-versed they were at behaving this way in response to their own distress, and how difficult this was to change: “To be honest, it's quite exhausting. Especially when I'm trying to put a mask on like, trying to hide it, you know. And I'm pretty good at it now” (Participant G). Others described the expertise they had acquired at deflecting any suggestion of impairment:

Because that's what I've gotten good at for 20 some years man, you know, really good at just pretending, playing the part...And you just make fun of it, you just

make a laugh out of it; ‘Oh you’re a funny, you’re a happy guy’. Yeah man, it’s like the funny clown that’s fucken always depressed (Participant F).

Other participants described an aversion to drawing any attention to themselves for their problems, even though they could recognise the dysfunction of this: “I’m one of those people that, you know, trying not to make a big fuss about things and I’ll just kind of try to deal with it, just totally the wrong way of going about it” (Participant H). Such was the acquired expertise at appearing “fine” that many participants described that there was no way for any of their colleagues to have known that they were silently suffering to the extent they were:

I would have been the one in the room that was smiling the widest, laughing the loudest. Yet driving to work thinking, ‘Oh what if I just turned my car this way?’ Not because I wanted to, but because my anxiety was so intense at that time (Participant J).

Several participants described hiding distress deliberately so as not to be a burden on resource-stretched and time-poor teammates:

I had to ask for help constantly and need like someone to help me with my duties. And I just felt like a massive burden, and that I was, you know, worse than not being there at all...that was making me think that I didn’t belong...I just thought that if I asked for help I would be, that would be me being a burden. And I can’t have that (Participant W).

Other participants described that not revealing their distress was a source of professional pride for them, and that it demonstrated an unwavering commitment to upholding cultural standards:

I was pretty bad, I was real bad...like wake up crying every morning...Sleeping was just horrendous, just being in that deep, deep depression. I would go to work, be real terrible and as soon as I like turn the corner and head into camp then, boom. That facade would come over and I’d just be on point at work, nobody needed to know anything...I’m highly professional. I don’t think that you should be allowing your work life and your personal life to overlap (Participant Q).

One participant narrated a story of intense psychological confusion which prevented them from even knowing what to say to others: “I didn’t know what was happening with myself, let alone trying to explain it to someone else” (Participant M). This lack of understanding around their own mental health distress led many to not want to appear incompetent in front of others: “Because to

me it just felt stupid...is it really worth going to see [well-being providers] if I don't even know what's wrong with me? I knew something was wrong but I didn't know what it was” (Participant T). Some participants described that because of the state of distress they were in at the time, they were either not able to recognise that help was even an option, or they actively did not want help from the NZDF:

No, it didn't occur to me at all to get help honestly, like for me when I think about it, I was like I can get through this. I don't need help, like I can be strong, like I'm strong I can do it by myself, like all I've got to do is sit with my feelings and let it pass and do all that but I think it just got too much. And then I got too sad (Participant L).

Several participants felt that they blamed NZDF for being in the distress they were in, such as through their work duties having contributed to their relationship ultimately failing. For example: “I was really like I don't want support from NZDF. They're the reason for me being in this situation, my mindset was they're the reason I'm at this point” (Participant S). Irrespective of the diversity of participants’ backgrounds, genders, or the types of distress they experienced, hiding their pain from others and being alone with their struggles was common to all.

### ***Friction in the System: Fear of the System***

An important sub-plot in participants’ narratives of hiding their distress was the story around how they had learned to fear the consequences of seeking support. For instance, many participants felt like they had to protect their career from medical downgrades and release from service:

But no, I didn't reach out to try and get support...I was told that if you were ever in that position not to open up too much 'cause they'll, you know, you could get dismissed...I knew that in my mind as I don't want to say too much because they might kick you out or medically dismiss you or something. It's ‘not compatible with the Service’ or something like that. So I was pretty worried about that. I think it was in the forefront of my mind (Participant F).

Participants described many different structural barriers in the healthcare system. Despite sometimes wanting help, for some participants reaching out led nowhere:

One other time I rang helpline—the Defence Force helpline once—and I was very disappointed because I was really, really low and almost pretty much suicidal, so I rang the helpline for help and requested to see a counsellor and then the helpline

said ‘OK, give me give me your details. I’ll get back to you and I will assign one to you’—I never heard back from them. So I put a complaint in about that. It’s probably only thing I’ve ever complained about (Participant G).

The fear of consequences was often multi-layered, involving both a desire to continue to serve and also concern around the perceived unpredictability of how the healthcare system would respond to their distress:

And I felt like I was still very capable of doing my job and I didn’t want to put that at risk...I’ve seen my people, the people that I work with, get all of a sudden ‘You’re not deployable. You know, you’re taking meds or you’re having a rough time, you’re anxious’. And it really does depend on the doctor you get...I have seen what had happened to people who had put their hand up externally, and I wasn’t prepared to take that gamble ‘cause at that point I was still very focused on doing the best job I could (Participant D).

Fear of consequences was often compounded by the perceived difficulties of navigating the healthcare system. Some participants found the process of trying to access care stigmatising and demeaning:

The kind of continued stigma of me having to sort of go cap-in-hand to get extra sessions and continuously trying to—I’m having to explain myself, and I just don’t want to be doing this. You know, I shouldn’t have to go and explain myself like enough people in the organisation at high level know why I need to go and get counselling. I shouldn’t have to be going and keep explaining it, you know, I’m not making this shit up (Participant R).

Others found the process of trying to arrange appointments was enough to stop them from attempting to get help altogether:

There was a bit of avoidance around the idea of, you know, being on the blower and going; ‘I want to make an appointment.’—‘What’s the appointment for?’—‘I’m just upset’. You know?...I just didn’t want my name on the screen saying [name and rank] mental health reasons...there was just friction. I was probably looking for any reason to avoid it, and that was enough, that feeling of slight fear or you know, inhibition to wanna do it was enough for me to avoid it (Participant D).

Several participants described seeking different well-being services from outside of the NZDF healthcare system, either due to frustration with failed attempts with providers, or due to the sense of a lack of suitable options:

It just felt overall easier and it felt like I could find help that was more tailored to what I thought I needed...I felt like I wouldn't have that discretion if I did it through NZDF. I felt like it would be 'hey, if you're ticking the mental health box you're going to this guy'...I didn't feel that the NZDF was going to provide exactly what I wanted...I wasn't confident that they had the resourcing or the flexibility to offer it, that was simply it (Participant B).

Many different barriers prevented participants from initially accessing care, including hiding their distress, not recognising the signs of mental distress, and fear of the consequences. Crossing the help seeking threshold was challenging for all personnel and insurmountable for some, leaving participants to fight alone with their mental health distress.

### ***Surviving the Abyss***

Of the 21 participants interviewed, three described narrowly surviving suicide attempts serious enough to require hospitalisation. Other participants described events that on reflection were indirect suicide attempts, such as driving recklessly or riding a motorcycle in such a way that could very easily have ended in death. Many other participants described severe suicidal ideation and suicidal planning:

Like 'I literally don't want to be alive right now', and it's not that I wanted to kill myself, I just wanted my pain to end. And it was terrifying when you're in that moment. Because I was like, you know, this has been a battle for the last few years for me, like of me trying to literally survive my mind (Participant O).

Even despite well-being providers completing formal suicide risk screening, in some cases participants described lying about the extent of their suicidal ideation and planning:

[The support provider] had made me fill out a suicide awareness, a risk form as well, like a few of those paper works and things and I didn't fill those out honestly at all ... Yeah, so I lied black and blue through those suicide forms unfortunately (Participant Q).

Several participants adopted the same language that they used to describe their discipline toward service duties, and applied it to their description of their suicide attempt: "That just put me over the edge I think, that just broke me. And I'm just like, well, I mean. I mean, what's the point? You

know. And that just made me think. Yeah, just do it. Get it done” (Participant G). Participants described how they were able to leverage their military-trained abilities of discipline, planning, and focus, and orientate these same skills towards their decision to end their life. One suicide survivor described their determination to carry out their suicide:

When I made my decision, I went home and I packed some bags and I left because I didn't want my mum to come home from work and find me dead on the floor, so I actually took off. I turned my phone off. I didn't want to talk to anybody. I think I didn't want to talk to anybody because I didn't want somebody to change my mind. I had already made my decision of what I was going to do. And I knew what I was doing and how I would affect people to a certain extent like I knew I was going to break my mum's heart. But it's like, you know when you have the blinkers on? I don't think anything could have changed my mind...I just felt like there was nothing else for me that could help me. Yeah, it's just the head-space that I was in was so dark (Participant F).

Many participants described their mental health crisis as the worst period of their lives, and several were lucky to escape it.

## **Still not Helping**

### ***Barriers to Effective Care***

Despite accessing care, many of the same concerns that had kept participants away from accessing services in the first place also prevented effective treatment once they had entered the healthcare system: “Like I was a perfect little patient in terms of telling them what I think that they needed to hear because I wasn't ready to acknowledge that I wasn't well myself” (Participant N). Some participants reflected on how they hadn't truly been revealing the signs of how distressed they were to alert others to the seriousness of their struggles:

So I'll be looking at this [mental health continuum] framework, like ‘Hey bro, look I'm in the red here man’ but I'm saying it in a way that's like—‘Doesn't sound like it.’ You know, ‘You're joking about it’...I'm not giving the cues perhaps for the person to understand or take it seriously (Participant F).

At the time of their crisis many participants were unaware of how their “mask of competence” (Shields & Westwood, 2019, p. 425) prevented them from communicating their true experience:

I just felt like [the psychologist] wasn't taking me seriously, and I thought at one point I was like, 'What do I have to do for anyone to take me seriously? Do I actually have to go and try to kill myself for anyone to start like taking me seriously?' But I told my mum that and she said 'Maybe you're going in there with like a brave face and not, maybe you're just not communicating that properly'...I think that's extremely dangerous to be honest (Participant P).

Participants frequently described the painful tension of being in distress but also being stuck and afraid to fully engage with support:

This talks to the system itself I suppose. [The social worker said] 'Hey so, we'll get you some help. What do you want to do? I think we should have a break from work for a period of time.' I was like, 'What!?' And that's kind of a Catch-22 in your head. You're like, 'Fuck man if I do that. You know there's gonna be some troubles' (Participant A).

Many participants described the paradox of wanting help from medical and well-being providers, but simultaneously wanting to protect themselves from revealing too much: "It just makes you kind of keep quiet about things...Why would I tell you the truth when it could be potentially risky for me?" (Participant N). Several participants described the one-two punch and double-bind of having to simultaneously manage both their mental health distress and also the devastating effect that it was having on their careers:

When you're in crisis and you have the courage to put your hand up and potentially look for help, why are we telling people that their careers are potentially going to be impacted? Like that's just adding stress on stress on stress in that moment (Participant L).

Several participants had direct experience of the negative impact of medical consequences of support-seeking, either themselves or from helping colleagues get help:

So while this [service person] is literally in crisis and I finally get her to come with me to seek support in terms of a referral, to look to get medication, her biggest fears were met by, we're not going to refer you, and two, if you do go on medication your career's potentially looked at. So she walked out of there and she was just defeated (Participant K).

Making career-impacting decisions during periods of heightened distress significantly worsened the difficulties that many participants were struggling to cope with:

Getting asked what I wanted to do and if I wanted to leave the [service] or if I wanted to take time off, it really stressed me out. You know, like those are big decisions that you should not be making when you're in that sort of depressed state...I was just much more in like a state of like trying to survive (Participant J).

Many participants described the randomness of whether or not mental health professionals ended up being of any help to them: "I've had a fair bit of dealings with counsellors and things in the last probably 10 years. A bit hit and miss you know" (Participant G). Some participants reflected on how well-being providers had not engaged them in ways that led to meaningful support: "I don't really feel like he listened to what I said...He talked a lot, so most of the sessions were just him talking and me kind of being like 'yeah, yeah, well whatever'" (Participant S). Others found that providers were not trained to be able to provide a safe therapeutic container to support their acute struggles and crisis:

So it's like it was almost just a waste of time and I could see she was like visibly like squirming. She was like retreating into the corner of the room, going 'far out man I can't handle this kind of level of conversation' 'cause she's not, that's not what she's there for (Participant R).

Other communication failures arose from a lack of signalling appropriate cultural understanding or empathy, or by inadvertent inattention by busy providers:

It felt like [the support provider] was you know, like, almost going 'Oh no you just need to harden-up a little bit'. It felt like that. I honestly doubt if he would have said something like that, but it's just the impression I got. I felt like I was being told I needed to learn some techniques and, I needed to learn how to breathe properly or something like that, and I was just thinking like, 'I don't feel like you helped me at all'...I don't know if it was his tone or, it was like he was just waiting for the next patient to come in, and I didn't feel like he'd given me 100% of his attention maybe. It was kind of like swept under the rug (Participant E).

Where participants had been referred to external civilian providers, some described the lack of appreciation for the military context as a barrier to understanding and progress:

[Civilian providers] are not connected to the organisation so they don't have any preconceived ideas about anything. But the minuses are that you have to explain everything in great depth...they don't understand that you're in a job where you

could die, or your friends can die because it's just not something that they encounter or experience (Participant T).

A combination of lack of therapist military cultural understanding, the reluctance to reveal problems, and the limits placed on the amount of support that NZDF funded, all combined for some into a significant barrier to effective help:

That took at least three sessions for us to even start talking about why am I here to start talking, right? 'Cause you gotta build rapport with people...Then you find out, oh, you've only got 10 sessions. Well, I've already used a third of those on nothing really, so now I'm on the clock, right? It's the knowledge that there's a finite amount. That does not help, that compounds the issue. You're constantly on the clock. Everything is a race against time. Which induces pressure. You perhaps don't want to explain things as much as you would want to explain it 'cause it's like. Well, that took 12 minutes and I only explained one thing, so I'll just cut the next one short (Participant S).

Failing to connect with meaningful help caused a once-bitten, twice-shy effect (Seidler et al., 2020) for some participants which led them to reject using all NZDF support services altogether:

And I kind of like doubled-down on the [self-reliance] 'cause I found it hard to ask for help in the first place, I kind of double-downed, you know, it's hard-er to ask for help now, because you know when I did ask for help it didn't seem like I was getting it (Participant L).

Despite the many difficulties of initially crossing the help seeking threshold, once enrolled in the military healthcare system many participants failed to find the support they needed.

## **Identity and Culture**

### ***Threatened Belonging***

Interwoven throughout the stories of seeking and engaging in support were important threads of military culture, identity, and belonging. Participants storied their attitudes towards help seeking often as originating from their socialisation into the NZDF, especially during initial training experiences:

I was a little bit scared they were gonna say like 'oh if you can't deal with it then maybe the [service] isn't for you' because that's what the recruit instructors always said...So I was kind of scared I was going to get kicked out (Participant E).

Participants pointed to how fragile and tenuous they felt their place was within the NZDF—how it was hard won and easily lost (Vandello & Bosson, 2013): “One person can make one decision and that crumbles and shatters the foundation of what somebody feels is their identity” (Participant W). Some participants linked their difficult and troubled backgrounds to how they had derived a deep sense of meaning and purpose from being in the military: “Many of us are born with that huge hole in our identity” (Participant Q). This sense of belonging that being in uniform had come to represent was therefore precious and had to be protected at all costs:

The organisation, it breeds us to believe that our job’s our identity...once I got there [to my pinnacle role] I was like ‘I made it’ and so I hooked my name tag to that job and then I felt like this [mental health] bubbling up was a threat to that so I wanted to guard it as best I could...it makes it difficult to detach from your trade, your position...it's supposed to be more than a job, but it shouldn't become who you are. And I think that's a hurdle trying to link it back with people struggling with mental health because nowhere in that picture of any human or an aviator or a soldier or sailor does it say anything about, struggle, mental health and it's not what the image is (Participant D).

Other key experiences within the military training system were formative for learning what cultural rules applied to acceptable behaviour around help seeking, with some participants describing particularly distressing training episodes:

I asked for help from my manager on initial trade training. I got told that I was stupid...he made me crawl on the floor and speak to him through the wall grate, I wasn't allowed to open his door. I wasn't allowed to look at him... so I just felt a bit degraded because everybody else would just walk past me and they just laughed. It was kind of as if it was accepted. I shut down after that...that's the last time I talked to anybody about anything (Participant H).

Participants described how the culture of self-reliance and avoiding support was always around them, transmitted via various key phrases and particular culturally loaded expressions that implied being a burden to their unit and superiors: “To be quite honest, people see it as a weakness—‘You're seeing counsellors? What's wrong with you? Like, oh—you're an admin nightmare!’” (Participant I). Stigmatising attitudes were commonly communicated amongst peers: “Like you’re having a bad day or are you just being a bitch or something?” (Participant G). Leaders in various levels in the organisational hierarchy perpetuated this transmission, adding to a heightened sensitivity and fear of becoming labelled:

Like as with my soldier—it's like what are people saying about me? They're treating him like a nut job and I was exactly in the same situation. Comments the [commander] makes about him, they shouldn't be saying, like, 'Oh, he's just a problem 'cause he's got these mental health issues'. Or, 'He can't do his job because he's crazy'. And they'll laugh about it...what example is that setting for the soldiers or anyone below them? Especially when they make comments about him in front of other soldiers (Participant V).

Participants also discussed how entrenched stigmatising attitudes were in particular cultural sub-groups within NZDF: “I feel like it's just that tough-guy kind of act around their mates...They don't want to look weak, but it's not easy to change” (Participant I). Despite acknowledging the considerable efforts NZDF had gone to around mental health promotion, many participants were sceptical that stigma could be changed:

I know it's stupid, but that stigma, just sometimes we can't change it and I'm trying as a commander trying to change the stigma around NZDF psychs in my unit, in my soldiers, and trying to, but it's just it's still very pervasive and very much there (Participant L).

Combat trades were often talked about as bastions of hyper-masculine culture: “There's a reluctance and hesitance to talk about those things, particularly in those you know those more combat orientated arms where everybody is a tough-guy and we just gotta tough ourselves up” (Participant R). Adding to this complexity were the societal norms that participants felt pressured by, which were also discussed as acting directly against NZDF messaging around help seeking: “That speaks to other issues of you know the New Zealand male psyche where everything is just ‘harden up and crack on’” (Participant G). The threat to social identity was woven throughout participant narratives resulting in a pervasive sense of vulnerability to conditional belonging.

## **Tribal Values**

### ***Iwi versus Employer***

The NZDF's bicultural narrative of being an iwi was discussed by many participants as both a unique strength and a unique liability that added significant expectations about their sense of tribal membership:

You don't get this in the Australian Army or the Canadian Army or the British Army...here it's very clearly communicated from early on...We make a massive deal. We bring the recruits onto the Mārae. They go through the whole thing.

They're made to feel part of a new culture and I had recruits from Germany, from America, Poland, South Africa. All these different cultures. And we say 'Welcome. You are now part of a new culture'...NZDF sells the special idea of joining an iwi...you're joining a whānau. In Army you're in Ngāti Tumatauenga, you're in an iwi (Participant R).

Participants reflected on their sense of connection to NZDF and compared it to the strength of family bonds, making the sense of injustice when treatment and outcomes were poor that much worse:

And I literally left one family for another family, but that family had a lot of different rules and expectations...What's happened here isn't just loss of trust with people or an organisation, its family violence in a way, like this was my family that hurt me and changed me and when you look at it that way, of course how I feel is why I feel, these were my people, this was my home. And I've lost that (Participant M).

Participants variously described the perceived disconnect between espoused values around belonging and tribal membership, and organisational imperatives such as medical discharge. This contributed to a strong sense of cynicism in the corporate use of Māori values, such as when leaders used well-known whakatauki:

We say 'he tangata, he tangata, he tangata' [from the Māori proverb stating that people are most important]. And it's a joke. People go, 'he tangata—whatever'... and you see it everywhere. It's not just the remuneration thing either, you see it everywhere. The people are first—as long as the aircraft is airborne. If it's not, it's clearly not the priority...You can wear a pink shirt to work [as part of a well-being campaign] and you can forward on mental health [material/ emails] and come and have a sausage [during promotion events] and all the rest of it, but it means nothing unless when people like myself come to you and say, 'hey, I'm struggling' that you don't just fucken throw them to the side (Participant D).

Many participants struggled to resolve the paradox of how the New Zealand military could call itself an iwi with strong Māori values, yet simultaneously place seemingly arbitrary institutional limits on mental healthcare:

And this is the problem. Cause if I work for [a large New Zealand employer] Frontera or New World or the Post Office. I'm not joining an organisation that

openly portrays, you know you're in an iwi... We have mana. We have manaagakitanga. We encompass all these different cultural things right?... I wouldn't get that mantra and that mandate from Post or New World or New Zealand Rail. I'm just an employee doing a job within a thing right? But Defence sells itself—it prides itself—on this you know this whanau, this family, this organisation and you know. You dedicate your life to it. You may give your life to it... That's the story. And then the reality is, yeah, 'there's 10 hours of mental health treatment. You haven't managed to attain what you wanted to get? Well leave now or don't talk about it again. You've had your shot' ... It can't have its cake and eat it, unfortunately. That's a dichotomy for me and an issue that I don't see being resolved... they're just empty statements, you know. They're just empty statements (Participant R).

Overall participants felt that NZDF should be managing mental health care better than other employers in New Zealand, and that NZDF should be an institutional leader in mental healthcare practices: “We do have that heightened expectation that Defence should do things better than what society is doing, we should be role-modelling for the rest of the country... ..whanaungatanga, manaakitanga... that's far more important than you know a technical, you know policy or whatever” (Participant W). Other participants defended the limitations to the organisation's ability to provide care and championed the lengths the NZDF healthcare system went to for them, describing how NZDF was fulfilling its mandate to provide mental healthcare for its personnel:

I think Defence Force is on the right track... Yeah 'cause some people expect too much. You know, and like, there's only so much Defence Force can do. Their main role is deployments and you know, like serving the community and stuff like that. But there's only so much they can do, and what they're doing is, like enough. I mean, I can't think of anything else they could do. You know, like what? They're gonna give you like, fucken, a year off to go and sort your shit out? They can't really do that, you know. They can't really afford to do that for every person that's having problems... So you gotta be realistic about it too what they can do for you, and they're probably doing a lot more than what other employers would do (Participant G).

The paradox of iwi and employer added a tone of cynicism and mistrust to many participants' descriptions of their mental health distress, and many storied a narrative of disillusionment with the social promise which they felt had been offered to them and then broken.

## Helped and Hindered

### *Summary of Barriers to Care in NZDF*

Participants described a narrative of paradox when accessing mental health care through the NZDF system—it helped, and at times it made things worse. Engaging with the system was frequently stressful, disappointing, and added to the mental health strain participants were already experiencing. Fighting alone with sometimes extreme psychological hardship and pain was a common subplot across the diversity of participant experiences. Participants struggled with both needing help but fearing it. Personnel felt their belonging and identity were at risk and worried about the double-bind that if they sought help they would be kicked out of the tribe and lose the things they valued most. Participants described not trusting the randomness of the healthcare system, of maybe getting lucky and connecting with someone who understood them and was capable of helping, but often being reluctant to risk everything on that chance. Underpinning these narratives was the pervasiveness of resilience culture, of not being a burden, and of avoiding becoming the target of ridicule. The dominant cultural narrative of NZDF as an iwi was described as a unique aspect to the New Zealand military experience which many felt also came with additional tribal responsibilities around mental healthcare that were not being upheld. Paradoxically, despite the significance of their socialisation into the NZDF iwi, many participants felt the assuredness of their belonging was fragile and tenuous. Overall, the barriers to getting effective help in the NZDF were often found to be the shadow-sides of its many strengths.

## Chapter 8: Journal Article 2

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### Abstract

Research on military mental health recovery has tended to focus on therapy outcomes while backgrounding the role of diverse healing influences. The New Zealand Defence Force (NZDF) is a bicultural military integrated with Māori customs and cultural perspectives on holistic health and well-being. This study used narrative analysis to examine the semi-structured interviews of 21 active duty NZDF personnel who had accessed mental healthcare to understand what factors contributed to their return to wellness. Narratives described an orientation towards recovery as a process, where many interrelated well-being and social factors together supported the return to health. Culturally available Māori well-being metaphors were adopted as heuristics by service members in their storying of growth and healing. Findings are considered in terms of how well-being and recovery are conceptualised and promoted within militaries with diverse cultures. Discussion focuses on how narratives within military institutions can promote resilience and support service member recovery from mental distress.

### Introduction

Despite exposure to extreme circumstances and stressors most military personnel show a resilient recovery profile (Bonanno, 2021a; Bonanno, 2004a). Even in veterans with a high lifetime exposure to trauma, two-thirds nevertheless show low levels of psychological distress (Isaacs et al., 2017). Compared to the literature on barriers to accessing care and therapy outcomes, far fewer studies have focused on the factors that support successful recovery in military populations (Fikretoglu et al., 2022). Prior experience with therapy has been associated with treatment completion in U.S. veterans with PTSD (Maguen et al., 2019), and positive attitude towards treatment is associated with engaging in care (Adler et al., 2015; Britt et al., 2020), underscoring the importance of building trust in military healthcare systems. Positive attitudes toward help seeking have also been found to moderate the relationship between psychological distress and better mental health overall in a sample of New Zealand Defence Force (NZDF) personnel (Hom et al., 2020).

The understanding of rates of mental distress within the New Zealand (NZ) military and veteran community lags behind other nations (Veterans' Affairs New Zealand, 2022). While

NZDF personnel exhibit healthy soldier effects (McBride et al., 2022; McLaughlin et al., 2008), NZDF has a high proportion of at-risk groups for mental distress and suicidal behaviour, specifically young males and Māori (Stuart & Bennett, 2017). In a mixed active duty and veteran NZDF population (N = 1817; 56% current serving) 10% were identified as likely to have clinically diagnosable PTSD (Richardson et al., 2020), with Māori more likely to be at risk of PTSD compared to New Zealand European members. This is comparable to earlier research on NZDF Vietnam War veterans, which also found a 10% rate of PTSD (MacDonald et al., 1997). Anxiety and depressive disorders were the most common mental health issues leading to medical release from service over 2006 -2013 (9.2% of discharges) with PTSD leading to medical release in only 0.5% of discharge cases (Iremonger et al., 2015). More research is needed in order to understand both the prevalence rates and mental health protective factors in this important sub-population of New Zealand society (Cardow et al., 2021).

Relatedly, the socio-cultural environment in which military members reside can greatly affect their experiences of mental distress, help seeking, stigma, and recovery (Calhoun et al., 2010; Tedeschi & McNally, 2011). Culturally available narratives of trauma, coping and growth provide templates which can aid or hinder recovery in the aftermath of a crisis. Narratives provide a map to others that can guide them through the disruption of trauma (Frank, 1995) and sharing stories of recovery is an important part of cultural transmission—it provides a model and a cognitive tool for the teller and the listener to understand the journey (Cain, 1991, p. 215). In addition, culturally influenced cognitive styles—such as sense of agency, locus of control, and ascription of causality—can all affect the development of posttraumatic growth (Calhoun et al., 2010). Culturally prevailing attitudes towards spirituality and religiosity may also positively influence trajectories of recovery, for example by influencing expectations of growth following suffering through the familiarity with wisdom teachings and philosophies (Calhoun et al., 2010).

### ***NZDF Culture and Mental Health***

The NZDF is described as a unique fusion of British military tradition with Māori culture and customs (Bargh & Whanau, 2017; Hohaia, 2016; NZDF, 2023a). *Te Ope Kātua O Aotearoa* is the Māori language (*Te Reo*) description of the NZDF as the main warrior force for the people of Aotearoa New Zealand (NZDF, 2023a). The “best of both worlds” narrative (New Zealand Army, 2020, p. 14) recognises and honours the significant integration of Māori within New Zealand forces in conflicts since the First World War (Walker, 2012). Incorporation of aspects of Māori culture within NZDF is recognised to support operational effectiveness, for example by imparting significant Indigenous war fighting strategies and skills, and also predisposing NZDF personnel

towards diplomacy and cultural sensitivity in deployed environments (Bargh & Whanau, 2017; Hohaia, 2016; Scoppio, 2018). The NZDF approach to mental health is also integrated with Māori models of holistic well-being (NZDF, 2018; Nicholson et al., 2023), particularly *Te Whare Tapa Wha* (TWTW; Durie, 1985). Māori conceptualizations of health have been increasingly incorporated into New Zealand health services since the 1980s (Durie, 2011) with the simplicity of TWTW making it widely applied throughout New Zealand (McNeill, 2009). TWTW is a metaphor to describe the interconnection of four *taha* (walls) or domains of health; physical health (*taha tinana*), spiritual health (*taha wairua*), mental health (*taha hinengaro*), and social and family health (*taha whanau*) (Durie, 1985, 1994). From an indigenous perspective these four aspects of well-being are reliant on one another and without one the house would collapse (Kiyimba & Anderson, 2022). TWTW is a valuable heuristic in the New Zealand context to understand service-user narratives of their relationship to each area of wellness (Kiyimba & Anderson, 2022), while also providing a trauma-informed approach to engaging with Māori (Pihama et al., 2017). Embracing indigenous worldviews may additionally confer psychologically protective benefits, especially in the NZDF context. For instance, research with NZDF chaplains has found that a general acceptance towards spirituality within NZDF was largely attributable to the importance placed on *wairua* (spirituality) within *te ao Māori* (the Māori worldview) and its cultural adoption within NZDF (Hill et al., 2016). Despite approximately 5% of active duty members accessing mental services annually (Stuart & Bennett, 2017), there is a dearth of understanding around what is effective in supporting recovery from mental distress in NZDF service members. The current study adds to this gap in understanding around mental health in NZDF personnel by exploring narratives of what supported recovery in active duty NZDF personnel who had accessed mental health support.

## Method

Eligible participants in this study were active duty NZDF personnel who had completed a referral for clinical psychologist or psychiatrist support. Twenty-one active duty service members participated; 9 Air Force, 7 Navy, and 5 Army. Service experience ranged from 2 to 29 years and included personnel who had commissioned from the ranks, as well as those who had changed service and trade. Ranks included five officers and 16 non-commissioned (enlisted) personnel. Age range was between 19 – 52 years. Seven participants identified as Māori, 2 identified as Pasifika, and 12 were New Zealand European (*Pākehā*). Eleven participants identified as cisgendered women, nine as cisgendered men, and one participant identified as a non-cisgendered person. Participant experience of mental distress included; depression, anxiety, eating disorders,

combat trauma, PTSD, moral injury, self-harm, suicide attempt, survivor of sexual assault, relationship distress, partner/family suicide attempt and mental illness, personality disorders, military sexual trauma, alcohol use disorder, and ADHD. Several participants had experience of being admitted to either civilian or military mental health hospital wards.

This research used relational ethics and aspects of *tikanga Māori* (cultural protocols) to inform a culturally sensitive approach to qualitative research within NZDF as a bicultural setting (Hodgetts et al., 2021; Hopner & Liu, 2021). The centrality of narrative analysis aligned with Māori oral traditions of *korero* and *purakau* (storytelling; Ware et al., 2018) which also served to centre and enhance the *mana* (respect, status) of consumers of mental health services (Moekemaxwell et al., 2008; O’Hagan, 2001). Participants were engaged throughout using principles of *whanaungatanga* (cultivating trusting and genuine relationships). Outreach e-mail invitations were sent via NZDF well-being providers which built on established trust and existing relationships. Arranging meeting details with participants via phonecall initiated rapport building while also ensuring participants were eligible, had completed treatment, and were willing to proceed. Participants were invited to attend in comfortable civilian clothes at a preferred location to remove obstacles to open discussion (i.e., uniform), to encourage *manaakitanga* (demonstrating hospitality and care) and to enhance the experience of *hui* (fostering social gathering and dialogue). Consent was obtained prior to commencement of all interviews. The process emphasised to participants that confidentiality would be preserved in all outputs of the research. As an additional organisational level of *manaakitanga*, an NZDF order was put in place to protect participants from being subject to disciplinary action should any historic duty-breaches be divulged. This research was approved by the Massey University Human Ethics Board and the NZDF Organizational Research Ethics Board. Participation was voluntary and participants received no remuneration for taking part.

Tikanga Māori was incorporated into the in-person interviews<sup>4</sup> using an informal and semi-structured conversational format. Whakawhanaungatanga included welcoming participants into the conversation space by offering tea and coffee, and offering to start and close the session using a *karakia* (Māori prayer). These simple acts integrated respect for Māori cultural traditions around the transmission of knowledge over time (Ware et al., 2018). Interviews varied over 60 – 150 minutes and the opening question aimed to encourage a rich narrative description: “Can you please tell the story of seeking help through the NZDF mental health system?” Periodically

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<sup>4</sup> One interview was conducted via Zoom due to Covid-19 disruptions

participants were encouraged to provide more detail to their stories. For example, “Could you please tell me more about what else helped in your recovery?” All interviews were conducted by the first author. Use of *te Reo Māori* (Māori language) by participants was left verbatim in transcript sections and is italicised with translation in brackets on first appearance.

Analysis used a narrative focus (Murray, 2000; Riessman, 2008) and was influenced by Māori narrative techniques such as *kaupapa kōrero* which considers storytelling through an indigenous worldview (Ware et al., 2018). Recorded interviews were transcribed and coded by the first author, and analysed iteratively according to a-priori narrative elements, such as central characters, as well as by beginning, middle, and end (Frank, 1995; Riessman, 2008). Familiarization through the transcription and coding process allowed for deep immersion into the participant accounts and the identification of narratives and structures within the stories. Studies on New Zealand veterans’ experiences have acknowledged the value of research being conducted by “one of their own” from within the tribe (Cardow et al., 2021, p. 5). In this study the authors’ insider status as current and ex-serving NZDF members allowed for the easy development of rapport with participants during interviews, and a rich and complex understanding of their experiences (Hayfield & Huxley, 2015). This military cultural competence (e.g., Westphal & Convoy, 2015) was balanced with researcher reflexivity during frequent meetings among the authors during the analysis process (Riessman, 2008). Narratives are situated in particular historical, cultural, and institutional contexts (Murray, 2000; Wong & Breheny, 2018). Therefore, the analysis (interpretation) focused on how participants storied their recovery using available narrative devices (Radley & Billig, 1996). Analysis also attended to how storytellers themselves assigned causality—for example, how service members described what worked for them in their recovery (Riessman, 2008). In this way the narrative analysis was used as a “portal” into how participants understood and communicated their experiences (Hiles et al., 2017, p. 157).

## Results

Participant narratives of recovery involved complex interrelationships between different aspects of well-being: “Every single aspect of your life, will, in some way, shape or form affect the others you know, subtly or significantly” (Participant L). TWTW was frequently discussed by participants and used to story the mechanism of recovery: “It’s like building Te Whare Tapa Wha, the four walls” (Participant E). Given the prominence of Māori cultural principles interwoven throughout the narratives and practices of NZDF, results are presented heuristically using the four TWTW domains of health.

### ***Taha Hinengaro: Mental and Emotional Well-being***

The impact of participants' mental health distress was described using far reaching terms, touching all aspects of their lives including their work duties:

Your mental health and your sense of value and purpose and everything absolutely affects your productivity for your *mahi* (work). It absolutely affects your connections and your interactions with other people. It absolutely affects your spirituality or religion, whatever it is (Participant A).

Participants frequently storied their journey to well-being as an orientating towards recovery as an ongoing process: "I feel like you have to be in the right headspace to be able to help yourself" (Participant B). Participants also described initially rejecting this recovery orientation, or resisting the idea that their recovery would take time and effort: "I remember [the social worker] was like 'it's going to be a long hard journey [to recovery]'. I'm like 'I don't want a long hard journey, I just want to be happy now'" (Participant T). Many participants described hiding their distress in various ways, self-managing their struggles, and not accessing care initially: "A lot of the reason why I haven't been able to get the support I needed is 'cause of myself... it's not anybody else, it's me. Like they're reaching out with their hand and I'm not reaching back" (Participant E). Participants frequently described the process of their change in orientation as taking time and consistent messaging from others: "It took a while to realise where I was going, like just having to, I guess having someone there to kind of explain everything, over and over again, made me realise that, OK, yeah. I'm lost. I need help" (Participant I). This change in posture—from rejecting and avoiding help—to being willing to approach difficult activities associated with recovery was described in a variety of ways with some explicitly acknowledging the therapeutic value of this change:

Taha hinengaro, I do that in many ways, but one of the things for me is kind of like just creating discipline and pushing myself into things that I wouldn't normally do, like boxing, as much as I dislike boxing, I like being uncomfortable 'cause, it makes me feel like all the other things that are going on for me I'm able to deal with them...it's just that mind-over-matter thing really (Participant L).

Finding a clinician who participants were able to meaningfully work with was often described as critically important, which led some participants to seek support external to the NZDF: "It felt like I could find help that was more tailored to what I thought I needed" (Participant J). Participants described a qualitatively different therapeutic experience from finding a well-being provider that was right for them, once they were ready to engage in the treatment process: "I just feel like the

progress that I've made with [the psychologist] over this last year puts my first treatment to shame kind of thing. I'm just like two totally different people... I was in a completely different headspace" (Participant B). Participants also frequently described a change in work duties as providing a sense of agency and control: "I finally had a say around where I could go and what I could do with my career. I think that helped as well. I wasn't so powerless in my life" (Participant A). While work stress was a significant precipitator of mental distress onset, many participants described how a change in work duties often initiated new possibilities in their career and helped to provide a renewed sense of optimism:

At the time, I really didn't enjoy my job, I'm doing a different job now which I love and I feel like that had a lot to do with my healing as well because it was something that I enjoy doing (Participant V).

### ***Taha Whanau: Social Support and Relationships***

Taha hinengaro and taha whanau were frequently tightly intertwined and many participants described how their living situation instability was a key factor in the onset of their mental distress. Several participants told complex stories that involved relationships being negatively impacted by postings to other locations and the impact that had on their sense of well-being. Finding a place to live after relationship dissolution or posting to a new part of the country was often supported by NZDF well-being providers:

So I ended up talking to the padre and saying 'hey look, is there anything that you guys can do?' There was a lot of work done in the background with him and my boss as well. My boss was really helpful, and talking to like the housing department and they ended up getting us a married quarter (Participant B).

Participants universally described the importance of a variety of different relationships in supporting their recovery. Leaders and managers were often pivotal in providing for a reassuring climate around work duties whilst recovering. Participants also credited some managers as orientating them towards other resource and sources of support:

But it was my boss that said to me "look, I understand where your mind is at. But I also know how important it is to get out there and reconnect. Even if it's with people, with animals, or just nature" (Participant W).

Many participant recovery stories had at their centre an ongoing relationship with a well-being provider (e.g., medical officer, social worker, or psychologist). These relationships provided

regular formal or informal support (e.g., therapy, coffee dates) and an atmosphere of knowing that support was on hand if they needed it:

I feel like just [my psychologist's] reassurance of him being there, if I ever needed to talk to him while I was away [on exercise or duty] he was more than happy to find time out of his day to give me a quick zoom call anything like that. So I really appreciated that and he was sending me like more tasks and stuff to do while I was away too just like more exercises that I could try to see if they helped kind of thing. So he was really active, and I liked that there wasn't any pressure. He was just chill, was just like, "hey, I'm still here" kind of thing (Participant I).

Several participants described how important it was to have advocacy support by others (e.g., well-being providers, managers) to navigate organisational processes. This was especially true during periods of distress where many participants described how difficult they found it to accurately convey their experiences. A constellation of different and interconnected relationships often proved effective:

Having [the social worker] as someone to advocate, sit everyone down telling what the situation was, then having the external [psychologist] support to have a yarn to someone and learn those strategies. Have access to the doctors—I ended up getting on [medication]—so having them back you up with supporting what the psychologist and the social worker is saying and to give you the medical side of it, to let you then have three months, two months, one, whatever it happened to be, time to reintegrate (Participant F).

Other participants described connecting to other service members and peers in important ways that supported their narrative reconstruction during recovery. These connections came about both through formalised courses, as well as through informal opportunities during work duties where participants were able to re-story themselves back to their community:

I did this course [on Māori holistic well-being]. That was huge ... that course was amazing. Like the atmosphere, when you sit in a circle and everybody tells their story, it's like goosebumps it's. It's indescribable, and the connection that you feel to complete strangers in a circle and they're so vulnerable when they're telling you their deepest, darkest secret. Or you know the worst experience of their life and. Yeah, that was. That was really helpful coming out of that (Participant B).

Many participant descriptions revealed a rich network of characters and community that were important in their journey back to wellness:

It was the [service] Mārae and all the people working there, and it was my boss and my work friends—they were my biggest contributors to helping me get better, feel better, and just rebuild that positive mindset that I'd lost (Participant V).

***Taha Tinana: Physical Health***

As part of their recovery many participants described developing new routines or reinvigorating their relationships to existing coping mechanisms such as to healthy diet and exercise. Exercise in particular was frequently cited as a cornerstone to mental health recovery: “There's a few other tools that I've tried, but the exercise is probably only one that's really worked the best” (Participant M). Many described their recovery as a journey towards having a sense of greater stability in their lives:

A huge part in my recovery is working out. Found a new, like a passion for it, and I don't know. It's just really helpful and I was losing weight and I was feeling better about myself and, you know, endorphins and feeling good after it, and just getting a routine I think really helped me get back on track really (Participant B).

Other participants described that their recovery was built on the lessons from prior episodes of poor coping:

In the past I've kind of just drunk more, partied more. But this time I kind of focused more on fitness and so instead of punishing myself with alcohol, I punished myself at the gym. Lost a lot of weight. I feel like that's better than going down the other pathway. My eating was clean, all that kind of stuff was really focused (Participant L).

Many participants described that it was the process of trying different things that made the difference for them: “And then [my psychologist] gave me some guided meditations...And it was just like she just gave me so much, so much stuff. ... I felt like I was, you know, getting somewhere” (Participant E). Others described how several well-being interventions together complimented each other:

I did a little bit of yoga that made me feel a bit better...I have a breathing technique app on [my phone] I felt a lot better after doing that... And then I downloaded Headspace and the Defence Force obviously has a free subscription, which is awesome. ... just to complement the use of the antidepressants when I

first started taking them and that was really good and I thought this was amazing. Look how much benefit I'm getting from this now, I really need to keep doing this (Participant I).

### ***Taha Wairua: Spirituality and Values***

Interwoven throughout participant stories of recovery were narratives of meaning, values, and connections to spirituality. Spiritual well-being was described in especially salient ways by many Māori participants: “I always look at Te Whare Tapa Wha... if I've got the other three in-tune then my taha wairua is sorted. I let any one of the others go then that affects my taha wairua” (Participant H). Several Māori participants described how re-establishing a relationship to their identity and connection to Māori practices was essential to their recovery process:

I'm learning te Reo and doing the classes and things like that. Go back to my Mārae. And those are all like wairua spaces where you actually feel really good for your soul, I feel like. And so yes, yeah it really has helped. Māoridom and especially when you go through the Te Whare Tapa Wha stuff (Participant E).

Connecting to Māori practices was often discussed in terms of being deeply healing: “The sense of like deep, authentic, welcoming and feeling home” (Participant L). Some participants sought out explicitly Māori orientated therapies as part of their recovery, such as those delivered by *tohunga* (traditional healers), including *rongoa* (Māori medicine) or *mirimiri* (traditional Māori massage) and described their benefits: “And she's quite a *wairua* driven person, so she can feel things before you even turn up, so stuff like that...It's really, really nice and I feel really *tau* (settled and grounded)” (Participant M).

Participants frequently described their recovery as involving a shift in their personal priorities. This was often conveyed by positioning well-being to be of first-equal importance in their lives: “Yes we signed the line and we're here to do a job first and foremost, but our mental well-being comes before anything” (Participant N). Other participants described this change as one of the most important life-lessons they had learned:

So I'm just very much like your well-being and mental health is a priority and then your work and stuff is very much down here, it's so important to maintain that. And before that I was just like I didn't give a shit about mental health. I just didn't know anything about it. I was so naive to all of that, I'm glad I've learned that when I'm still relatively young ...I'm only realizing it now. I'm actually really grateful you know it's a good life lesson (ParticipantA).

Perhaps like on a spiritual level you just feel it. After everything that I had just been through, I knew that I had to start putting myself first more. I needed to push for it. I need to fight for it (Participant B).

## **Discussion**

This study used narrative analysis to explore participants accounts of what supported their mental health recovery in 21 active duty NZDF personnel. Narratives involved developing many interrelated well-being factors that together supported the return to health. The well-being metaphor of TWTW became adopted and re-storied by service members in their descriptions of recovery, revealing the influence of institutional-level narratives on individual stories (Murray, 2000). The results from this study align with prior literature that highlight the protective effects of holistic orientations to military mental healthcare, as well as the importance of framing resilience and recovery as ongoing processes (Bonanno, 2021b; Schott, 2022).

### ***Holistic Well-being in Military Cultures***

The recovery narratives in this study have important connections to other studies that show the protective effects of holistic well-being concepts. Prior research has identified that religion or spirituality can be a protective factor for people following trauma exposure, as a potential avenue through which to find meaning and to support a readiness to face existential issues (Shaw et al., 2005). In one review of military posttraumatic growth, the most commonly reported statistically significant association was between ethnicity and posttraumatic growth, with higher posttraumatic growth occurring for members of ethnic minority groups (Mark et al., 2018). One possible explanation for this finding is a greater emphasis on spirituality among ethnic minorities. Prior research in NZDF has identified how the permeation of wairua is an accepted part of wider New Zealand military culture (Hill et al., 2016), possibly contributing to a protective aspect of the broad acceptance and integration with concepts from te Ao Māori in the New Zealand military context. Māori service member descriptions in this study and in others (Kohere, 2022) also reflect important indigenous health principles of establishing balance between all interconnected aspects of well-being (Durie, 1985; Kiyimba & Anderson, 2022). Important features of well-being described by participants in this study connect to western military mental health models, notably Comprehensive Soldier Fitness (CSF), which also includes social, physical, emotional, family, and spiritual domains (Seligman & Fowler, 2011). Critiques of CSF have included an apparent bias toward individualised psychology at the expense of social factors and the backgrounding of protective relationships (Lang, 2022). CSF rebranded to Comprehensive Soldier and Family

Fitness (CSF2) in 2009 which included more focus on relationships—noting that “a soldier is only as fit as his loved ones” (Peterson et al., 2011, p. 16). This change in emphasis does highlight an important contrast to indigenous models such as TWTW, however, in that far from being a suite of individualised interventions, indigenous wellness derives fundamentally from collectivist ways of being (Rua et al., 2017). As previously noted by Durie (1985), for Māori a sense of secure identity is located within the group, and tribal affiliation is a fundamental building block of health. While TWTW leverages the metaphor of four walls, it is “an artificial separation predominantly for the benefit to non-indigenous people who have not been raised with a worldview that seamlessly integrates self, other, place and spirituality” (Kiyimba & Anderson, 2022, p. 352). While participant narratives in this study described aspects of the four domains of health as important factors in their recovery, it was the essential interconnectedness of well-being behaviours intertwined with supportive relationships that altogether supported their return to health. The findings from this study have important implications for how well-being and recovery are conceptualised and promoted within militaries with diverse cultures and more generally as a paradigm of maintaining fitness for duty.

Participant narratives also pointed to the importance of military healthcare systems connecting service members to resources that are best suited to their diverse cultural needs. For instance, many participants in this study described the criticality of finding a well-being provider which they trusted, leading some participants to seek this outside of the military healthcare system. A choice of provider with military cultural competence has also been noted to be critical in a qualitative study with active duty U.S. soldiers (Cheung et al., 2016). A meta-analysis by Oldham et al., (2012) found that providing patient choice of therapist increases attendance rates in psychotherapy which also aligns with findings from a barriers to attendance study in veterans with PTSD (Browne et al., 2021). Participants in this study also described the richness of healing experiences found in alternatives to clinical interventions, such as *wānanga* (communal Māori learning environments), as safe spaces to share and wrestle with complex emotions. There can often be a lack of recognition and acknowledgement of the impact of the loss of social structures that provide for safe and appropriate ways to express emotion and share, bond, and heal—so called “collective ceremonies” (Van der Kolk, 2014, p. 402). This is also seen in work with U.S. veteran group therapies that facilitate psychological safety and engagement in the work of emotional processing (Shields et al., 2017). The findings from this study point to the importance of continuing to identify culturally appropriate interventions that support service members in addition to the current range of therapeutic options.

### *Resilience as a Flexible Process*

Participant descriptions of their change in willingness to orientate towards recovery as a process aligns with the literature on psychological flexibility as an important protective and healing factor in military personnel. Recent scholarship has described a resilience paradox, in that while a large number of factors have been associated with resilience, the ability to predict who will have resilient outcomes using these factors remains modest (Bonanno, 2021b). The ability to flexibly respond to stressors in an iterative way is argued to be more important than the specifics of resilient traits per se—for example the ability to respond to stressors and then update responses based on situational factors is more important than any list of specific resilient behaviours (Bonanno & Burton, 2013). This aligns with prior research that emphasises psychological fitness and flexibility in the military, which aims to provide service members with the ability to be adaptive under complex circumstances (Bates et al., 2010). Participant narratives also reflected aspects of the military literature on hardiness (Bates et al., 2010; Hammermeister et al., 2010) as a learnable set of attitudes including a sense of agency and openness to change (Bartone, 2006). Participants described in various ways how they were initially opposed to the change involved with recovery, such as engaging in treatment, and how through often a socially supported process they developed an openness to engaging in therapeutic behaviours. Many participants also described the experimental nature of figuring out what worked for them—trying different interventions. Relying on rigid coping strategies can potentially become problematic as the demands of the situation change, for example adopting emotional suppression on the battlefield but requiring emotional disclosure in intimate relationships (Bonanno et al., 2004b). Psychological flexibility (PF) has been found to be a protective factor in a sample of retired and active duty NZDF personnel, where participants who scored higher on a measure of PF exhibited reduced odds of PTSD (Richardson et al., 2020). New Zealand soldiers have also been found to show better emotion management, reduced substance use and lowered aggression one month following an intervention designed for developing PF (Harvey et al., 2017; Harris, 2006) demonstrating that developing PF is an acceptable intervention to support resilience in NZDF personnel.

Several participants described a paradox in their recovery when navigating dual priorities of commitment to service duties and personal well-being as both fundamentally important. A clash of cultures has been noted to exist between the military and mental health cultures (Bryan & Morrow, 2011) and increasingly it is recognised that providing culturally competent care for military requires the appreciation of this tension and dynamic by mental health providers (Riggs

& Mallonee, 2017; Westphal & Convoy, 2015). For example, within the *Way of the Warrior* handbook (New Zealand Army, 2020) on the same page are listed apparently opposing behaviours that are “expected of soldiers if they are to live up to the Army’s values”: “a willingness to sacrifice oneself for the mission, unit or comrade”; and “asking for help when you are struggling” (p. 50). This seeming values-clash can be confusing without the necessary skills to navigate this dichotomy (Castro & Kintzle, 2014). Other authors have noted that tension between collectivist and individualist values often present in clinical therapy, where one approach is to learn to adopt a more flexible approach to rule rigidity—and to ensure that rules are freely chosen (Fung, 2015). This approach is in alignment with critiques of traditional approaches to mental health promotion which recommend getting away from trying to convince service members to go against their beliefs, and instead to deliver mental health services in a way that is complementary to existing values (Bryan & Morrow, 2011). NZDF has released resources in this vein such as *Staying At The Top of Your Game* which incorporates many of the themes around mental skills training and framing mental health education as performance enhancement using a strengths and growth mindset focus (New Zealand Defence Force, 2023b). Given the reality of values conflicts in service life, PF remains an important area of focus for both proactive skill building and as part of the recovery process.

### ***Limitations***

This study focused on NZDF personnel who had accessed mental healthcare, and therefore did not capture all relevant well-being experiences of service members who had not accessed clinical services. Future studies should include a broader population of the NZDF community in order to fully appreciate the “indigenous assets” that exist within the NZDF population (Schott, 2022, p.185). In addition, TWTW was not intended to take into account all variables that impact on health and well-being (McNeill, 2009), for example the influence of leadership styles on mental resilience and recovery (Bartone, 2006). While this study identified the adoption by participants of TWTW as an organisational narrative, future studies should investigate how other aspects of organisational culture influence NZDF personnel in their recovery from mental distress.

### **Conclusion**

This study adopted a novel approach to exploring and understanding what worked for active duty personnel in their mental health recovery. Participants described a variety of well-being behaviours that they found helpful—in addition to therapy—which provided a synergistic effect aligned with the Māori model of well-being TWTW. Central to most narratives was an

orientation towards recovery and resilience as an ongoing and flexible process, which required a degree of personal discovery using trial and error. Interwoven through descriptions of recovery was the prioritization of health and well-being as first-equals with service, resulting for some in a narrative of paradox. The results from this study support interventions which aim to equip service members with proactive tools with which to navigate challenging values conflicts in the line of duty, to ensure that those who serve also have the tools to serve themselves.

## Chapter 9: Discussion and Implications

This chapter summarises findings from across the three results chapters and discusses their clinical and organisational implications. This thesis added several novel contributions to the literature on mental health help seeking by NZDF personnel. Participants described a hero's journey of recovering from mental distress and becoming better than they were before. Mental health recovery involved the synergistic interconnection of many different well-being behaviours as well as supportive relationships. The NZDF mental health system was described in paradoxical terms that both helped and hindered participant recovery. Woven throughout participant stories were important aspects of social identity, culture, and belonging, and the NZDF narrative of *iwi* evoked for many a profound sense of tribal membership that included expectations of immutable tribal membership. The findings from this research identified both good news and bad news for the NZDF, as participant narratives revealed many positive and supportive factors within military healthcare, as well as many tensions and dilemmas. This chapter provides recommendations on how care for NZDF personnel can be addressed by clinicians and other well-being providers using masculine and military culture-informed practices. The chapter concludes by providing recommendations for NZDF narrative messaging and policy considerations.

### Summary of Key Narratives and Findings

#### *Better Than Before*

Participants described their recovery from mental distress by adopting the hero's journey narrative structure, which involved recognition of the need to change, resistance, suffering, receiving support to cross the help seeking threshold, growth and transformation. The journey of recovery was described as helping personnel to become better-than-before—more caring, more attuned to others, better leaders within the NZDF, and better humans more generally. Participant stories in this study share many similarities to the positive changes in posttraumatic growth told by earlier generations of New Zealand veterans.

#### *Holistic Recovery*

Participants adopted TWTW as a key heuristic to describe building up their house of well-being during their recovery. Participants described learning to adopt an orientation towards recovery as a process of skill-building that required experimental trial and error. What worked for NZDF personnel in their mental health recovery was the interconnectedness of many different well-being behaviours intertwined with supportive relationships. A change in values was described as one of living a more balanced life with paradoxical first-equal priorities of well-being

and service. Combined, the two over-arching narratives in the articles in Chapters 6 and 8 identified many different aspects of care and practice that were effective in supporting NZDF personnel in their recovery. This represents a story of success for the military mental healthcare system.

### ***Helped and Hindered***

Participant accounts of getting support were also a narrative of paradox, as the NZDF mental health system both helped and hindered during their period of distress. The participant mental health experience was frequently storied as one of fighting alone with their struggles. Participants described having learned to fear the healthcare system, with many different cultural and healthcare barriers adding to the friction of crossing the help seeking threshold. Fears and attitudes that had prevented participants from initially seeking support were still present as barriers to effective care once they had entered the healthcare system. The mask of competence could not be easily dropped when participants were in crisis; they had learned resilience skills, but not the skills they needed to get effective help.

### ***Identity and Belonging***

Both barriers to support-seeking and barriers to effective care were intimately interconnected with elements of identity, culture, and belonging. The best-of-both-worlds narrative of the unique bicultural orientation of the NZDF was storied as both a strength and a responsibility which participants frequently felt was not being honoured. The paradox of joining the tribe was undercut by a fragile sense of conditional belonging, and the narrative of iwi led to a sense of moral injustice when participants found themselves treated as mere employees. These findings represent opportunities for NZDF to improve the practices, policies, and messaging that support service members who experience mental health distress. The key narratives and contributions of the research project are summarised in Table 3.

**Table 3***Key Narratives and Contributions*

<b>Key Narratives</b>	<b>Finding</b>
Better than before	NZDF personnel storied their mental health recovery using the hero's journey.
Holistic recovery	Mental health recovery in NZDF personnel involved many different well-being behaviours and supportive relationships, in addition to therapy.
Helped and hindered	The NZDF mental health system contributed both support and difficulties to NZDF personnel in mental health distress.
Identity and belonging	Barriers to effective care were interwoven with issues of NZDF culture, identity, and belonging.

**Navigating Paradox**

Overall, participants in this study described many different tensions and dilemmas in their narratives of help seeking, consistent with the paradoxes of military service (Castro et al., 2015). Values conflicts are likely to always be central to the military experience—service life and warfighting are inherently filled with ethical dilemmas (Held et al., 2019; Hill et al., 2016). The review of military culture identified that cultural strengths become vulnerabilities to help seeking when overused and uncritically examined (Westphal & Convoy, 2015). In many respects the participants in this study did exactly what they had been taught to do since day one of joining and in alignment with the NZDF values: They persevered when things were emotionally tough, pushing themselves to their limits and sometimes beyond (Courage); they sacrificed themselves so as to not add to their teammates' already full plates (Comradeship); they were committed to their roles and would not risk abandoning their mates or their responsibilities even though they were functioning but suffering (Adler & Castro, 2013; Castro & Kintzle, 2014) (Commitment); and they learned from their mental health experiences and in many cases shared these lessons back to their communities (Integrity; NZDF, 2023a). In a culture that values “a willingness to sacrifice oneself for the mission, unit or comrade” (New Zealand Army, 2020, p. 50) participants in this study did exactly that. In fact, arguably, participants behaved as one might expect in an organisation where “combat readiness is at the heart of what the NZDF does” (NZDF, 2023c, p. 10) and how NZDF “trains to win in war” (NZDF, 2017, p. 13). As several participants so aptly

articulated, the image that is portrayed of the modern NZDF warrior does not include mental health struggle. From the perspective of the warrior ethos (Coker, 2007), participants' willingness to drive through adversity is representative of their socialised will-to-fight (Lander et al., 2019) and while it resulted in fighting alone with psychological hardship, this appeared to be interwoven into the very processes of joining and being socialised into the NZDF culture.

Military service is well known to involve paradoxical institutional aims and messaging, (Molendijk et al., 2016). On one hand NZDF must prepare personnel for war, on the other hand it must do everything it can to mitigate mental health risk (Health and Safety at Work Act, 2015). Untreated mental health distress can pose a serious threat to operational outcomes especially in high risk deployments (NZDF, 2014), and many participants in this study described the hidden cost their distress was having on their duties. The double-bind that NZDF personnel are in is also written clearly in NZDF training material—"willingness to sacrifice oneself" and "asking for help when you are struggling" (New Zealand Army 2020, p. 50). Supporters of military personnel and veterans must come to understand and appreciate these paradoxes if they are to have any chance of providing effective care (Castro et al., 2015). Continuing to send out discordant mental health messaging, such as just reach out, places an expectation on those within masculinised military cultures to voluntarily act counter to how they have been trained, which either denies or fails to appreciate the influence of cultural mechanisms on behaviour (Seager, 2019). Several participants invoked the term Catch-22 to describe their dilemma—continue to hurt alone behind a mask or attempt to access help but risk losing their job (and identity, and tribe) and endure that instead. This perceived no-win situation contributed to many participants in this study staying stuck in their psychological hardship while avoiding the additional stress of accessing help.

### ***The Dual Agency Dilemma***

Participants in this study described in a variety of ways how they had learned to fear the NZDF healthcare system. Many described being socialised against help-seeking early on in their careers and how they had internalised an orientation of emotional self-management that dissuaded them from even considering help-seeking. Adding to this was fear around the unpredictability of the healthcare system, leaving many who were not prepared to shoulder the additional uncertainty of unknown help-seeking consequences. These fears align closely with the most endorsed reasons for not accessing help identified in both NZDF and ADF research around loss of operational opportunities or career penalties (Boyd, 2017; Forbes et al., 2018). The review of the impact of involuntary medical discharge also showed the often terrible psychosocial consequences for veterans who are medically removed (Australian Institute of Health and Welfare, 2022; Burdett et

al., 2021). Given how much is at stake, it is understandable that during their period of heightened mental health distress and vulnerability, participants in this study did not feel robust enough to take on such a hugely destabilising personal risk. Building trust in military healthcare is therefore a considerable challenge when that same system is responsible for the loss of medical gradings, and at times, careers (Heyman et al., 2022). As has been acknowledged, the nature of warfare demands a high level of physical and psychological health from personnel which means that “discharge and release from service is an inevitable and necessary part of business” (Iremonger et al., 2015, p. 82). The necessity of medical fitness for duty means that the risk of termination due to mental health issues is likely to remain a barrier for many that need help (Gould et al., 2010). Military healthcare providers are left with a paradoxical institutional narrative they must navigate in order to persuade personnel into care which often only acknowledges one side; asking personnel to trust the healthcare system—but quietly reserving the right to medically dismiss. In NZDF this dissonance is largely left unspoken by the institution and it intersected with the narrative of belonging and *iwi* which left many participants in this study feeling betrayed, morally injured, and openly telling their peers to not trust the system. In the NZDF, medical discharge due to a mental health issue is rare, but whether honest transparency and communication around these facts would positively change perceptions or cause inadvertent backfire effects remains to be empirically investigated. Trusting the paradox of military healthcare that offers no guarantees is therefore understandably difficult. Personnel need to “see through first-hand experience that receiving care for either a physical or mental health need does not adversely impact their career” (Castro & Kintzle, 2014, p. 6). The recovery stories in this thesis are testimony to how much the NZDF healthcare system supported personnel, often during the worst time of their lives. However as many participants expressed, the first step is the hardest, and some proportion of personnel may never choose to take it.

### ***Changing Attitudes***

NZDF puts considerable effort into training and resources around recognising the signs of mental health distress and where to get help (Bennett, 2019; NZDF, 2023b; Stuart & Bennett, 2017). Several participants in this study stated that they clearly thought NZDF was doing everything that it possibly could to support its personnel, one participant even saying they thought NZDF was doing more than what any other New Zealand employer would do. The results of this study therefore present a considerable conundrum around how best to encourage NZDF personnel to access care earlier, when every participant described fighting alone with their distress for considerable periods, sometimes decades. Personnel either failed to recognise what was happening

to them, did not remember support was an option, did not want any support from NZDF, thought they could deal with it, or feared for their careers, identity and belonging. Participants variously described how before their mental health struggles they could not identify with mental health messaging and in many cases fundamentally rejected it. Evidence is mixed that providing mental health literacy on recruit training has any impact on help seeking, and positive effects may be negligible even under the very best possible training conditions (Fikretoglu et al., 2019). Perhaps it is simply too much to expect that a few hours of classroom-based intervention could reverse the weight of societal (Goldstein, 2001) and institutional (Daley, 2013) norms, the force of social identity threat (Veldman et al., 2021), and the social pressure (Kashdan, 2022) during one of the most transformative indoctrination processes of recruits' lives (Arkin & Dobrofsky, 1978).

Ironically, the very skills needed to navigate military values clashes were learned by participants actually going through the transformational crucible of their own mental health distress. Posttraumatic growth seems to enable the holding of paradoxical sentiments, for example the idea that “while I am more vulnerable I am also stronger” (Tedeschi et al., 2015, p. 504). Participant stories in this study align with military posttraumatic growth reviews showing how the softer skills of tend-and-befriend (Taylor et al., 2000) can often be acquired when core beliefs are disrupted. Participants in this study also reflected how posttraumatic growth can facilitate becoming more comfortable with intimacy and compassion (Tedeschi et al., 2015). These findings are striking when positioned against the traditional masculine culture of truncated emotional range and expression, particularly in military populations (Shields, 2016; Shields et al., 2017; Goldstein, 2001). Stories of participant growth and positive change in this study therefore point to how important it may be to proactively strive to develop these capacities so that personnel can more readily face the many paradoxes inherent in their duties (Castro et al., 2015).

#### *Encouraging Psychological Flexibility*

Participant narratives in this study found that, like many veterans, NZDF personnel were not equipped to navigate the many conflicting mixed-messages they had been exposed to (Castro & Kintzle, 2014). Understood through the social paradigm of NZDF warrior values, enduring suffering and hardship are celebrated, not sacrificing oneself for comrades fails to live up to the highest ideals of the tribe, and suffering for others is noble and to be encouraged. Understood through mental health culture, however, establishing boundaries and implementing self-care practices are prized and encouraged, unnecessary suffering is to be avoided (Bryan & Morrow, 2011), and not taking responsibility for one's own escape from suffering is akin to being stuck in the chaos narrative of unresolved distress (Frank, 1995, 2004). Traditional military resilience

programmes have been criticised for promoting a one-sided positivity narrative that constrains and curtails any acknowledgement of the harsh realities of service life (Schott, 2022). NZDF and its community of well-being providers cannot simply expect personnel to have the necessary skills to be able to confidently manage conflicting and confusing cultural messaging while they are in crisis; to be able to both endure hardships (e.g., “embrace the suck”; Adler & Castro, 2013, p. 44) and to express emotional difficulties (e.g., “open up”; Seager, 2019, p. 236). A more proactive approach to acknowledging paradox and values tension may be one way to signal support for the inevitable stresses that these discordant plots cause in the lives of military personnel. NZDF service members are already known to grapple with existential issues such as killing and being killed in the line of duty (Hill et al., 2016) and war can often require personnel to violate some of their most deeply held moral values (Held et al., 2019). Being honest with this complexity acknowledges that to some extent, this is the price of entry for being part of the warrior community (Goldstein, 2001).

Military personnel would benefit from proactively learning skills that target values conflicts and dilemmas, even in the absence of experiencing mental health distress (Castro et al., 2015). For instance, Dialectical Behaviour Therapy (DBT) specifically adopts an orientation to navigating paradox (e.g., acceptance and change), teaches distress tolerance and emotion regulation skills (Linehan, 2016), and has been found to be effective when used within the U.S. VA system (Landes et al., 2016). Another third-wave therapy approach, ACT, emphasises that suffering during the experience of double-binds is completely normal and to be expected, and helps to develop psychologically flexible behaviour repertoires to navigate values conflicts (Nieuwsma et al., 2015). In addition, developing the ability to either flexibly express or suppress emotions dependant on the appropriateness of the context has been found to be predictive of emotional adjustment over time (Bonanno et al., 2004). As previously discussed, psychological flexibility has been found to be protective for New Zealand military personnel and veterans (Richardson et al., 2020), and specific training in psychological flexibility has proven useful for current serving NZDF personnel (Harvey et al., 2017). Learning to adopt a more flexible approach to rule rigidity, and to ensure that rules are freely chosen (Fung, 2015), may offer an alternative approach to always self-sacrificing, always sucking it up, and always being in a no-win conflict between the military culture and the healthcare cultural paradigms.

The importance of learning to flexibly alternate between what is required during times of demand and recovery align with important concepts within both te Ao Māori and modern high performance psychology. Māori conceptualisations of warriorship are intimately connected to a

balance between the house of *Tūmatauenga* (the god of war) and the house of *Rongomātāne* (the god of peace): “With the warrior of old, it was never just about the ability to wage war, it was also about the ability to wage peace – it was just as important to be skilled in that area” (Wallace, 2023, p. 18). Māori Vietnam veterans have described the psychological costs to them of being stuck in a mental state of war on their return home from deployment: “When you teach a person to kill and you haven’t taught the person how to come out of that area...kind of deprogramming or in Māori terms, *whakanoa*” (Reynolds & Smith, 2009, p. 31). Similar periodised cycles of stress balanced with recovery are recognised as essential within high performance domains (Kellman, 2010), and deliberate recovery forms part of the basis of military psychological fitness (Bates et al., 2010). By teaching personnel to more flexibly apply the values of military culture when the situation demands, personnel may still “knowingly risk their life in the service of a job they love” (Frisk, 2018, p. 908), and during other periods, be able to rest and recover knowing that mental well-being is supported and can be prioritised.

### **Helping Personnel Cross the Threshold**

The importance of social support as a key enabler of mental health help seeking is acknowledged to be particularly important in military cultures (Forbes et al., 2019). Peers and well-being supporters were critical in this study for helping participants access care and cross the help seeking threshold, some participants even describing how supporters had been literally life-saving for them. Several participants described the key turning point in their narrative was often a serendipitous chance encounter with friend or well-being provider. This aligns with research on the critical “coincidental other” in connecting male survivors of suicide to mental health support (Seidler et al., 2021, p. 7). In a similar way NZDF chaplains have described their effectiveness in supporting personnel through building up trusting relationships with soldiers by being actively involved in units, engaging in physical training and exercises, and by “loitering with intent” (Hill et al., 2016, p. 72). Embedding mental health providers on units is one way to foster trusting relationships and reduce stigma by bringing care to the individual, allowing for early recognition of issues, and ensuring continuity of care throughout the deployment cycle (Schaefer et al., 2022). This approach aligns with how participants in this study also described how important it was for their recovery to have someone alongside their recovery journey, such as an expert companion (Tedeschi et al., 2015) who appreciated the challenges associated with mental health distress in the military. The U.S. Air Force has found that the presence of embedded providers increases accessibility, awareness, and credibility by providers having an increased familiarity of unit tempo and the specifics of their mission (Martinez et al., 2023). Increasing the presence of supportive

relationships where personnel spend most of their working time may increase the chances that vital support encounters will take place.

### *Peer Support*

In the same way that the health system both helped and hindered, peers and leaders in this study were both storied as key allies as well as key sources of stigma. Partners and friends have been found to be important connectors to mental health support in ADF (Forbes et al., 2018) and NZDF research (Poulter, 2021; Bennett, 2019). The potential of empowering military relationships has also previously been stressed by New Zealand Army soldiers; “comradeship and courage go hand in hand. You don’t have courage without your bros” (Kohere, 2022, p. 90). In New Zealand veterans research, contact with other veterans has been found to be destigmatising and facilitated connection to support services (Austin et al., 2020). However, positive or negative outcomes in veterans have also been found to tightly pivot on important social attitudes. For instance, regard and status for military service—or social rejection and alienation—have been found to be important aspects of New Zealand veterans’ post-war experiences (Hopner, 2014). Personnel in this study found that while peers were important helpers in their journey, they were also the ones most likely to communicate stigmatising attitudes or to tell personnel to stay away from healthcare. Similarly, many leader behaviours in this study were storied as dichotomously stigmatising or supportive, either communicating disdain for soldiers with mental health issues, or conversely helping to connect them to a huge variety of support resources across the full breadth of TWTW.

Social safety signals are argued to be especially important facilitators of help seeking in military studies, and having peers and leaders who can make it psychologically safe and acceptable to seek help is a critical enabler of unit help seeking culture (Pury et al., 2013). Given the centrality of teams and camaraderie in military culture (Pressfield, 2011; Westphal & Convoy, 2015) attitudes towards mental health help seeking are heavily influenced by mates and unit climate. Unit-level peer support training that addresses how to help “battle buddies” access care has been found to be effective at increasing self-reported supportive behaviours in U.S. Army personnel (Britt et al., 2018, p. 287). Likewise, peer supporters have been found to be central to the success of U.S. VA programmes (Cohen et al., 2012), integrated posttraumatic growth programmes (Moore et al., 2021), and in group therapy where camaraderie and the sense of supporting fellow participants is described as “soldiers helping soldiers” (Shields et al., 2017, p. 221). Leveraging comradeship ensures that, as key gate keepers of accessing care, peers and

leaders are empowered to be supporters of help seeking rather than bastions of attitudes that make the problem of stigma worse.

### *Empowering Access to Support*

As the *Invictus* poem so notably captures—“I am the master of my fate” (Henley, 1891/2016, p. 57)—the journey of healing is frequently a transformation from hopelessness to agency (Adler, 2012). Military service often involves the removal of considerable autonomy and choice from soldiers (Harvey et al., 2017), so it is not surprising that many participants in this study described that reclaiming a sense of agency was a key subplot of their recovery narrative. NZDF personnel are known to want to take control over their own mental health recoveries (Boyd, 2017) and across NZDF surveys around one quarter of personnel agree with statements that they would not seek mental health support through NZDF (Bennett, 2019). Several participants talked about how important it was to remove the structural barriers to accessing mental healthcare and how the military system felt disempowering when it came to accessing appointments, having to humbly ask for mental health appointment approval, and feeling like they could get tailored support to their needs and preferences if they went outside of the NZDF system. Additionally, participants felt pressure in their therapy sessions to resolve their difficulties as fast as possible given the policy constraints placed on the number of sessions they could receive. As discussed in Chapter 2, the Canadian military’s success in closing the help seeking gap has been attributed to massive investments in improving access; doubling the number of mental health clinicians and investments in flexible policies such as out-of-hours and telehealth services (Fikretoglu et al., 2018). Closing the help seeking gap within NZDF is therefore likely to require sophisticated solutions that include providing increased options across both military and civilian providers (Fikretoglu et al., 2022).

Offering the choice of uniformed or civilian provider based on personal preference has been described as crucial by U.S. veterans (Cheung et al., 2016). Choice of therapist has been shown to reduce drop-out in civilian studies (Oldham et al., 2012) and in veterans with PTSD (Browne et al., 2021). Encouraging choice also leverages positive military action-orientated tendencies (Seidler et al., 2018; Westphal & Convoy, 2015), may be protective against PTSD when it reduces avoidance (Neilson et al., 2020), and emphasises a strengths-based attitude of taking control of the mental health journey (Neilson et al., 2020; Seidler et al., 2018). Making it easier to get help via any pathway may significantly contribute to building trust in the military healthcare system—NZDF personnel have been found to show higher help seeking intentions if they have accessed support in the past (Boyd, 2017). Several participants described how it was

only on their second or third attempt at therapy that they connected with a provider that was right for them, which unlocked significant breakthroughs in their journey. Many Māori participants in this study described how beneficial it was to connect with providers who could support their mental health recovery from a te Ao Māori perspective. Empowering a tailored approach to therapy options aligns with general recommendations to improve the range of choice of mental health treatments in New Zealand (Government Inquiry into Mental Health and Addiction, 2018) and with specific recommendations for New Zealand veterans (Patterson, 2018). Empowering military personnel with a meaningful choice of mental healthcare providers would promote agency rather than current policies which offer a take-it-or-leave-it approach (Castro et al., 2015). Increasing the appeal of mental health support by encouraging true agency may tip the balance in favour of personnel crossing the help seeking threshold (Crawford et al., 2015).

## **Improving Therapy**

### *Military Cultural Competence*

The importance of providing culturally competent therapy when supporting military personnel has typically been ignored or underappreciated (Westphal & Convoy, 2015; Atuel & Castro, 2018). Participants in this study described both the advantages of civilian therapists, such as being removed from the prying eyes of the military system, but also the downsides of low military cultural competence in civilians which detracted from focusing on important clinical issues. Increasingly it is recognised that providing culturally competent care by mental health providers requires the appreciation of the tensions and dilemmas military personnel face when struggling with mental distress (Riggs & Mallonee, 2017; Westphal & Convoy, 2015). While NZDF has historically employed general scope psychologists, at the time of writing in 2024 it is only just beginning to introduce uniformed clinical mental health expertise and relies on civilians for much of its clinical mental healthcare. Less than 20% of surveyed mental health professionals across the United States were found to have high military cultural competence in one study, and those who were culturally competent may not have been able to deliver evidenced-based care for common military mental health struggles (Tanielian et al., 2014). Military cultural competence requires that practitioners develop an understanding of the intersection between masculine gender and military cultural norms, and to integrate appropriate communication and methods into their practice (Atuel & Castro, 2018; Shields & Westwood, 2019). The Uniformed Services University (2023) has provided an online course aimed to inform practitioners of the impact of military culture on how clients may present in therapy. Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has recently established the Military and Veterans' Mental

Health Network (MVMHN) to support culturally competent service delivery (Lane & Wallace, 2020). Further research on how best to support NZDF service members from across the community of current providers (e.g., Hinton et al., 2021) may also ensure that valuable cultural lessons are made available to those support military clients.

### *Engaging Military Clients*

Even when in care, participants in this study described having trouble “dropping the mask of competence” once they were finally sitting in front of support providers (Shields & Westwood, 2019, p. 425). In addition to providing evidenced-based therapies for soldiers and veterans, approaches from across a variety of orientations that account for, and align with, military culture may provide fruitful ways of ensuring engagement with service personnel (Zwiebach et al., 2019). For instance, one approach (Radically Open DBT [RO-DBT]; Lynch, 2018) treats issues of over-control such as rigid, rule-driven and perfectionist behaviours and has been successfully applied to military cultures where veterans are taught to relax their guard and improve social signalling to facilitate more supportive relationships (Hempel et al., 2018). This approach places more emphasis on a paced and structured way of developing the therapeutic alliance than other behaviour therapies, given that overcontrolled clients tend not to readily communicate perceived weakness or emotional vulnerabilities (Lynch et al., 2015; Luoma et al., 2018). Other approaches such as those from within ancient Stoic philosophy have been described as therapy for those who hate therapy, for example by adopting more masculinised language such as becoming a warrior of the mind (Robertson, 2022). Framing and therapeutic tone from this tradition may more readily align with the military cultural orientation towards emotional resilience, and Stoicism shares the same philosophical underpinnings (Murguia & Díaz, 2015) and exercises (e.g., exposure, cognitive distancing) with CBT (Robertson & Codd, 2019). Importantly and in-alignment with participant narratives in this study, writing interventions based on facilitating a quest structure in personal narratives have been found to be associated with lowered depression and improved wellbeing in civilian samples (Rogers et al., 2023). Explicitly encouraging military clients to restory their struggles as part of their own hero’s journey may be an important values-congruent way to positively engage military personnel in therapy and to encourage their own sense of agency and meaning-making.

In addition to ensuring that military personnel receive the best therapy help they need, it is essential for well-being providers to examine their own biases and potential for a culture-empathy gap when supporting military personnel (Lane & Wallace, 2020). Some participants in this study found that well-being providers either failed to engage them in culturally appropriate ways or felt

that they were being blamed for their struggles. Overall therapy experiences described by participants in this study were extremely varied. Approaches to mental health treatment for those from masculinised cultures have tended to focus on changing the talking behaviour of clients, rather than changing the listening behaviour of providers (Seager, 2019; Seidler et al., 2023). U.K. counsellors were found to have biased attitudes towards those from masculinised cultures, and imposed particular forms of expression that were more feminised, prior to training in gendered ways of expressing help seeking (Seager, 2019). Disparaging therapist attitudes can stigmatise military personnel further by subtly blaming them for their distress while ignoring the impact of their culture (Shields & Westwood, 2019). Several participants in this study described leaving their mental health appointments having lost faith that therapeutic support was of any relevance to them.

The way in which care is expressed to clients from masculine cultures is also an important therapeutic component, as softer styles of empathy expression can be interpreted as “babying” and implying an inability to handle one’s own problems (Shields et al., 2017, p. 221). Paradoxically, under supportive and culturally-sensitive conditions, therapeutic interventions can become realigned with military-culture ideals of “being courageous”, “doing hard work”, and a place of “battle for [the] heart and mind” (Shields, 2016, p. 71). Similar sentiments were expressed by some participants in this study, referencing their therapy experiences as being aligned with military and masculine language and jargon. Tailoring well-being interventions includes the use of military or masculinised language, a strengths-based framing, and the celebration of military achievements, while minimising clinical language, a focus on problems, and the implication of weakness (Shields et al., 2017; Seidler et al., 2018). Adapting language and messaging to align with military cultural values restores dignity to the individual and brings to light inherent cultural capacities and convictions that enhance service members’ ability to cope with difficult mental health experiences (Shields & Westwood, 2019).

## **Improving Messaging**

### ***Spreading Good Stories***

As discussed earlier in the thesis, successful interventions in military populations align their messaging to be in accordance with existing values and beliefs (Bryan & Morrow, 2011). The narrative of recovery storied through TWTW in this study demonstrated how personnel can take ideas and motifs from within the available culture and adapt them to help explain their mental health journey. Narratives provide a map to others that can guide them through mental health

disruption (Frank, 1995) and telling stories of recovery is an important part of cultural transmission—it provides a “model and a cognitive tool for the teller and the listener to understand the journey” (Cain, 1991, p. 215). Other culturally aligned mental health heuristics could similarly be promoted in the interests of providing the community with narrative templates to easily access during times of distress. Perhaps the most important message to come from this and other similar studies is that mental health treatment-seeking in the military context is fundamentally an act of courage (Pury et al., 2013). For instance, narratives in this study found that there was plenty to be afraid of—participants described being scared of the healthcare system, afraid of their thoughts of self-harm, scared of the risk of stigma, and scared about possible career impacts. However, it was the act of approaching these fears head-on that contained the revelation that frequently shifted participant perspectives. Moral and psychological courage are required to face up to the emotional experience of mental health treatment and to overcome the urge to want to avoid it (Kushner & Sher, 1991; Paige & Mansell, 2013), particularly the fear associated with addressing mental health healing such as through exposure therapy (Pury et al., 2013). Courage is required to risk the threat of stigmatised social rejection and possible career impact in order to live according to one’s values and pursue what is considered the right thing to do (Pury et al., 2013). Indeed, one of the main determinants of help seeking in a U.S. Army longitudinal study was agreement with the item “it takes courage to get treatment for a mental health problem” (Adler et al., 2015, p. 348).

Leader messaging can similarly support hardiness in military personnel by providing ways of interpreting challenging experiences (Bartone, 2006) and can enhance posttraumatic growth by providing ways of making meaning following trauma exposure (Wood et al., 2020). Military well-being providers have been encouraged to fit messaging to conform with a positive framing of masculine archetypal behaviours, for example; taking action is taking control, strength and discipline are needed to master setbacks, and looking after your health and energy is also protecting your family and your mates (Seager, 2019). In several examples of personal courage in this study, participants shared their “good stories” (Frank, 2004, p. 82) of mental health recovery back with their units, which encouraged other personnel to come to them for advice and support. Improving trust in the mental health system can often involve sharing examples of positive stories, such as the many contained in this research. Interestingly, no-one in this study described seeking help explicitly because they had heard a good story of help seeking from another service member. There were plenty of examples of participants sharing stories of the downsides of help seeking, which suggests that either bad news stories are more frequently communicated in the cultural

transmission within NZDF, or that good news stories were not as memorable or salient for the participants in this study. More could therefore be done to communicate successful help seeking stories within NZDF to facilitate the cultural expectation of growth and health following mental distress and hardship. In particular, video interviews of soldiers who had sought help and recovered were found to be an important part of unit training that changed attitudes towards providing positive peer support in U.S. soldiers (Britt et al., 2018) and visible mental health champions can role-model supportive behaviours to others (Acosta et al., 2014). The narratives in this study and others point towards the utility of mental health messaging that frames help seeking in terms aligned with existing masculine norms such as courage and overcoming hardship (Shields & Westwood, 2019). NZDF values (2023d) and their recommended framing to enhance well-being messaging are shown in Table 4.

**Table 4**

*NZDF Values and Wellbeing Framing*

<b>Value</b>	<b>NZDF description</b>	<b>Wellbeing framing</b>
Courage	Having the strength – moral and physical – to do what's right, even in the face of adversity. Speaking up when you see things that are unfair or wrong. Admit when we're wrong, and to try to be better.	Taking control of your own well-being journey takes courage. Approaching challenges head-on is essential for growth. Getting expert advice is a health and well-being enabler.
Commitment	Doing your best. Looking for ways to get the job done, and sticking with something even when it feels impossible. Working together in difficult situations.	Getting better over time takes commitment—there are no shortcuts. Learning effective well-being skills and implementing them regularly takes commitment.
Integrity	Conducting yourself honestly, ethically and to the highest professional standards – even when no one is watching. Accepting responsibility. Learn from failures and help others to avoid the same pitfalls.	Integrity is taking ownership of your own mental health journey. Taking accountability for your health and well-being supports your operational readiness.
Comradeship	Respecting what makes people different. Treating others as you'd like to be treated. We are a family. We work together as a team, recognising we are stronger together. Comradeship is about being inclusive.	Maintaining your personal well-being leaves more in the tank to give to your family and team. Everyday comradeship involves role-modelling to mates how we stay healthy while managing challenges.

Leveraging NZDF values is one way to help recast mental health messages to communicate to personnel that they are indeed relevant and aligned with their existing beliefs (Shields & Westwood, 2019) while also indirectly normalising and validating engagement with support (Seidler et al., 2023).

### ***It's Not Just You***

Institutional tensions lie at the heart of the stigmatising predicament for military personnel (Acosta et al., 2014; Britt, 2000; Lefeber & Solorzano, 2019), and they are unlikely to go away. In their audit of U.S. military mental health policies, just under half of all policies (47%) were found to potentially make stigma worse (Acosta et al., 2014). By failing to bring these policy contradictions out into the open, the cultural narrative that remains is often that the problem of stigma is simply “all in your head” (Lefeber & Solorzano, 2019, p. 17)—the problem of a disordered individual—rather than the inevitable consequence of being in a potentially no-win situation. Narratives in this study often reflected the internalising of the institutional dilemma when participants described how conflicted they were about getting help and how they felt like they had been in a no-win situation. While each participant storied their distinctive wrestling with the military mental healthcare bind, this challenge was common across all narratives. However, the potentially soothing knowledge that this is a common and shared experience for many NZDF personnel was something that participants were fundamentally blind to. By messaging honest recognition of the challenging reality personnel are in, it may paradoxically help to normalise and relieve personnel of some of the stigmatising burden of believing there is something uniquely wrong with them when experiencing the predictable anxiety of being in an institutional predicament (Castro et al., 2015; Eldridge & Fraser, 2019).

### ***Invoking Māori Values***

Perhaps the most confronting narrative tension in this study was around the conflicting views of whether the NZDF actually has the mandate and capacity to enact the responsibilities that claiming iwi affiliation entails. Hohaia (2016) in her examination of te Ao Māori learning in NZDF pointed to similar questions in the institutional adoption of some visible cultural practices but not others, describing this as “spectacle without substance” (p. 50). Importantly, these policy issues were found to have real world consequences for the service members in this study, as during the most vulnerable time of their lives personnel discovered that the premise on which they thought they belonged was found to be much more contingent than they realised. The invocation of “Māori warrior culture” has been termed the martial race myth, and its use as leverage to encourage Māori into the military can be traced to at least the First World War (Walker, 2012, p.

1). Historically, Māori were never full time soldiers; they were members of the community first— gardeners, hunters, fishermen, tohunga (healers), artists (King, 2003) and when occasion to fight arose the whole community would support the preparations for, and return home from, war (King, 2003; Webster, 1998). Walker (2012) notes how the social construction of the Māori martial race myth has been exploited and used to goad men into war in the past and how it remains alive today within NZDF as an invocation of warrior forbears under the *tapu* (sacred designation) as “the fighting sons of Tumatauenga” (p. 1). The ongoing Māori branding of the NZDF serves to promote the idea that the New Zealand military is welcoming to Māori, and appeals to identity as a recruiting mechanism (Bargh & Whanau, 2017). Many participants in this study, both Pākehā and Māori, storied their NZDF identity as being deeply and vitally important to them, but also as completely vulnerable to loss.

It is initially difficult to see how the contradictory messages of employer and iwi could ever be resolved. The best-of-both-worlds story is highly valued by NZDF (e.g., New Zealand Army, 2020); however, the sloganeering of Māori whakatauki by senior leaders in this study was met with eye-rolling cynicism. This led to huge backfire effects of mistrust (Lefebber & Solorzano, 2019) and participants storied the NZDF as selling the idea of iwi, but only when convenient. This may actually require that organisational realities and employment definitions are proactively clarified in order to ensure that false expectations are not inadvertently set up—or left ambiguous by, but nonetheless advantageous to, NZDF. While employment may be temporary, and to some extent unavoidably transactional, the action of joining the metaphorical tribe of those who have ever served is indeed irreversible. Even after active duty service ends, this sense of belonging can last a lifetime (Cardow et al., 2021). These two understandings should never be confused however, as implying certainty when dispensability is the reality actually worked to destabilise the sense of social safety for many participants in this study.

## **Conclusion**

### ***Aspirational, Not Resolvable***

This thesis sought to understand the experiences of NZDF personnel accessing support through the military mental healthcare system and discovered much to commend and also much to progress. Despite research (e.g., Fikretoglu et al., 2022) and commentary (e.g., Acosta et al., 2014) celebrating improvements in access to care and reduction in stigmatising attitudes, everyone in this study described struggling with these very same issues in the present day NZDF. Fear of help seeking is sometimes pejoratively storied as just an “old-school” military mentality that we

need to grow out of (e.g., Hinton et al., 2021, p. 105). However, that fear was described by every single participant in this study, challenging the notion that help seeking barriers are a relic of the past—no, struggles to get help were found to be contemporary aspects of modern day service. Even in allied militaries that have poured tremendous resources into removing structural barriers to care by improving access and availability, stigmatising barriers remain (Fikretoglu et al., 2018; Hinton et al., 2021). Despite investing in an exceptional military mental healthcare system, personnel may still not use it. While the positive mental health outcomes of personnel in this study should be celebrated, things that get in the way are inherently woven into the fabric of the NZDF, and the concerted effort needed to shift these should not be underestimated. Both top-down (leadership and organisational) and bottom-up (individuals and peers) approaches share responsibility for positive mental health culture (NZDF, 2014). Any one of the numerous double-binds military personnel experience is enough to prevent help seeking (Castro et al., 2015), and skills from across a broad variety of therapeutic orientations may be needed to effectively support military personnel and the paradoxes of their service (Tedeschi & Moore, 2021). Similarly a one-size-fits-all approach to reducing stigma's impact on help seeking is unlikely to be effective (Williamson et al., 2019) and there is no one magic bullet that will finally close the gap between those who need help and those who get it (Acosta et al., 2014). Perhaps it is impossible to expect in a culture that values strength that help seeking will ever be truly destigmatised (Eldridge & Fraser, 2019). Nevertheless, and in line with the NZDF value of courage (sticking with something even when it feels impossible; NZDF, 2023d), continuing efforts to support personnel in their mental distress and recovery must remain aspirational even in the face of the potential unresolvability between the warrior and the healthcare paradigms. This is how to embrace the paradox of providing mental health support in the military.

## Chapter 10: Conclusion

This chapter provides a summary of the recommendations resulting from this research collated from both journal articles and the preceding discussion chapter. Recommendations include helping personnel cross the help seeking threshold, improving therapy for NZDF personnel, improving mental health messaging, and training service members to navigate values tensions and the paradox of service. Closing reflections include some indications of how the valuable lessons contained within the participant narratives in this project have been disseminated to NZDF well-being providers and to the wider military mental health community. Finally, reflections describe how conducting this research as an insider to the NZDF and veteran community proved to be a uniquely challenging and validating experience.

This thesis sought to understand the experiences of NZDF personnel accessing mental health support and identified a web of conflicting narratives service members must unknowingly navigate in order to get effective care. These mixed messages are not necessarily deliberate, or sinister, they are the natural result of NZDF having dual agendas and personnel inevitably get caught in the middle. Taking an oath of service is a highly venerated enactment of warrior values, and several participants spoke about the considerable sacrifice that their service had entailed. Juxtaposed against this were participant stories of the challenges of getting help and connecting to care that supported them when they needed it. The mental healthcare system worked, but personnel were concerned about its unpredictability, and in several cases participants were lucky to survive their mental health crises. When personnel did connect to care that was effective for them, they began a process of adopting a variety of different well-being behaviours and connecting with supportive relationships which altogether supported their recovery and positive transformation.

This thesis is ultimately presented as a story of hope. A narrative sub-plot told by many participants in this study was that if you become unwell in the NZDF, your social identity is under threat. A refreshed organisational narrative is possible, however; one that describes how service can challenge you, change you, and grow you. Another sub-plot told by many in this study was that accessing care can be unpredictable and untrustworthy. A new organisational narrative might empower personnel to be in control of their own mental health journey with support tailored to their specific preferences and needs. A subplot of fear described how personnel worried their mental health issues meant they did not belong in the military, whereas a new narrative might say that everyone brings their history with them into the warrior community, and what matters is learning to successfully navigate the inevitable paradoxes and challenges that service life will

bring. Instead of impossible to fulfil employment expectations, a refreshed and realistic narrative is possible of modern day employment that is separate from—yet inherently connected to—a lifelong belonging to the New Zealand veteran community. Table 5 provides a summarised list of the research and organisational recommendations from this thesis.

**Table 5**

*Recommendations to NZDF*

<b>Focus area</b>	<b>Key points</b>
Help personnel cross the help seeking threshold	Embed support providers on units where there is a need to increase the likelihood of incidental well-being interactions.
	Conduct peer support training.
	Empower connection to support options by making it easier to book and access appointments.
	Encourage agency by allowing personnel to choose their preferred well-being provider, e.g., civilian, uniformed, Māori.
	Research senior officer experiences of accessing mental health support. As there were no senior officers in this research, investigate if senior officer narratives align with the current findings.
	Research gendered-healthcare use. Investigate if statistically higher help seeking intentions in NZDF female service members (Boyd, 2017) translates into actual higher rates of care use.
Improve therapy	Provide and require military cultural competence training for civilian providers, including in areas such as military culture and dilemmas, how to examine provider bias, and education around language use.
	Ensure the availability and provision of a variety of recommended therapeutic approaches, for example, DBT, ACT, RO-DBT, and approaches that facilitate posttraumatic growth.
	Invest in alternatives to clinical interventions, such as wānanga, whakanoa, and other social healing rituals.
	Investigate NZDF well-being providers' experiences of care provision, their lessons, and their perceived barriers to providing effective care (as per Frank & Born, 2021).

Focus area	Key points
Improve messaging	<p data-bbox="655 271 1380 421">Empirically investigate if communication around the facts of mental health release from NZDF service positively improves perceptions or causes backfire effects.</p> <p data-bbox="655 434 1380 555">Provide clarification around care provision and boundaries, including honesty around employment limits to care.</p> <p data-bbox="655 568 1380 689">Clarify institutional messaging around the differing roles of NZDF as an employer versus the wider veteran community as a metaphorical iwi.</p> <p data-bbox="655 703 1380 741">Align mental health messaging to NZDF values.</p> <p data-bbox="655 754 1380 857">Make posttraumatic growth stories within NZDF more salient and visible to facilitate the cultural expectation of growth following mental distress.</p>
Navigate values conflict	<p data-bbox="655 875 1380 949">Acknowledge and normalise dilemmas and values-tensions in military service.</p> <p data-bbox="655 963 1380 1113">Provide psychological flexibility training and teach specific skills that target values conflicts and dilemmas, even in the absence of experiencing mental health distress.</p> <p data-bbox="655 1126 1380 1272">Clarify paradoxical messaging during training and in training materials, i.e., what does it mean when personnel are expected to both sacrifice for others and seek help when needed?</p>

In addition to this list, over the course of this thesis many sources were consulted that included lengthy lists of recommendations on how to improve military healthcare systems, included here for completeness: Recommendations on research to improve pathways to care in allied militaries (Fikretoglu et al., 2022); how to improve stigma in the U.S. military (Acosta et al., 2014); U.S. soldier recommendations on improving military mental healthcare (Cheung et al., 2016); improving military suicide prevention policy (Lefeber & Solorzano, 2019); and positive framing of mental health literacy as mental skills development (Bryan & Morrow, 2011).

### Closing Reflection

This thesis has been unexpectedly cathartic for me, and the process of conducting this research while still serving offered some unique opportunities and challenges. As I described in the opening orientation around my motivation for engaging in this research, I knew that just speak up styles of messaging were discordant, but I could not have appreciated how deep the reasons for

that were before doing this thesis. The amazing thing is that I feel like I have finally come to understand these areas that have bugged me for over 20 years, and over 8 of those years as a military psychologist doing my best to support other service members. Appreciating these dilemmas would have been helpful somewhat sooner in my career and has led me to be motivated to broadcast these lessons to those who will hear. In the course of this thesis I have therefore delivered the following conference presentations and workshops based on the results of this research: At the 2023 NZDF social worker conference; 2023 annual NZDF chaplains conference; 2023 annual NZDF psychologists conference; a Zoom presentation to the International Initiative on Mental Health Leadership, which included participants from RAND, Phoenix Australia, New Zealand Veterans' Affairs, and the U.S. military; a Zoom presentation to Te Kiwi Maia, a veterans and first responder charity; a workshop on NZDF well-being provider implications for chaplains, social workers, and psychologists from Ohakea, Linton, and Trentham; and a workshop presentation to the Massey Psychology Clinic students and staff, Manawatu Campus, Palmerston North. Finally, I was hugely honoured to be invited to present to the *2024 APA Division 19 (Military Psychology) Research Summit* and participate in a panel discussion based on the journal article in Chapter 8 *Narratives of Holistic Recovery* (Grimm et al., 2023).

### ***From Barriers to Care—To Identity and Culture***

The creation of this thesis has been somewhat of a transformative journey for me. Through witnessing participant stories and engaging deeply with the issues contained in them, the focus of this thesis has morphed and changed. My initial thinking, reading, and the writing in Chapter 2 focused on military mental health in terms of rates of mental distress, barriers to care and treatment outcomes. I discovered of course that the participant accounts often had at their centre issues around the deeply human need to belong. The further I ventured into the interviews the more interested I became in exploring issues around gender socialisation and the influences of culture. A key turning point was discovering Joshua Goldstein's *War and Gender* (2001), particularly Chapter 5 "Heroes: The making of militarized masculinity" (p. 251). This helped me to appreciate participant stories of struggling to connect with help as narratives of identity and fear of loss of belonging. Arthur Frank's *The Wounded Storyteller* (1995) was instrumental in pointing me back to the ancient narrative story form of the hero's journey made famous by Joseph Campbell (1949/2004). Catherine Riessman's *Narrative Methods* (2008) was instrumental in helping me appreciate the power of personal stories to confront institutional assumptions. Through this process I have grown my thinking from individualised service members' experiences, to

much broader political questions around what stories are important to tell around mental health distress in the NZDF in contemporary society.

### ***The Personal Nature of Insider Research***

Being an active duty psychologist while researching this topic, and also training as a clinical psychologist, offered some unique challenges and benefits. I have been struck by how often I have come across disparaging attitudes held by clinicians that misunderstand military culture, and while I have endeavoured to speak up and offer my perspective, there is clearly a broader need for education around this in New Zealand. I was pleased to discover the Military and Veterans' Mental Health Network, and helping my civilian colleagues to develop military cultural competence is something I remain committed to. Feedback from NZDF well-being provider colleagues who had referred personnel to this research was that participating in the study had been a therapeutic and validating experience for many participants. This affirmed for me that the lengths sought to provide participants with cultural and organisational safety (i.e., the DFO[T]) were indeed justified.

Finally, and deeply personally, during the writing of this thesis in 2023 one of my colleagues and mates, a current serving officer and veteran, tragically took his own life. While I can't ever know what he was wrestling with in his last moments, I have a better understanding now of some of the complexities that could have been with him, pushing and pulling in paradoxical directions. While we can't hope to resolve all the dilemmas of military service, we can better support our people as they do their best to live through them. So in that sentiment, Stevo my friend, this is for you.

Carsten J. Grimm

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## Appendices

### Appendix A: Defence Force Order (Temporary)—Exemption From Reporting Requirements for the Purpose of Research



Headquarters NZDF  
Defence House  
34 Bowen Street  
Wellington 6011  
NEW ZEALAND

18 May 2022

See distribution

DFO(T) 04/2022

#### EXEMPTION FROM REPORTING REQUIREMENTS FOR THE PURPOSE OF RESEARCH

##### Authority

1. Issued by the Chief of Defence Force pursuant to s 27 of the *Defence Act 1990*.

##### Purpose

2. This Defence Force Order is an order in relation to N1003847 SQNLDR CARSTEN J GRIMM ('the researcher') and Q1009599 LTCOL STEPHEN P KEARNEY ('the supervisor') for the purpose of providing an exemption from the routine mandatory reporting requirements imposed on service members.
3. The purpose of this exemption is to enable the researcher to conduct research into the NZDF mental health system ('the research'). The result of which is likely to benefit the NZDF by improving access to and treatment outcomes of service members.

##### Requirement to report allegations of offending

4. It is an offence under s 39 of the *Armed Forces Discipline Act 1971* whereby a service member fails to comply with a lawful order of which they know, or could with reasonable diligence have had knowledge where the order is a Defence Force Order or a general, standing, daily, or routine order made for any part of the *Armed Forces*.
5. In accordance with the following written orders, the researcher and the supervisor would be required to report any allegations of offending:
  - a. DM 69 (2nd Ed), Vol 1, Chap 1, Sect 2, Para 1.2.2, requires officers and NCOs to "ensure that good order and discipline is maintained". This is a requirement to report allegations of offending to be dealt with under s 102 AFDA and DM 69 (2nd Ed), Vol 1, Chap 4.
  - b. Stand Alone DFO 06/2016, Chap 1, Paras 11 – 12 repeats the requirement for compliance with, and reporting obligations under, DM 69 (2nd Ed), Vol 1.

##### Exemption to the requirement to report allegations of offending

6. In order to maximise the utility of the research findings, the researcher and supervisor, for the purpose and duration of the research, are exempt from the reporting requirements outlined above at paragraph 5.

7. The researcher and the supervisor must otherwise comply with DM 69 (2nd Ed), Vol 1 and Stand Alone DFO 06/2016 in order uphold their responsibilities as commissioned Officers in the Armed Forces.

#### **Responsibilities**

8. The researcher and the supervisor are to:
  - a. take appropriate action, including if necessary, the requirement to report any allegation of offending, whereby the research discloses threats of harm to self or others in accordance with DFO 3, Part 14, Chap 4 and the *Privacy Act 2020*;
  - b. take appropriate action, including if necessary to report any allegation of offending, whereby the research discloses a threat to NZDF or single Service operational effectiveness;
  - c. ensure that the research (or any product thereof) complies with DFO 3, Part 14, Chap 5 (Authority to Conduct Human-related Research); and
  - d. follow any additional direction from CDF in relation to reporting allegations of offending.
9. In addition, the researcher is to act as directed by the supervisor in relation to the reporting of allegations of offending.

#### **Cancellation**

10. This order is to be cancelled on the conclusion of the research by the researcher or his terminal date including any extension (whichever occurs first).



**KR SHORT**  
Air Marshal  
Chief of Defence Force

#### **Distribution**

CPO  
ACHR  
DDH  
CMO  
Chief Mental Health Officer  
Director Integrated Wellness

## Appendix B: Participant Information Sheet and Consent Form

### Participant Information Sheet

**Project title:** In Search of Healing Narratives Amongst Warriors: Exploring the Lived Experience of New Zealand Defence Force Service-Members Seeking Mental Health Support

**Lead Researcher:** SQNLDR Carsten Grimm, Defence Health Psychologist | Doctor of Clinical Psychology student, Massey University

**Contact:** [REDACTED]

Tēna koe,

Thank you for thinking about being part of this project looking at what it was like to seek mental health support through the NZDF system. This Participant Information Sheet will help you think about whether you would like to take part. It sets out why we are doing the study, what will happen if you choose to meet with the interviewer, what the benefits and risks to you might be, and what will happen after the study ends. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. Feel free to do this.

This study is being led by an NZDF Psychologist who is studying at Massey University for a doctoral degree (called a ‘Doctor of Clinical Psychology’). It is totally up to you if you take part in this study – there is no obligation (i.e., no pressure). If you don’t want to take part, you don’t have to give a reason, and it won’t affect you in any way. If you want to take part now, but change your mind later, you can choose to have your interview data removed from the study within 1-month after your interview is completed. To have your data removed, simply contact the researcher (details below).

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of this Participant Information Sheet and the Consent Form to keep. Please make sure that you have read and understood all of the pages.

#### Confidentiality Parameters

It is important to be aware that because the lead researcher is an NZDF Psychologist, and both the lead researcher and yourself are members of the NZDF, that there could be circumstances that would require disclosure of your personal information to personnel outside of the research team, including:

- a. Where the information is relevant for determining operational effectiveness of the NZDF.
- b. Where disclosure would prevent harm to, or prevent endangering, any person.
- c. Where there is legal authorisation, a legal requirement or a court order to disclose the information.

**DFO(T) 04/2022**

As an extra layer of protection to you, this research is covered by DFO(T) 04/2022 *Exemption from Reporting Requirements for the Purpose of Research*, dated 18 May 2022.

CDF has directed the researcher to prioritise participant confidentiality over maintaining discipline in order to ensure researcher-participant trust and to encourage honest reporting of NZDF mental health experiences. This means any discussion of past or current breaches of DM 69 Manual of Armed Forces Law are held as confidential in this research only and will not be shared with anyone. Obligations remain to disclose information in order to prevent harm to any person or for determining operational effectiveness of the NZDF.

**What is the Purpose of the Study**

In this study, we are looking at what it was like to access support for a mental health concern through the NZDF well-being system.

While there is research in other countries and militaries on what leads to help seeking, we are interested in experiences specific to Te Ope Kātua/ NZDF. Additionally, we are seeking to understand what the experience was like of going through the NZDF mental health care system, from beginning to end, to understand what was good and what could be improved.

The goal of our research is to find out what it is like to seek support, and to go through the NZDF mental health care system. The findings are likely to contribute to the improving mental health care for members of the NZDF. They may also help other countries to better support members of all militaries with mental health concerns.

Our group is made up of one NZDF Psychologist who is studying for a Doctor of Clinical Psychology, as well as Massey University clinicians and academics who are interested in improving outcomes for NZDF personnel. The NZDF Chief Mental Health Officer is a supervisor of this research also.

This study has been approved by the NZDF Organisational Research Ethics Committee, and the Massey University Human Ethics Committee. Contact details for these ethics committees are at the end of this form.

**Who Are We Looking For to Participate In This Study?**

You are invited to be part of this study if you have been externally referred for a mental health concern while you were serving as Regular Force in the NZDF. You may have initially seen a Padre/ Chaplain, Psychologist, or Social Worker who then made an appointment for you to see a clinical psychologist, counsellor, or other support professional outside of the NZDF. We are specifically keen to talk with personnel who were referred to have appointments with support providers outside of NZDF in this research.

We are asking NZDF support personnel (Social Workers, Psychologists, Chaplains etc) to pass on this study information to personnel who they have helped to access external mental health support. No details

are passed to the research team of personnel who have been externally referred by NZDF support personnel – participants must contact the researcher directly themselves to participate.

We expect to have around 10 NZDF personnel in this study. This is an estimate based on past research and the final number is flexible depending on the information gathered from the study, i.e., we may end up having a few more people in the study depending on who wants to be part of it.

It is important to note that even though the researcher is an NZDF Psychologist – the interview conversation is not a referral, is not intended as therapy, and is not in any way intended as treatment for a current mental health concern. If you have a current mental health concern you should not participate in this research and instead contact your local Base/ Camp Support Team.

### **What Will my Participation Involve?**

If you agree to participate in this study, the interview will probably take somewhere between 45 minutes– 1.5 hours of your time, in a few cases maybe longer if there's a lot you want to talk about – it's up to you (more on that below). The interview will be just like a chat - an informal conversation. It will focus on your story of going through the NZDF mental health care system.

In some cases there may be a lot that you would like to talk about, and we may agree to split the conversation over several sessions to make it easier – so that it's not so tiring, or so it fits in better with your schedule.

In some cases, I may ask if I can get in touch with you again to discuss more about something you said. You are not under any obligation to continue with the study at any stage—even if you agree, you can change your mind at any stage without any consequence to you.

In organising to meet with you I will try to fit in with a time and location that makes it easy for you—the aim is to make it easy for you to be part of this research, while also allowing for you to choose a location where you would feel most comfortable to speak openly and freely.

I can arrange a space for us to meet on your Camp/ Base, or you might prefer a quiet room where you work, or a quiet room at the Camp/ Base Mārae or Tūrangawaewae. I will do my best to travel to you, but given Covid disruptions etc, we may need to meet via Zoom or MS Teams.

You are welcome to bring a support person with you—a friend, colleague, partner, or family or whanau member. But please note—they are not invited to be part of the actual chat (interview)—that part will be just between you and me (the researcher) so that we can ensure everything you say is treated with the confidentiality that it deserves. Your support person can stay and hang out nearby while we talk if you like, or they can come back at the end, whatever is easiest.

The interview will be audio recorded so that it can be transcribed (written out word for word) and looked at for the things this research is focusing on. Your name or other identifying information will not appear anywhere in any written work, so you will not be identifiable—no-one will be able to identify what you

said. Outside of the research team (and your support person if you bring one) no-one will have any way of knowing that you took part in this research.

If we agree to meet for our interview that involves you driving your own vehicle, you will receive a petrol voucher to cover your transport costs for this interview. If you bring a support person and they want to go get a coffee or snack while we talk—that's on us too.

### **What are the Possible Benefits and Risks of this Study?**

There are no guaranteed benefits, however, you might like to be able to share your experiences with an interested and supportive person in an informal setting. You will also be helping us to understand what it is like to use the current NZDF mental health system so that we can work to develop better options for NZDF personnel.

In terms of risks, it is possible that talking about your mental health experience might make you feel uncomfortable, upset, or distressed. If this happens during the interview, we will stop and we don't have to continue. There is a list of services at the end of this information sheet should you feel you need support following the interview.

It is also possible that through participating in the study some participants may become more concerned over a current issue they are facing. Should this occur or any other unexpected issue come up there is a list of services at the end of this information sheet.

### **What Are My Rights?**

Your participation in this study is voluntary. It is up to you whether you take part or not. If you do decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form. If you do not want to take part you do not need to give a reason. If you decide to take part but then change your mind, you are free to withdraw, without giving a reason, up to 1-month after the completion of your interview. If we decide to meet over several sessions, you can withdraw up to 1-month after the final time we meet. The decision to not take part or the decision to withdraw will not affect your employment within NZDF in any way. You may choose to review your interview transcript if you wish.

You may decline to answer any question during the interview without having to give a reason. You may ask for the audio recorder to be turned off during the interview at any stage without having to give a reason.

You can have a copy of the study when it is finished – and I will let you know of any opportunities to be informed of any outcomes—for example any webinars on the findings. You will be told of any new information related to the study that becomes available during the course of the study that may have an impact on your health.

### **What Happens After the Study?**

At the end of the study, your audio recordings will be kept on a password protected laptop and on password protected and encrypted storage (e.g., Dropbox) for 10 years. Data relevant to our research will be entered

into a password protected file on the lead investigator's password protected computer. This data will be identified by an identification code, not your name.

The results from this study will be part of the lead researcher's doctoral thesis (which will be published on the Massey University website), will be published in journal articles, and will be part of a report to NZDF on the findings and recommendations.

Your name or other identifying information will never be used in any research reports or publications—rest assured that findings from the study will not report identifying information in any way that would allow members of the NZDF (or anyone) to figure-out what you have said as part of this study. Only members of the study team will be able to access your data. Your data will be stored for a period of 10 years and will be destroyed after this time.

If you wish, we can send you a summary of the results after the completion of the study. The study findings may also be published in academic journals and presented at conferences.

### **Who Do I Contact If I Have Concerns or For More Information?**

If you have any questions, concerns or complaints about the study, you can contact:

#### **Lead Researcher**

SQNLDR Carsten Grimm, Defence Health Psychologist

Doctor of Clinical Psychology student, Massey University



#### **Research and Clinical Supervisors**

Dr. Ian de Terte, Senior Lecturer, Massey University. [I.deTerte@massey.ac.nz](mailto:I.deTerte@massey.ac.nz)

Prof Darrin Hodgetts, Professor, Massey University. [D.J.Hodgetts@massey.ac.nz](mailto:D.J.Hodgetts@massey.ac.nz)

LTCOL Steve Kearney, Chief Mental Health Officer, NZDF. [stephen.kearney@nzdf.mil.nz](mailto:stephen.kearney@nzdf.mil.nz)

#### **Ethics**

For any ethical concerns please contact the NZDF Organisational Research team:

[OrgResearch@nzdf.mil.nz](mailto:OrgResearch@nzdf.mil.nz)

This research has been approved under DFO 3.14 [5]. Approval Number 2022/02.

This project has also been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 22/28.

If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

#### **Who do I contact if I need support?**

All members of NZDF and the Defence community can contact 0800 NZDF4U (0800 693 348) for 24/7 confidential support spanning both telephone and face-to-face support. This includes Regular Force, Civilians, Reserve Force, families and veterans.

For more help contact information you can also visit <http://health.nzdf.mil.nz/mind/take-action/who-to-contact/>

**Other helplines:**

National Helplines: Lifeline Free Phone (anytime): 0800 543 354

Suicide Crisis Helpline Free Phone (anytime): 0508 828 865

Depression Helpline Free Phone (anytime): 0800 111 757 Free Text (anytime): 4202

**More support information for NZDF personnel:**

More support health and well-being links for NZDF personnel can be found on the NZDF Health internet here: <http://health.nzdf.mil.nz/mind/take-action/links-and-apps/>

### **Participant Consent Form**

**Project title:** In Search of Healing Narratives Amongst Warriors: Exploring the Lived Experience of New Zealand Defence Force Service-Members Seeking Mental Health Support

**Lead Researcher:** SQNLDR Carsten Grimm, Defence Health Psychologist | Doctor of Clinical Psychology student, Massey University

**Contact:** [REDACTED]

**By signing this consent form I agree that:**

I have been given sufficient time to consider whether or not to participate in this study.

I understand that there may be circumstances that justify disclosure of my personal information to personnel outside of the research team:

- a. Where the information is relevant for determining operational effectiveness of the NZDF.
- b. Where disclosure would prevent harm to, or prevent endangering, any person.
- c. Where there is legal authorisation, a legal requirement or a court order to disclose the information.

I understand that this research is covered by DFO(T) 04/2022 *Exemption from Reporting Requirements for the Purpose of Research*, dated 18 May 2022. CDF has directed the researcher to prioritise participant confidentiality over maintaining discipline in order to ensure researcher-participant trust and to encourage honest reporting of NZDF mental health experiences. This means any discussion of past or current breaches of DM 69 Manual of Armed Forces Law are held as confidential in this research only and will not be shared with anyone. Obligations remain to disclose information in order to prevent harm to any person or for determining operational effectiveness of the NZDF.

I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.

I am satisfied with the answers I have been given regarding the study and I have a copy of this Consent Form and Participant Information Sheet.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my employment with NZDF.

I agree to the interview being audio recorded. If the interview is conducted via Zoom or MS Teams I agree to the interview being recorded.

I understand that if I decide to take part but then change my mind, I am free to withdraw, without giving a reason, up to 1-month after the completion of my interview. If we decide to meet over several sessions, I can withdraw up to 1-month after the final time we meet.

I understand that there may be risks associated with participation in this study.

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

I understand I can review the transcript of the interview if I choose.

I know who to contact if I have any questions about the study.

I understand my rights and responsibilities as a study participant.

I understand that participating is for research purposes and is not 'a referral' or for mental health treatment.

I understand that my responses will be used for data analyses and that anonymised data will be reported as part of a thesis, journal articles, and a report to NZDF on the project findings.

I understand that should any unexpected distress occur from participating in this study I can call the NZDF mental health help line number (NZDF 4 U; 0800 693348). I can also contact a

member of the Base/ Camp support team at any time if I feel like I need further support, or any of the helplines and support website links provided on the participant information sheet.

**Declaration by participant:**

I hereby consent to take part in this study:

Participant's name (printed):

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Signature:

Date:

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**Declaration by member of research team:**

I have given a verbal explanation of the study to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (printed):

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Signature:

Date:

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**Appendix C: Email Invitation to NZDF Well-being Providers Inviting Research Participants**

Tēnā koe,

I am inviting NZDF service members to participate in qualitative research interviews on their experiences of accessing support through the NZDF mental health system. This forms part of my doctor of clinical psychology research into the lived experience of NZDF service members accessing mental health support. I am seeking all views and experiences with the aim of informing improvements in the mental health outcomes for NZDF personnel.

I particularly would like to speak with service members who:

Have been referred to external clinical psychologists, counsellors, or other external support agencies.

Have had negative experiences of the NZDF mental health system.

Have had positive experiences of the NZDF mental health system.

In other words, any and all views are welcomed and valued.

Interviews will be confidential, and no identifying information will be connected to service members who participate. The information will be audio recorded and transcribed for my research purposes (i.e., for identifying themes and analysing trends). Themes, notes, and quotes will be used in the resulting thesis (published on the Massey University website), in published articles resulting from the research, and a report offering recommendations to NZDF on how to improve the NZDF mental health system. Again, participant identity will be anonymised and kept confidential.

If you have referred someone to an external agency for support and you think they would consider participating in this study—please could you consider forwarding this email invitation and participant information sheet to them and invite them to contact me to arrange an interview time. Please do not forward potential participant information directly to myself in order to protect client confidentiality.

If you have any questions or would like to discuss this research please do not hesitate to contact me directly.

Ngā mihi,

Carsten.

## Appendix D: Interview Guide

This interview guide functioned as an aide memoir during the interview process and was not intended as a checklist to be rigidly adhered to. Interview questions were informed by Pury et al. (2013). The interview was intended as an informal conversation. Key areas;

1. Describe the experience of service personnel seeking help (and accessing care for) a mental health issue in NZDF. Do the described experiences conform with identified barriers to care/ self-stigma literature?
2. Describe the system experience (narrative) within NZDF; i.e., between help seeking ("start") and outcomes ("finish")? Note how participants tell their story. Where do they start? What is the story arc? What is most important for them to talk about? For each stage of the journey: A) What was that like? B) What helped? C) How can we make it better?

### *Interview question prompts*

*Whakawhanaungatanga/ Establish relationship and rapport building.* Whānau, upbringing, why did you decide to join the military? Previous mental health experiences?

*Please tell me the story of you seeking support?*

- When did you become aware you needed help? Precipitating event(s), help seeking, barriers to care, any identifiable stigma? What helped (i.e., facilitators).

The process: who did you see? How was the referral managed? Who were you referred to? What was that like?

- Treatment: What treatment did you engage in? NZDF support, external referral. e.g., psychotherapy, pharmacotherapy, chaplain, peer support groups, treatment by doctor/psychiatrist/psychologist, etc.) (follow-up questions: how long were you in treatment? How many sessions did you attend? Do you know what your diagnosis was?)

*System experience:* Did you encounter any problems or concerns with the healthcare system when seeking treatment?

- Did you have any other difficulties accessing the treatment you needed? (e.g., scheduling conflicts, time constraints, and transportation)
- What do you think was the biggest barrier you faced in getting into treatment?

*Treatment expectations:*

- What did you expect? What was it actually like?

*Facilitators of getting help:* What else helped? Who helped you? What helped most?

- What do you think was the single most helpful thing in getting you in to treatment?

- Values +/- identity conflicts? Describe any points of tension between the NZDF values and your own personal values? How did you navigate those tensions?
- Did you experience any doubts of your own about seeking treatment? (Follow-up: What about any beliefs that prevented you from seeking treatment sooner or might have initially hindered seeking treatment? (e.g., pride in self-reliance, focus on job and family functioning, providers will not understand/believe, treatment not helpful, treatment is for the weak/crazy, and treatment is only for extreme problems)

*Impact:* How did you manage your work? Responsibilities? Relationships; colleagues, loved ones, to the organisation? View of self or any identity changes?

*Lessons:* “If there were one thing you could tell yourself at the start of this journey, what would it be?”

## Appendix E: Research Case Study

Research Case Study  
Massey University, Clinical Psychology

### CASE STUDY 6

**“The help I've got has been a force multiplier in me basically being alive”:  
Narrative Analysis of an NZDF Service Person’s Experience of Engaging in Clinical Care  
for PTSD**

In accordance with the Code of Ethics for Psychologists Working in Aotearoa/New Zealand the privacy of this client is maintained by utilising pseudonyms and adapting identifying information.

Candidate: Carsten J. Grimm  
Clinical Psychology Programme, Massey University  
Student ID: ██████████

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**Supervisor:**

Dr. Ian de Terte  
Associate Professor  
Massey University  
Wellington Campus

**Candidate**

Carsten J. Grimm  
Registered Psychologist (Clinical Intern)  
Mental Health and Addictions  
Manawatu Locality

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This case was completed during internship in 2024 and represents the work of the candidate

## Abstract

Military personnel can experience significant exposure to traumatic stressors and also significant cultural barriers to obtaining mental healthcare, meaning many of their needs for psychological support can go unmet. This single case study examined the narrative account of Peter, an active duty New Zealand Defence Force (NZDF) soldier, who had accessed mental health support in order to understand his experience of utilising the NZDF mental health system. Two narratives dominated Peter's account of accessing help, the first being a better-than-before recovery arc similar to many features of the hero's journey. Paradoxically, accessing care both helped and hindered Peter as many features of the healthcare system made things more difficult for him and a variety of cultural factors made accessing meaningful care challenging. This analysis suggests that NZDF military personnel experience significant barriers to obtaining effective mental health care despite support being available. Recommendations include both NZDF and clinical providers ensure that practices and procedures align with the best evidence around supporting military personnel for mental health distress. Reflections are offered on how conducting the research influenced the author's learning during clinical internship.

*Keywords:* Military; mental health; narrative analysis; indigenous health; posttraumatic growth; help seeking; military healthcare system

## Introduction

The mental health of New Zealand Defence Force (NZDF) personnel is vital for the achievement of military missions on behalf of the people of New Zealand (NZDF, 2014). The NZDF Regular Force (RF) consists of 9,500 uniformed personnel across three services of Army, Navy, and Air Force (NZDF, 2022). Military service can expose personnel to a variety of stressors in both operational (i.e., deployment) and in-garrison environments (Campbell & Nobel, 2009). Combat trauma exposure in particular is recognised as a common mental health risk for service members (Westphal & Convoy, 2015). Just under half of all RF NZDF personnel (46%) reported they had experienced a traumatic event in their lifetime and 27% of the RF said that trauma had been a result of time in service with the NZDF (Bennett, 2019). While a high number of NZDF personnel are relatively young and healthy compared to the New Zealand population, NZDF has a high proportion of at-risk groups for suicidal behaviour, specifically young males and Māori (Stuart & Bennett, 2017). In an epidemiology study of reasons for medical discharges from service in the NZDF over 2006—2013, 19.5% of all medical releases were found to be due to

mental illness and behavioural disorders (Iremonger et al., 2015). The most common mental illnesses leading to medical release were anxiety and depressive disorders (9.2% of discharges) and PTSD was found to lead to medical release in only 0.5% of discharge cases in this study. However, this is somewhat at odds with an investigation of PTSD conducted in a mixed RF and veteran NZDF population ( $N = 1817$ ; 56% current serving) where overall 30% of participants reported experiencing sub-clinical PTSD and 10% were identified as likely to have clinically diagnosable PTSD (Richardson et al., 2020). In New Zealand veteran studies around 10% of veterans suffer from PTSD consistent across the Vietnam and contemporary generations of veterans (MacDonald et al., 1997). However the low rates of medical discharge for PTSD in NZDF personnel (just 0.5%) suggests that either PTSD is not recognised while still serving (a hidden problem), or that there is a delayed presentation of this in the New Zealand veteran community (a latent problem) which is common in military populations (Bonde et al., 2022).

### ***Treatment Outcomes***

Despite a focus on improving military mental health care over the last two decades, a significant proportion of service members do not access care when needed. Across studies in allied nations, of those personnel with a probable mental health disorder approximately 25% continue to not receive any support or access any help (Fikretoglu et al., 2022). Compared to overseas research, the rates of accessing mental healthcare within NZDF is less well understood (Iremonger et al., 2015; NZDF, 2014). It is estimated that approximately 5% of RF members seek mental health support through primary care health services annually (Stuart & Bennett, 2017). In the *NZDF Health and Wellbeing Survey*, 24% of NZDF service personnel indicated they would not seek support internally for a mental health concern, with 7% saying they would not seek support at all due to a preference for managing issues alone and concern about career impacts (Bennett, 2019). The majority of military mental health research has focused on PTSD treatment with few studies focusing exclusively on the treatment of common mental health conditions such as depression and anxiety in military samples (Thompson et al., 2016). Current treatments specifically for military and veterans with PTSD as recommended by the U.S. Department of Veterans' Affairs (U.S. VA) and American Psychological Association (APA) include Cognitive Behaviour Therapy (CBT), Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) as well as Eye Movement Desensitisation Reprocessing (EMDR) (APA, 2017; U.S. VA, 2023).

Despite a huge amount of research attention, military personnel and veterans have in general been found to benefit less from psychotherapy for PTSD than non-military populations (Haagen et al., 2015; Straud et al., 2019). In a review of randomised control trials, Steenkamp and

Litz (2013) found that while PE and CPT were superior to waitlist or psychodynamic supportive counselling ( $d$ s ranging 0.24—0.68), and despite treatments providing improvements, most veterans (around 60%) retained their PTSD diagnosis at treatment completion. Similarly in a more recent meta-analysis of therapy outcomes for PTSD treatment (28 studies), remission rates were found to be lower for veterans (50%) than for civilians (65%) (Straud et al., 2019). An additional concern with the currently recommended therapies for military personnel is the high rate of therapy dropout. Therapies that focus on trauma symptoms such as CPT and PE have been found to have higher dropout rates among veteran and military populations when compared to non-trauma focused approaches (Edwards-Stewart et al., 2021). The literature on military mental health treatment has increasingly focused on how to facilitate posttraumatic growth following trauma exposure, in addition to the traditional approach of aiming to reduce PTSD symptoms (Mark et al., 2018; Tedeschi & McNally, 2011). Posttraumatic growth was first coined by Tedeschi and Calhoun (1995) and has been described as the experience of positive changes resulting from the struggle with major life crises. Symptoms of PTSD have been found to frequently co-occur with posttraumatic growth following trauma exposure (Tedeschi & McNally, 2011) indicating that both distress and growth can occur concurrently (Calhoun et al., 2010).

### ***Narrative Psychology in Military Studies***

Narratives can be found in myths and legends since the dawn of humankind (Riessman, 2008) and narratives of soldiers and war have appeared since antiquity (Kucmin et al., 2016). The NZDF is a unique fusion of the British European military tradition with the Māori warrior culture (Bargh & Whanau, 2017; Hohaia, 2016; NZDF, 2023a) and the NZDF prides itself on a best of both worlds narrative (New Zealand Army, 2020) that recognises the importance of Māori integration into the three services, and the important historic contribution Māori soldiers have made to conflicts New Zealand has participated in since the First World War (Walker, 2012). Constructing narratives is one of the primary ways in which humans make sense of the world and assign meaning to events (Murray, 2000) and the ways in which military personnel story themselves and their experiences are shaped by a variety of societal, institutional, and cultural values (Kaspersen, 2021). Until recently few studies had conducted narrative research in contemporary cohorts of military personnel (Tappenden et al., 2022; Crespo & Fernandez-Lansac, 2016). Understanding the narratives that service personnel commonly adopt is critically important because the types of stories people tell during periods of recovery from distress can have profound and long lasting impacts on their mental health (Adler et al., 2015). For instance, adult community patients whose narratives reflected an increase in personal agency over time have been found to

show improvements in their mental health during therapy (Adler, 2012). Improvement in PTSD in trauma patients has been found to be associated with an increased ability to generate healthy, balanced trauma related beliefs (aka. accommodation) in both brief expressive writing and gold-standard PTSD therapies (Alpert et al., 2023). Similarly, themes of growth and agency were found to be associated with lower scores of posttraumatic stress, depression, and anxiety symptoms in U.S. veterans who wrote about stressful experiences during their military service (Tappenden et al., 2022). In narratives of moral injury experiences, Afghanistan veterans described a process of personal transformation in grappling with their experiences, as well as how difficult and important it was to open up and share with family, friends, and other veterans (Held et al., 2019). Similar narrative themes of taking control of the recovery process have been described by veterans in group therapy, where a critical perspective change involved moving from being a passive recipient of care, to an agent engaged in a “battle” in the “hard work” of therapy and healing (Shields et al., 2017, p. 222).

### ***Rationale for the Current Study***

The client perspective of seeking and obtaining mental healthcare among currently serving NZDF personnel is vital for understanding where barriers and opportunities for intervention exist (Fikretoglu et al., 2022; Adler et al., 2020). While approximately 5% of NZDF personnel seek mental health support annually (Stuart & Bennett, 2017) narratives of help seeking in this community are not as well documented compared to allied nations (Veterans’ Affairs New Zealand, 2022). The aim of this study was therefore to conduct an in-depth investigation of how one NZDF service member recounted their journey through the NZDF mental health system. This research sought to address the gap in understanding around how military personnel describe their experiences when initiating support seeking, what barriers to care they encountered, and what contributed to treatment outcomes.

## **Method**

### ***Study Overview and Research Context***

The current case study was part of a larger qualitative investigation exploring the mental health help seeking experiences of 21 active duty NZDF personnel. Eligible participants were active-duty NZDF personnel who had accessed support for any mental health matter and had been referred to clinical psychologist or psychiatry services. Those still undergoing treatment were ineligible. Participants were recruited via email outreach through existing NZDF support providers; psychologists, chaplains, social workers, and medical officers.

### ***Participant***

I selected one participant for this in-depth analysis due to the rich and informative narratives of engaging in clinical care that he provided. Peter (name and identifying details changed) had served on several deployments including to Afghanistan, and Iraq. He had struggled with depression, PTSD, and suicidal ideation for many years before his mental health precipitated a crisis in 2016 and at that stage he sought professional support.

### ***Interview Procedure***

The interview was in-person using an informal and semi-structured conversational format. The opening question aimed to encourage a narrative account and rich description: “Can you please tell the story of seeking help through the NZDF mental health system?” Periodically Peter was encouraged to provide more detail to his descriptions, for example, “Why did you choose to talk to the chaplain and not to another well-being provider?”. This research was approved by the Massey University Human Ethics Board and the NZDF Organisational Research Ethics Board.

### ***Narrative Analysis***

Peter’s account was analysed using narrative analysis (Riessman, 2008). A narrative approach to service personnel as storied beings is well suited to the exploration of how people make sense of and bring order to the disruption that illness produces in their lives (Radley, 1994). The focus in this study was on identifying illness narrative templates; restitution (i.e., yesterday I was healthy, today I am sick, but tomorrow I will be healthy again), chaos (anti-narratives of despair), and quest narratives (i.e., the hero's journey) (Campbell, 1949/2004; Frank, 1995). A similar analytical approach has been used to explore U.K. veteran recovery experiences from physical and psychological trauma (Carless, 2014). An audio recording of the interview was transcribed and coded to identify aspects of narrative structure and sub-plots. Researcher reflexivity and reflection on the construction of the narratives occurred during frequent supervision (Riessman, 2008).

### ***Findings***

Peter described his journey as an active-duty soldier seeking mental health support in terms of a quest narrative (Campbell, 1949/2004; Frank, 2004). However, there were many barriers to accessing effective care for Peter which provided a narrative of paradox, in that the healthcare system both helped and hindered his recovery. At the start of Peter’s story he described his combat experiences and the many traumatic events he was exposed to on deployment that

precipitated his mental distress. However, Peter did not seek support for these experiences when returning home from war:

So I got on that plane with all the trauma from seeing my dead friend to seeing like little Iraqi girls coming out of the medical tent with no arms, 'cause they picked up an aerial delivered mine. You know, all that kind of shit right? And go oh cool landed back home...I got an empty house did the classic coming back off the deployment thing, just getting hammered with your mates that were on tour with you. Waking up screaming. You know those usual kind of things. And then going down and sort of just, you know, sort of back into normal life again.

Peter storied the following 10 years as trying as best he could to continue living his life how he had been trained to through the Army. While he struggled with depression, his PTSD symptoms had significantly delayed features (Bonde et al., 2022), which may have been due to Peter's tight grip on his diet and exercise coping strategies:

Like I can tell you right now between like 2003 and maybe 2012, 2013, a solid decade, I didn't even know I needed help, right? I just thought I was dealing with stuff and I was the man and everything was cool as right. At the height of my depression...outwardly I'm projecting this like amazing I'm awesome. And yeah, you talked to my wife at the time she said man, you look like a skeleton like you were too thin, but the only thing I felt I could control in my life at that time was my diet and exercise, right? So I was just like eating nothing and exercising a lot. So then I felt I, you know? Oh, look at me. I'm controlling a thing right? I wasn't happy at all.

Things had to get very bad in Peter's life before he became willing to seek support for his troubles, which is another common experience for military veterans. Peter storied this phase as among the most difficult time of his life and mirrored aspects of the hero's journey of entering the abyss—involving physical, emotional, and social suffering (Campbell, 1949/2004; Frank, 1995):

Things got progressively worse for me, not better. A couple of like, I guess I call it suicide attempts, right? But not your traditional type of suicide attempts. I had a 300 kilometre an hour motorcycle and I would routinely take it to over 280 K/Hr right at the top of its speed, like close my eyes take my hands off the handlebars and just see what happens...It would just keep going the way it was going and I didn't end up carrying out that thing, right? So yeah, but then 2015-2016 I made

some real stupid choices and almost lost my family and that was when it all came to a head and I was like right, I need some help.

### ***Crossing the Help Seeking Threshold***

Peter described many difficulties when initially attempting to connect with mental health providers. In the hero's journey, crossing the threshold of change often can involve support from a key figure or helper (Campbell, 1949/2004) which Peter described as an NZDF chaplain helping him connect to medical care. Like many military personnel, one of his main concerns about seeking support was the risk that he might be declared unfit for duty and lose his medical clearance—and potentially his career:

Part of the issue also goes into doctors. I can remember being taken into the doctor by the padre. And sitting down and explaining my tale of woe and his first cab off the rank was 'right, I'm going to medically downgrade you', and I was like 'right, stop you right there, 'cause if you do that, I'm gonna walk out right now so that you don't do that. 'cause I'm [in a trade] with a high level security clearance and if you medically downgrade me, that means I won't be able to do my job. And the last thing I want to do right now is to be sat in my house mulling over my issues on my own, no thanks. I actually want to continue to go back to work'. So there needs to be an adjustment with the medical profession as well. So not just go. OK, let's look at the tick box...there needs to be a bit of an adjustment with that as well, to be honest.

Despite accessing care, Peter found that there were many friction points in the military healthcare system that prevented him from receiving effective treatment. Some well-being supporters did not provide him with a safe therapeutic container, leaving him doubting that mental health support was trustworthy or even relevant to him:

I went up to [the psychologist's office] there was young Captain in there and I went in there I started telling my story and you know basically I was in tears, right? And she was just like, 'I don't know what to do, I've got a dude in my office crying and I'm just like way outside my comfort zone' so she's like, [dramatic expression] 'I'll get you some external help'. And I never heard from her again...I got nothing against her, but she was clearly [out of her depth]...So it's like it was almost just like a waste of time and I could see she was like visibly like squirming. She was like retreating into the corner of the room, going far out man I can't

handle this kind of level of conversations 'cause she's not, that's not what she's there for, right?

### *Friction in the System*

Peter described many restrictions on how much support he could receive and the negative impacts that had for his ability to engage in a meaningful and ongoing therapy process:

I guess that's where the negative side comes in. You know the positive side of it is that I've got their help. But the negative side is that there's always a financial window put on it. And it seems to be real restrictive, and it doesn't seem to take into account that mental health is a very individual thing, right?...I'd say after three on the fourth session we actually started looking at things. And then you find out, oh, you've only got 10 sessions. Well, I've already used a third of those on nothing really, so now I'm on the clock, right? And I was very conscious of every session of like extracting every second out of it. 'Cause I'm on the clock man. I've only got ten of these and then I'm done right?...you're constantly on the clock. Everything is race against time. Which induces pressure. You perhaps don't want to explain things as much as you would want to explain it 'cause it's like. Well, that took 12 minutes and I only explained one thing, so I'll just cut the next one short,

Peter found that the mental health system discouraged him from accessing care and made him feel disempowered:

And the kind of continued stigma of me having to sort of go cap in hand to get extra sessions and continuously trying to. I'm having to explain myself and man. I don't. I just don't want to be doing this. You know, I shouldn't have to go and explain myself like enough people in the organisation at high level know why I need to go and get counselling. I shouldn't have to be going and keep explaining it, you know, I'm not making this shit up.

Peter described how a pervasive lack of understanding around how mental health treatment works in the military added to a sense of stigma and shame for him around the difficulties he was facing:

What I feel like you sort of get quite often with Defence and you know, people in Defence, they just look at you and go. 'Well, you had 10 sessions of counselling why aren't you fixed?' Like, 'because that's not how it works, mate'. And by you stigmatising me and doing that, you're actually making things worse... You wouldn't get a broken [truck] take it into the workshops for them to go right. We've

got 3 hours to repair this, and if we don't repair in three hours, we're going to put it in the scrap heap. And here's a complete engine change. Oh well, looks like it's on the scrap heap. We don't use that methodology right?

### ***Military Cultural Competence***

During his experiences of engaging with civilian mental health providers, Peter described how their lack of cultural competence in treating military personnel detracted from him being able to focus on important clinical issues:

It's not a problem like going to external counsellors, it's got pluses and minuses right? Pluses being they're not connected to the organisation so they don't have any preconceived ideas about anything. But the minuses are that you have to explain everything in great depth...civilians they don't understand that you're in a job where you could die, or your friends can die because it's just not something that they encounter or experience, right? And through no fault of their own...So that's where having actual military you know psychologists and counsellors would help, plus you have, you know you'd be afforded easier access 'cause they'd be in Base locations that you can actually get to, you know.

### ***Supported Recovery***

Several areas of clinical practice helped Peter to relax into therapy and start to engage in the process of addressing his past trauma; “the more I talk about it, the more my burden is eased I'd say”. Through counselling Peter was able to learn how to cognitively reframe his past experiences so as to not feel so personally responsible for many of the traumatic experiences he encountered on his deployments:

Like there's no point lingering on the stuff behind you, right? The understanding that I couldn't have stopped my friend being killed. Right? I had no way of then leaving the firefight I was in to jump on a plane to go to attend his funeral. It couldn't be done so. Detach yourself from those issues that the baggage you carry...so that freedom was like that load being lifted from me right? And that was the catalyst for me to move forward. So for me it was it was talking, a lot of talking and a lot of unloading and a lot of affirmation from my counsellors is that these aren't your problems. They are not your fault, you know.

Peter had a childhood with many adverse experiences including sexual trauma which is common for many New Zealand soldiers and veterans (Richardson et al., 2020) and can

compound to make service-related PTSD symptomology worse (Burdett et al., 2021). Peter was able to use his therapy to address these issues in his life before he joined the military (Stevenson, 2020), which finally allowed him to address the stuck points of distorted beliefs of guilt and self-blame around these early experiences (Monson et al., 2014):

You know, when I was almost raped by another man when I was, uh, uh, sort of late teenager like. Did you do anything to indicate to that person that that was what you wanted? No. Well, then there is not your fault. You know you weren't walking around with a giant sign up going 'please rape me, I'm up for it'. Like, OK, cool then. That's not your fault.

Despite initially being highly sceptical, through grounding exercises therapy taught Peter to re-connect to his emotions and allow himself to feel self-compassion, something that soldiers and men in general can be socialised out of (Goldstein, 2001):

One of the techniques that [the psychologist] taught me was she was like I want you to imagine a place like a place you may not have even been to it, but a place that you associated with calm and for me I chose Mount Fuji right. I don't know why, but I just did. It's a well-known thing. I can picture it in my mind. I've never been there, but I've got an idea what it looks like. So she basically told me this technique of what I'm going to do when you starting to feel stressed, or overburdened, or whatever it is, just take a minute or two, just close your eyes, pick yourself on the foothills of Mount Fuji surrounded by cherry blossom and just breathe in those smells and just see those sites. And just like kind of reset yourself. Right, and that and similar mantras are good ways of bringing yourself back to reality.

Similar to the transformational journey of the hero's return (Campbell, 1949/2004; Frank, 1995), Peter described healing and reconciliation with key characters in his trauma narrative:

You know, and [my best friend's widow] reiterating to me to my face. It wasn't my fault, you know. That was good, but I wouldn't have got there if I hadn't started the counselling right? And sure, I'm crying about it now because it's hard for me to talk about it, but at least I can talk about it to a relative stranger where it was like I said before I'd started this counselling process it would just not have come up. You wouldn't have got through the steel veneer that I had up at all times you know.

Peter concluded his story with a better-than-before posttraumatic growth subplot, redeeming his earlier struggles with new wisdom, a refreshed sense of self-compassion, and reconnection to important relationships in his life:

And that's what I say to people. I will never be the man I was before the [traumatic death of my friend], but I'm a better man now than I was in 2016, right? And [my wife] says it quite often, that you know, she's getting her husband back piece by piece, you know? And that's been a hard thing for me to understand is the damage that I was causing in my family right? It wasn't just me, it was the damage being caused in my family. Without a shadow of a doubt. The help I've got has been a force multiplier in me basically being alive.

## **Discussion**

This single case analysis used a narrative psychology approach to explore how one soldier experienced, understood, and made sense of his journey through the NZDF mental health system. Peter's story followed a better-than-before narrative arc where growth and change in his core beliefs around therapy and vulnerability redeemed earlier periods of chaos and struggle. The structure of Peter's story of recovery in this study shows remarkable similarity to research across allied militaries, such as the difficulty of dropping the "mask of competence" (Shields & Westwood, 2019, p. 425), feeling lost with one's distress (Carless, 2014), a crisis catalysing an inflection point of change, and the gradual process of recovery (Palmer et al., 2016). The narratives of social reconnection and change in personal priorities described by Peter in this study align with the qualitative synthesis of posttraumatic growth themes in military samples (Habib et al., 2018) and also with stories told by earlier generations of New Zealand veterans (Hopner, 2014; Reynolds & Smith, 2009). While the idea that trauma can lead to transformation is rooted in ancient philosophical traditions and religions (Tedeschi & Calhoun, 1995) the importance of narratives in the development of posttraumatic growth in military and veterans has become much more salient with recent conflicts (Tedeschi & McNally, 2011). Peter retold his experience by adopting the quest narrative—"humanity's oldest structure"—of the call to change, rejecting the call, suffering and transformation, followed by the renewal of relationships based on a new understanding (Frank, 2004, p. 86). Importantly, of the wounded storyteller templates, the quest narrative structure affords most agency to the recovered story-teller, as chaos stories are consumed with unredeemed suffering and restitution narratives often centre the triumph of an intervention (i.e., it was the medication that fixed me) (Frank, 1995). The adoption of this

template is informative, as narratives of agency and growth are associated with positive mental health outcomes in both civilians and veterans (Adler, 2012; Tappenden et al., 2022).

### ***Clinical Implications***

The journey of healing from mental health distress is frequently a transformation from hopelessness to agency—and from isolation to connection (Adler, 2012). Through the process of re-storying, of healing the narrative rupture, and creating a new meaning, narrative can return a service member back to a healthy relationship to their work and beliefs, that involves living according to one's values in the face of adversity, and accommodates the trade-offs and flexible perspective and values that necessarily accompany conflicting priorities (Weiss & Coll, 2011). Embedded within his storying of recovery, Peter also described how difficult and important it was to open up and share with family, friends, and other veterans. This analysis illustrates many of the common narrative elements along the path of recovery from adversity and trauma in military personnel.

### ***Facilitating Posttraumatic Growth***

Therapy for veterans usefully adopts the principles of the hero's journey (Tedeschi & McNally, 2011). Several authors advocate for a holistic and integrated philosophy using several different therapy approaches when supporting military personnel (Stevenson, 2020). Unlike currently recommended approaches that focus on manualised therapies for PTSD treatment, clinical approaches to facilitating posttraumatic growth in veterans involve an integration of several orientations, such as cognitive-behavioural, narrative, existential, and interpersonal therapies (Tedeschi & Moore, 2021). Additionally, several areas have been identified as clinically relevant when seeking to facilitate and support posttraumatic growth in military and veterans in therapeutic approaches (Tedeschi & McNally, 2011). The first step is to provide education around the nature of disruption to core-beliefs and the skills that support recovery and growth. Emotional regulation skills are needed to be practiced in order to be able to do the work of engaging with trauma memories. Steps three and four are related, around meaningful disclosure to a trusted witness and the development of a narrative that integrates themes of growth and recovery (Tedeschi, 2020; Tedeschi & McNally, 2011). The final step—but perhaps one not ever fully finished—is clarifying new values and committing to living in accordance with them. This could involve acts of service back to the community and embodying what one has learned by assuming new life roles (Tedeschi, 2020). One programme for veterans that adopts this approach using residential and online follow-up components has been found to support mental health improvements across a range of metrics (e.g., PTSD, posttraumatic growth, psychological

flexibility) (Moore et al., 2021). Central to this programme—and critical to Peter’s recovery in the current study also—is *expert companionship*; the presence of a supporter or clinician who appreciates the paradox and ambiguity of trauma recovery, and the often messy process that can take months or years (Tedeschi et al., 2015).

### *Military Cultural Competence*

In addition to increasing access to care, the importance of providing culturally competent therapy when supporting military personnel has typically been ignored or underappreciated (Westphal & Convoy, 2015; Atuel & Castro, 2018). Cultural safety requires that service users have their background, culture, and unique characteristics all taken into account (New Zealand Psychologists Board, 2011). Providing users and consumers of mental health services with the power to comment on current practices is a fundamental tenet of cultural safety, as outlined by the New Zealand Psychologist Board’s *Guidelines on Cultural Competency* (New Zealand Psychologists Board, 2009). In this study Peter described both the advantages of civilian therapists, such as being removed from the prying eyes of the military system, but also the downsides of low military cultural competence in civilians which detracted from focusing on important clinical issues. Increasingly it is recognised that providing culturally competent care by mental health providers requires the appreciation of the tensions and dilemmas military personnel face when struggling with mental distress (Riggs & Mallonee, 2017; Westphal & Convoy, 2015). While NZDF has historically employed general scope psychologists, at the time of writing it is only just beginning to introduce uniformed clinical mental health expertise and relies on civilians for much of its clinical mental healthcare. Less than 20% of surveyed mental health professionals across the United States were found to have high military cultural competence in one study, and those who were culturally competent may not have been able to deliver evidenced-based care for common military mental health struggles (Tanielian et al., 2014). Military cultural competence requires that practitioners develop an understanding of the intersection between masculine gender and military cultural norms, and to integrate appropriate communication and methods into their practice (Atuel & Castro, 2018; Shields & Westwood, 2019). The Uniformed Services University (2023) provide an online course aimed to inform practitioners of the impact of military culture on how clients may present in therapy. Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has recently established the Military and Veterans’ Mental Health Network (MVMHN) to support culturally competent service delivery. Research on how best to support NZDF service members from across the community of current providers (e.g., Hinton et

al., 2021) may also ensure that valuable cultural lessons are made available to those engaging with military clients.

### *Engaging Military Clients*

Even when in care, Peter described having trouble “dropping the mask of competence” once he was finally sitting in front of support providers (Shields & Westwood, 2019, p. 425). In addition to evidenced-based therapies for veterans with PTSD, therapy approaches that align with military culture may provide fruitful ways of ensuring engagement with service personnel (Zwiebach et al., 2019). For instance, one approach (Radically Open DBT [RO-DBT]; Lynch, 2018) treats issues of over-control such as rigid, rule-driven and perfectionist behaviours and has been successfully applied to military cultures where veterans are taught to relax their guard and improve social signalling to facilitate more supportive relationships (Hempel et al., 2018). Additionally these approaches tend to place more emphasis than other behaviour therapies on a paced and structured approach to developing the therapeutic alliance, given that overcontrolled clients tend not to readily communicate perceived weakness or emotional vulnerabilities (Lynch et al., 2015; Luoma et al., 2018). Other approaches such as ancient Stoic philosophy has been described as therapy for those who hate therapy by adopting language such as becoming a warrior of the mind, which may more readily align with a cultural orientation towards emotional resilience (Robertson, 2022), and shares the same philosophical underpinnings (Murguia & Díaz, 2015) and exercises (e.g., exposure, cognitive distancing) with CBT (Robertson & Codd, 2019).

In addition to ensuring that military personnel get the best therapy help they need, it is essential for well-being providers to examine their own biases and potential for a culture-empathy gap when supporting military personnel (Lane & Wallace, 2020). In this study, Peter found that well-being providers either failed to engage him in culturally appropriate ways, or failed to provide a safe therapeutic container for his distress. Approaches to mental health treatment for those from masculinised cultures have tended to focus on changing the talking behaviour of clients, rather than changing the listening behaviour of providers (Seager, 2019; Seidler et al., 2023). U.K. counsellors were found to have biased attitudes towards those from masculinised cultures, and imposed particular forms of expression that were more feminised, prior to training in gendered ways of expressing help seeking (Seager, 2019). Disparaging therapist attitudes can stigmatise military personnel further by subtly blaming them for their distress while ignoring the impact of their culture (Shields & Westwood, 2019). The way in which care is expressed to clients from masculinised cultures is also an important therapeutic component, as softer styles of empathy expression can be interpreted as “babying” and implying an inability to handle one’s

own problems (Shields et al., 2017, p. 221). Paradoxically, under supportive and culturally-sensitive conditions, therapeutic interventions can become re-aligned with military-culture ideals of “being courageous”, “doing hard work”, and a place of “battle for [the] heart and mind” (Shields, 2016, p. 71). Similar sentiments were expressed by Peter in this study, referencing his therapy experiences as being a “force multiplier”. Tailoring well-being interventions includes the use of military or masculinised language, a strengths-based framing, and the celebration of military achievements, while minimising clinical language, a focus on problems, and the implication of weakness (Shields et al., 2017; Seidler et al., 2018). Adapting language and messaging to align with military cultural values restores dignity to the individual and brings to light inherent cultural capacities and convictions that enhance service members’ ability to cope with difficult mental health experiences (Shields & Westwood, 2019).

### ***Reflections on Interviewing and Clinical Skills***

#### *Witnessing*

This case study has deepened my appreciation for the power of providing a safe container and witness to client stories. In very many ways, witnessing Peter’s story has many valuable crossover lessons for me in my clinical practice. Some of the biggest lessons were around the power of providing a safe container for the session, and the power of therapeutic silence to provide space for Peter to explore his own narrative in meaningful ways (Sommers-Flanagan & Sommers-Flanagan, 2017). Becoming unwell can create anxiety and turmoil, and one of the central tasks of the clinician is to bear witness to the chaos narrative and model the possibility of moving through the chaos rather than becoming consumed by it (Frank, 2004, p. 86). Clients can often experience a subtle social pressure to tell restitution narratives (Frank, 1995). This social preference for telling a tidy story that returns the narrator to “good as new” can create considerable dissonance for those who find it difficult to describe their experience in a way that has a “happy ending”, such as in chaos narratives (Frank, 2004; Orsini & Scala, 2006). Chaos narratives are difficult, frustrating and painful experiences for family and friends—and even therapists and clinicians—to listen to. By being covertly or overtly pressured to modify their stories in order to avoid clinician discomfort, patients can feel denied of their experiences. Witnessing and tolerating difficult client narratives—“hearing others’ stories” (Orsini & Scala, 2006, p 117) and resisting the urge to assert clinical control by reinstating the treatable restitution story is therefore one of the most benevolent and skilled therapeutic interventions (Frank, 1995, 2004; Orsini & Scala, 2006). Often the best thing for me to do to help facilitate Peter’s narrative creation process was to simply bear witness. Not being in a hurry to push clients out of their chaos

narratives into a more psychologically comfortable and perhaps familiar restitution narratives (Frank, 1995) was one of the central ingredients that allowed for the successful witnessing of Peter's narrative in this study.

### **Conclusion**

This single case study identified many culturally relevant aspects of providing mental health care to NZDF soldiers and veterans. Military culturally competent care involves appreciation of the ways in which communication and practice may need to be tailored to military clients to ensure that personnel are able to take advantage of the therapeutic space offered by clinicians. Through appropriate support, Peter's case demonstrates that a hero's journey and mental health recovery with growth and reconnection to important relationships is possible. By witnessing stories of trauma and providing a therapeutically safe space, therapists who support military personnel can facilitate and allow narratives of recovery and growth to occur that honour the modern day hero's of our contemporary service personnel.

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## Appendix F: Statements of Contribution for Doctorate with Publications

DRC 16



### STATEMENT OF CONTRIBUTION DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the candidate and the candidate's Primary Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of candidate:	Carsten J. Grimm	
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In which chapter is the manuscript /published work:	Chapter 6	
Please select one of the following three options:		
<input checked="" type="radio"/> The manuscript/published work is published or in press <ul style="list-style-type: none"> <li>• Please provide the full reference of the Research Output: Grimm, C. J., de Terte, I., Hodgetts, D., &amp; Kearney, S. (2024). Narratives of transformation and recovery among New Zealand Defence Force personnel accessing mental health support. <i>Journal of Military, Veteran and Family Health</i>, 10(3). <a href="https://doi.org/10.3138/jmvfh-2023-0086">https://doi.org/10.3138/jmvfh-2023-0086</a></li> </ul>		
<input type="radio"/> The manuscript is currently under review for publication – please indicate: <ul style="list-style-type: none"> <li>• The name of the journal:</li> <li>• The percentage of the manuscript/published work that was contributed by the candidate:</li> <li>• Describe the contribution that the candidate has made to the manuscript/published work:</li> </ul>		
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Candidate's Signature:		
Date:	18/08/2024	<small>Digitally signed by Carsten J. Grimm. Date: 2024.08.18 09:15:38 +1200</small>
Primary Supervisor's Signature:	Ian de Terte	
Date:	3-Sep-2024	<small>Digitally signed by Ian de Terte. Date: 2024.09.03 16:22:40 +1200</small>

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<input type="radio"/> The manuscript is currently under review for publication – please indicate: <ul style="list-style-type: none"> <li>• The name of the journal:</li> <li>• The percentage of the manuscript/published work that was contributed by the candidate:</li> <li>• Describe the contribution that the candidate has made to the manuscript/published work:</li> </ul>	
<input type="radio"/> It is intended that the manuscript will be published, but it has not yet been submitted to a journal	
Candidate's Signature:	
Date:	18/08/2024 <small>Digitally signed by Carsten J. Grimm Date: 2024.08.18 09:18:38 +1200'</small>
Primary Supervisor's Signature:	Ian de Terte <small>Digitally signed by Ian de Terte Date: 2024.08.03 16:24:23 +1200'</small>
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