8-10-2022 9:00 AM

An Interview Study of Beliefs About Confidentiality and Attitudes Towards Disclosure of Moral Injury in the Canadian Armed Forces

Cassidy Trahair, *The University of Western Ontario*

Supervisor: Saklofske, Don, *The University of Western Ontario*
Co-Supervisor: Nazarov, Anthony, *The University of Western Ontario*
A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Psychology

Abstract

Military members often encounter potentially morally injurious events (PMIEs) during their service. These encounters can put them at higher risk for developing moral injury, defined as the psychological distress following morally-transgressive situations. If untreated, this can lead to negative health outcomes like depression, suicide ideation, and post-traumatic stress disorder. However, the rate of help-seeking among military members experiencing mental health issues is low. Thematic analysis was used to evaluate barriers to mental health help-seeking among individuals with CAF experience, including perceived confidentiality of information, and whether PMIEs impact the decision-making process. The sample consisted of 9 individuals with CAF experience aged 26 to 64 years (M = 48.65, SD = 10.01; 1 woman, 8 men). The results of this study indicate that military personnel are not always comfortable sharing information with health care providers. Results should aid policymakers in creating programs to help facilitate help-seeking and utilization in the military.

Keywords: Confidentiality, Help-seeking, Canadian Armed Forces, Moral Injury

Lay Summary

Military members and Veterans often encounter traumatic events that can put them at higher risk for developing psychiatric disorders such as PTSD and moral injury. If untreated, these can lead to such negative health outcomes as depression, suicide ideation, and substance abuse. However, military members who experience mental health issues are less likely to seek support compared to the civilian population. This study used interviews with CAF Veterans to explore their perceived barriers to help seeking. The sample consisted of 9 individuals with CAF experience aged 26 to 64 years (M = 48.65, SD = 10.01; 8 men, 1 woman). Most participants expressed concerns related to confidentiality of their information within the mental health care system. They were worried that the information shared in their therapy sessions would be shared with their superiors. The results of this study indicate that military personnel are not always comfortable sharing information with a health care provider. Findings will allow clinicians and policymakers to determine whether specific regulations surrounding confidentiality should be modified to facilitate treatment-seeking.

ACKNOWLEDGEMENTS

I would first like to thank my parents, David Trahair and Elaine Baxter-Trahair, for supporting me throughout my academic career. I am forever thankful that you encourage me to pursue my dreams, believe in me no matter what, and always celebrate my achievements.

I am extremely grateful for my supervisor, Dr. Don Saklofske, for guiding me through my Master's degree and always encouraging me to grow as a student. Thank you for sharing your immense knowledge in the field of psychology and always supporting my ideas. Thank you for all the hours you have put in allow me to develop as a student. Thank you for all the indispensable opportunities you have provided me which allowed me to acquire knowledge and experience in the field.

I am also immensely thankful for those who helped me at the MacDonald Franklin Operational Stress Injury Research Centre (MFOSIRC), Anthony Nazarov, Callista Forchuk, Rachel Plouffe, Kevin Hansen, and Tri Li. Thank you for your constant guidance, expertise, and sense of community. I also would not have been able to complete this thesis had you not given me access to your participant pool as well as the Webex account used to interview participants.

I would also like to express my gratitude to Dr. Paul Tremblay, one of my committee members, for always taking time out of your busy schedule to assist me with any questions I have. Your expertise on qualitative and quantitative methods has been invaluable for me over the last two years. Thank you for always taking time out of your day to provide me with the guidance and resources I needed to complete this thesis. I appreciate all the effort you have put in to ensure I can achieve my goals.

TABLE OF CONTENTS

List of Appendices

List of Abbreviations

CAF:	Canadian Armed Forces
PTSD:	Post-traumatic stress disorder
PMIEs:	Potentially morally injurious experiences
MFOSIRC:	MacDonald Franklin Operational Stress Injury Research Centre
REDCap:	Research Electronic Data Capture
WREB	Western University Ethics Review Board
NDA	Non-disclosure agreement
R2MR	Road to Mental Readiness

CHAPER 1: INTRODUCTION

1. Introduction

Canadian Armed Forces (CAF) military members experience traumatic events and face ethical dilemmas during their service. These encounters can put them at higher risk for developing post-traumatic stress disorder (PTSD), as well as moral injury, defined as psychological distress in response to morally transgressive situations (Liz et al., 2009). Moral injury can stem from witnessing, perpetrating, or failing to prevent ethically ambiguous events (Litz et al., 2009). If untreated, moral injury can lead to such negative health outcomes as depression, suicidal ideation, substance abuse, PTSD, and more (Nazarov et al., 2015; Zinzow et al., 2007). Still, however, the rate of help-seeking in military members who have experienced mental health issues is lower than that of the general population (Hom et al., 2017). As well, many CAF members and Veterans delay treatment when it is needed (Fikretoglu et al., 2008). In fact, 40-60% of military members who could benefit from mental health support choose not to access available services (Hoge et al., 2004; Iversen et al., 2010). Relatedly, a systematic review conducted by Hom et al. (2017) investigated help-seeking and service utilization among current military members around the world and revealed that only 29.3% of participants with mental health problems reported seeking or utilizing mental health services during this period.

There is an abundance of evidence to suggest that military members and Veterans are more likely to suffer from mental health issues than the civilian population (Hom et al., 2017). For example, suicide is the second highest cause of death in military members but the tenth-leading cause in the civilian population (US Department of Veteran Affairs, 2018). Therefore, it is evident that the discrepancy between rates of help seeking in the military and civilians is not due to an absence of need in military members. Military members are also less likely to seek help for

mental health problems when experiencing moral injury compared to other types of mental health problems, especially as these moral transgressions often lead to feelings of shame and guilt (Litz et al., 2009). The purpose of this study is to qualitatively assess barriers faced by CAF Veterans when deciding whether to seek or utilize mental health treatment with a focus on issues surrounding confidentiality of information. I will also investigate whether these barriers to mental health treatment are more pronounced when Veterans experience moral injury versus PTSD. The following sections provide an overview of PTSD and moral injury as well as the research literature reflecting barriers to help-seeking and potential differences in help-seeking behaviours when CAF Veterans experience moral injury versus PTSD.

1.2. Post-Traumatic Stress Disorder

PTSD occurs as a result of experiencing or witnessing a severe or life-threatening traumatic event, such as combat (American Psychiatric Association, 2013). To be diagnosed with PTSD, the individual must demonstrate at least one of the following symptoms: 1) recurrent involuntary flashbacks of the traumatic event; 2) recurrent dreams about the event; 3) dissociative reactions where it feels as if the individual is experiencing the event over again; 4) psychological distress in response to reminders of the event, and 5) physiological reactions to reminders of the event (American Psychiatric Association, 2013). Individuals with PTSD will engage in avoidance of any stimuli associated with the traumatic event. They will also experience negative alterations in their cognition or mood such as an inability to experience positive emotions and an inability to remember specific aspects of the traumatic event (American Psychiatric Association, 2013). To be diagnosed as PTSD, symptoms must be present for more than one month and must not be the result of another ailment. PTSD provokes severe distress and can manifest through feelings of anger, aggression, and social isolation (Begic & Jokic Begic,

2001; Trickey et al., 2012). This can lead to avoidance of situations and environments that remind the individual of the event and can cause negative beliefs about the world and oneself (American Psychiatric Association, 2013).

Although many soldiers will experience traumatic events in combat, not all will develop PTSD. As such, several factors have been identified that put individuals at higher risk of developing PTSD. Those who are younger at the time of combat, deployed for a longer period, female, low socioeconomic status, racial minorities, lack social support, or have experienced trauma in the past are all at higher risk for developing PTSD (Bremner et al., 1993; Xue et al., 2015).

Still, soldiers who have experienced combat are two times more likely to develop PTSD than the general public (Van Ameringen et al., 2008). Consequently, many studies have investigated which treatments are most effective for the treatment of PTSD in military members and Veterans. Several treatments can be effective depending on the individual, but no one treatment modality is superior (Xue et al., 2015). For example, psychotherapy techniques in which the client does not have to discuss the specific traumatic event and treatments that are trauma-focused can both be remarkably effective (Wampold et al., 2010). As well, some individuals are more receptive to exposure-based treatment, whereas others are not (Wampold et al., 2010). Although there is not one specific treatment modality that is universally effective, research has identified several factors that contribute to effective PTSD treatment, including psychoeducation about PTSD, developing a safe and trusting relationship with the practitioner, and helping patients learn how to avoid revictimization (Wampold et al., 2010)

1.3. Moral Injury

Moral injury refers to a psychological distress that can follow acts that transgress an individual's deeply held moral beliefs (Litz et al., 2009). This can develop from perpetrating, witnessing, or failing to prevent these ethically-transgressive behaviours. These behaviours can include engaging in combat that causes the death of civilians, failing to give aid to injured military members or civilians, and more. This causes internal dissonance, as the individual is aware that their experience transgressed their moral beliefs, but they were not able to prevent it. If an individual feels remorse about the potentially morally injurious experience (PMIE), this often manifests into feelings of guilt. If they blame themselves, the individual will feel shame (Litz et al., 2009). These feelings of guilt and shame may make it more difficult to share details about the experience due to fear of judgment from others.

To date, moral injury is not as well understood as PTSD. However, many soldiers report experiencing PMIEs in combat. For instance, Wisco et al. (2017) found that 25% of soldiers reported witnessing transgressions, 25% reported experiencing betrayal, and 10% reported transgressing their own morals. In another study surveying United States soldiers who had previously been deployed to Afghanistan, many reported experiencing morally challenging events. Specifically, 32% reported being directly responsible for the death of an enemy and 31% reported witnessing injured women and children whom they were not able to help (Hoge et al., 2004, Nazarov et al., 2018).

PMIEs may not always result in an individual developing moral injury, as it depends on their perception of the event (i.e., whether they feel their morals were infringed upon; Litz et al., 2009). In a representative sample of CAF members and Veterans, Easterbrook et al. (2022) were the first to identify predictors of moral injury levels. In participants who had been deployed, childhood maltreatment, experiencing military-related sexual trauma, and stressful deployment

experiences were the strongest predictors of moral injury scores. In participants who had never been deployed, military- or civilian-related sexual trauma and being of a junior non-commissioned member rank (compared to senior rank) were the strongest predictors of higher moral injury scores.

Certain individual differences may place some military members or Veterans at a higher risk of developing moral injury. For example, shame-proneness is related to remorse and self-condemning thoughts, which are applicable to moral injury (Fisher & Exline, 2006). As well, neuroticism has consistently been shown to be negatively related to self-forgiveness, a trait that is integral for individuals trying to overcome moral injury (Litz et al., 2009; Maltby et al., 2001).

Research has clearly demonstrated that moral injury is not an uncommon issue, and it may result in serious mental health outcomes for Veterans. It is imperative, then, that we develop treatment plans and protocols to help facilitate the support of those experiencing moral injury. However, if individuals are not comfortable sharing details of their experiences that lead to moral injury or the emotions they are feeling as a result of moral injury, these treatment modalities may not be effective (Hook et al., 2005).

1.4. Barriers to Mental Health Help-Seeking and Service Utilization in the Canadian Armed Forces

Studies have explored barriers to mental health help-seeking in general in the military population. Stigma and the military culture are among the most commonly mentioned barriers to treatment seeking and utilization. The military tends to reinforce attitudes suggesting that seeking or utilizing mental health services makes an individual weak (McGuffin et al., 2021; Sharp et al., 2015; Tanielian et al., 2016).

Beyond stigma- and culture-related barriers, lack of perceived confidentiality is relatively understudied and can have major consequences for help-seeking behaviours and efficacy of support. According to the Canadian Code of Ethics for Psychologists, confidentiality refers to the duty to not share information from the client's therapy session with anyone without the informed consent of the client or if required by law (e.g., if there is evidence of immediate harm to the client or others; Canadian Psychological Association, 2014). Past studies have identified that a lack of perceived confidentiality contributes to military members' and Veterans' hesitancy to seek help from healthcare providers (Hom et al., 2017). Although mental health professionals are bound to client confidentiality, military members often report that they do not trust mental health practitioners with their personal information and are thus reluctant to share details of their trauma (Fikretoglu et al., 2008). This could be out of fear that if information from their therapy session is shared, they could face career consequences or be kicked out of the army (Zinzow et al., 2013). These concerns may not be unwarranted, as research has revealed that some mental health professionals do not have a full grasp on the policies related to disclosure of confidential information (Faustman, 1982; Jagim et al., 1978; Mengeling et al., 2014). When asked directly about concerns surrounding confidentiality of information shared with a health care provider, a systematic review conducted by Hom and colleagues (2017) revealed that 24-37% of a representative sample of military members identified confidentiality as a major area of concern.

One study identified the potential for information to be shared throughout the military chain of command (Frey, 2017). Meaning that details of a soldier's therapy appointment may be circulated to their bosses. These confidentiality breaches could be a result of military health professionals' unique dilemmas, in which they are required to comply with military regulations, as well as psychological ethics boards. Therefore, their professional ethical principles related to

confidentiality can conflict with the military duty to report. For instance, the psychologist has the dual responsibility of making sure their client is receiving the proper treatment and that the unit as a whole is able to function. If a military member shows signs that they may not be able to carry out a mission successfully, the psychologist may have to share the details of that session with their client's superiors. This lack of perceived confidentiality in military personnel can have dire consequences for those in need of mental health assistance, as this can lead to less honest reporting in military samples (Anestis & Green, 2015; Lothen-Kline et al., 2003).

Despite evidence for confidentiality as a barrier to treatment-seeking in a military setting, studies have not yet investigated this barrier qualitatively among CAF Veterans, and many limit confidentiality concerns to the endorsement of a single item (e.g., "My visit would not remain confidential"; Bonar et al., 2015; Chapman et al., 2014). In addition, it is not clear whether CAF Veterans perceive that their information will be kept confidential with specific civilian or CAF mental health service providers (e.g., medical doctor, psychologist, psychiatrist, chaplain). It is important that CAF Veterans are comfortable seeking and utilizing mental health services, as they are more likely than civilians to encounter experiences that can lead to PTSD and moral injury, conditions that can have severe consequences if left untreated.

1.5. Mental Health Treatment-Seeking and Service Utilization for Veterans Experiencing PTSD Versus Moral Injury

Evidently, CAF members and Veterans are more likely than the civilian population to develop PTSD and moral injury. However, many studies do not consider distinctions between these two psychological conditions while investigating help-seeking behaviours in military members (Richardson et al., 2020). Although PTSD and moral injury share similar features, they are not synonymous. Unlike PTSD, moral injury is associated with feelings of shame, guilt,

worthlessness, and self-blame (Bryan et al., 2018; Litz et al., 2009). These feelings may make military members and Veterans reluctant to seek mental health support due to fear of judgment by others if their information does not remain confidential. As well, the ethical ambiguity of PMIEs may lead to career or legal repercussions, which may further discourage military members from seeking help for moral injury. On the other hand, PTSD is largely a fear-based condition and therefore may not result in the same ethical, career, or legal consequences if they disclose information about their trauma to a mental health care provider. Given the important distinctions between moral injury and PTSD, it is imperative that researchers investigate these constructs separately in terms of their associations with mental health help-seeking and service utilization.

Nazarov et al. (2020) directly investigated the help-seeking patterns of active CAF members who experienced PMIEs. The authors concluded that these individuals were more likely to approach their family doctors or non-professionals (e.g., family and friends) rather than mental health specialists. They were also twice as likely to seek mental health support in the civilian sector than through the military. It is unclear why this pattern was found but given that civilian practitioners do not have the same dual responsibility as health providers in the military (i.e., to both military and patient), it is possible that a desire to circumvent military career consequences could be a factor. Although this study was pivotal in demonstrating help-seeking behaviours among CAF Veterans exposed to PMIEs, it does not address distinctions in help-seeking behaviours for those with moral injury compared to those with PTSD. More research is required to understand the mental health help-seeking behaviours of those experiencing moral injury to determine how to adequately ensure that CAF members and Veterans are comfortable seeking and utilizing the help that they need.

Recently, Nazarov and colleagues (2021) administered a survey that empirically measured the role that confidentiality plays in the decision to seek help. Using hypothetical scenarios outlining PMIEs and incidents that can lead to PTSD, they investigated the interaction between type of trauma (i.e., PTSD vs. moral injury) and level of confidentiality (i.e., explicitly stated vs. unclear). They also explored whether these relationships changed when the hypothetical characters were still serving versus released. The likelihood of seeking help was significantly lower in the moral injury versus PTSD condition in both the released and still serving categories. As well, the likelihood of seeking help in general was higher in the released versus active-duty category. Confidentiality had a greater effect on willingness to seek help and disclose information in the moral injury versus PTSD condition as well as the active versus released condition. Specifically, in instances of moral injury or when an individual is still serving, they are less likely to seek or utilize help if confidentiality is not assured. Perceived legal and career harm were also perceived as higher in the moral injury condition (Nazarov et al., in prep). These results clearly demonstrate that type of trauma can influence military members decisions to seek help. Thus, research needs to separate PTSD and moral injury when investigating mental health support in military members to sufficiently address the hesitancy to seek help in this population.

1.6. Rationale for the Current Study

As mentioned above, several studies have identified concerns surrounding confidentiality as a barrier to help-seeking for mental health conditions in military members. However, there is a dearth of research investigating how these barriers vary when experiencing PTSD versus moral injury. More research is needed to determine how to best encourage military members and Veterans to seek and utilize support when dealing with PTSD versus moral injury.

Confidentiality concerns are consistently cited as a barrier that plays a crucial role in military Veterans' decision to seek help for mental health concerns, especially when dealing with moral injury. However, studies regularly fail to go beyond merely identifying confidentiality as a concern. It is critical that we understand the thought processes underlying military members' decisions surrounding whether to seek out and utilize mental health care services. Only then will we be able to adjust policies and regulations in a manner that facilitates treatment-seeking behaviour. These confidentiality concerns also have consequences for research, as it is impossible to adequately study concepts like moral injury if military members and Veterans are reluctant to speak about their experiences. Thus, additional research is required to determine the true extent to which confidentiality concerns influence CAF Veterans' decisions to seek mental health care, and whether there are distinctions in help-seeking between those experiencing PTSD and moral injury.

To address these gaps in the research, this study is one of the first to qualitatively assess the thought processes of Veterans when deciding whether to seek help for mental health concerns. Specifically, the purpose of this study is to examine confidentiality concerns as a barrier to mental health care, and to assess whether these concerns are amplified for those experiencing moral injury versus PTSD. The qualitative lens of this study allowed us to focus on the experiences and beliefs of military members directly, which cannot be explored using a quantitative survey-based study.

The results of this study will allow policy-makers to determine whether specific regulations surrounding confidentiality should be modified to facilitate mental health treatment-seeking and service utilization. Clinicians will also gain a better understanding of their clients' concerns surrounding confidentiality and can ensure that they clearly outline confidentiality

regulations during treatment. Most importantly, this research will be useful to understand what is needed for Veterans to access and receive the mental health treatment that they require to heal following their experiences.

CHAPTER 2: METHOD

2. Method

The qualitative nature of this study allowed the in-depth analysis of first-hand experience of CAF members as well as their thought processes when deciding whether to seek or utilize mental health support. The following sections provide a background of the researcher, and outline the participant demographics, instrumentation, procedures, and analysis process.

2.1. Researcher Background

In qualitative research, it is important to identify the ways in which the researcher's own values and experiences can influence how the data are analyzed. The researcher obtained her Bachelor of Arts degree in Psychology at Western University in 2019. She majored in psychology and completed her undergraduate honours thesis investigating the relationships between facets of emotional intelligence and the Dark Triad of personality. Prior to beginning her master's degree, the researcher worked at Toronto Metropolitan University in the Biopsychosocial Development laboratory working with infants.

The researcher did not have any direct relationships with any of the participants. She familiarized herself with thematic analysis and trained the skills necessary to execute a qualitative study. Before conducting interviews with participants, she completed several mock interviews with individuals who had experience in qualitative research with military members.

2.2. Participants and Procedure

In order to be included in this purposive sample, participants must have been over 18 years of age and had previous experience in either the CAF Regular or Reserve Forces. Participants were not required to have any formal mental health diagnoses, nor any mental health help-seeking experience; this allowed us to recruit participants who both have and have not

sought help. Twenty individuals met this requirement, but due to time constraints, only nine interviews were analysed and coded. Of the nine participants whose interviews were analyzed, their ages ranged from 34 to 62 years (M = 47.78, SD = 9.69; 1 woman, 8 men). All participants were in the regular force (two Captains, two Sergeants, one Colonel, one Private, one Major, one Leading Sailor, and one Chief Warrant Officer).

All participants had either responded to a media release indicating they were willing to be contacted for future studies or had previously participated in studies at the MacDonald Franklin Operational Stress Injury Research Centre (MFOSIRC) and consented to being contacted for future opportunities. An email was sent to potential participants in batches of 20 (Appendix A). The email contained a link to the Letter of Information and consent form on the survey-hosting website known as Research Electronic Data Capture (REDCap; Appendix B), as well as a PDF attachment of the Letter of Information for those who wanted to provide consent via email, either through electronic signature or a printed and scanned copy. All participants provided consent electronically via REDCap. Once participants consented online, interviews were scheduled. Participants were compensated with a $25 e-gift card of their choice to either Amazon, Starbucks, or Tim Hortons.

2.3. Instrumentation

Participants completed semi-structured, open-ended interviews based on an interview guide (Appendix C). Items for the interview guide were created and modified over several meetings and mock interviews with other researchers familiar with qualitative research. Once the research team was confident that the interview guide addressed important topics of relevance, the researchers completed two additional mock interviews to ensure comfortability with the item content and adaptability of items based on participant responses. Interview questions addressed

perceived barriers to mental health help-seeking in general, confidentiality concerns, and barriers to mental health support when dealing specifically with moral injury. The semi-structured nature of the interview allowed the research team to address the most pertinent questions while also providing more flexibility depending on how the participant responded to each question. For example, if a participant discussed confidentiality concerns early in the interview, the interviewer could present these items to the participant first (i.e., interview items were not required to be presented in order).

2.4. Data Collection

Ethics approval was obtained through the Western University Ethics Review Board (WREB; Appendix D) and the Lawson Health Research Institute ethics system (ReDA; Appendix E). Participant invitations were emailed in batches of 20 to individuals who indicated they would be willing to participate in future studies at the MFOSIRC. Once consent was obtained, interviews were scheduled (see Appendix F for scheduling email scripts).

Interviews were conducted virtually via the Webex video conferencing platform and ranged from 45 minutes to 2 hours. Only the audio of the interview was recorded to ensure participant confidentiality. Participants had the option to skip any questions, stop the interview all together, or withdraw their data at any time; however, no participants chose to stop the interview or withdraw their data. Demographic information was collected by the researcher at the end of the interview, and the researcher recorded the responses to the demographic survey on REDCap. Participants also indicated which of the three gift card options they would prefer. Following study completion, participants were sent a thank you email with a link to their e-gift card. The audio recording of the interview was then sent to Transcript Heroes, who transcribed the interview content verbatim. Transcript Heroes is a Canadian registered Transcription Service

that was founded in 2015. See Appendix G for a flow chart of the process from recruitment to post-interview.

2.5. Data Analysis

This study used thematic analysis as outlined by Braun and Clarke (2006) to identify and analyze a set of themes describing barriers to help-seeking as perceived by CAF members and Veterans. The goal of thematic analysis is to find and report patterns or "themes" within the data (Braun et al., 2006). Thematic analysis differs from other qualitative techniques in that it does not subscribe to one pre-existing theoretical framework and can therefore be used within other frameworks (Braun et al., 2006). Thematic analysis allows for more flexibility than other qualitative methods as there is not a hard set of rules that one must follow when analyzing the data. Instead, Braun and Clarke (2006) describe general guidelines that can be used as a "recipe" to guide researchers through a thematic analysis.

In this study, themes were identified using an inductive approach, such that the themes are strongly linked to the data. Therefore, themes emerged based purely on what was said in the interviews. As well, themes were identified at a semantic level in that they were based solely on what the participants said and no further meaning was applied beyond this (Braun et al., 2006). The data are first described by labelling important concepts as codes and then organized to show patterns in the data. The data is then interpreted to hypothesize the meaning of the patterns in the data, as well as their broader meanings and potential implications. Braun and Clarke (2006) define a theme as something that captures patterned responses or meaning within a data set. Emerging themes are determined by the researcher's judgment and there are no hard-set rules for what is and is not considered a theme (Braun et al., 2006). Finally, the analysis was conducted within a realist paradigm which posits that language allows us to express meaning and

experience. This means the experiences and realities of participants were reported based on what was said by the participants. This is opposed to a constructionist thematic analysis which assumes that reality and meaning are a function of society and aims to describe the sociocultural contexts that influence individual accounts and responses (Braun et al., 2006).

NVivo, a software that is commonly used in qualitative and mixed-methods research, was used to analyse the transcripts and organize codes. This software allows for the analysis of text, audio, videos, and images. The five steps to a thematic analysis as outlined by Braun and Clarke were used to guide the analysis. In phase 1, the researcher familiarized themself with the data by reading the transcripts from start to finish. In phase 2, the researcher started generating initial codes. In this step, the goal is to identify specific codes linked to certain quotes in the text. It involves inductively identifying and labeling many codes from the raw data. This reflects the initial stage of creating the codebook. To complete this phase, the researcher read the interview transcripts line by line and determined whether any quotes were representative of a certain feature that could be part of a theme. Relevant quotes were highlighted and labeled as an individual code. Quotes from future interviews that also represent this code could then be added to this concept or new codes can be created.

Phase 3 involved searching for themes by identifying any patterns in the codes that could indicate a broader theme. To complete this step, the researcher engaged in constant comparison between existing data and initial codes, with the goal of investigating similarities between codes that may link them within a broader theme. In this phase, codes suggesting a pattern in the data were grouped together to create a theme. These themes are then reviewed to see if any can be collapsed. In phase 4, all identified themes were reviewed to ensure the coding units (i.e., quotes) made sense with reference to each theme. It was also determined whether there were any themes

that could be turned into sub-themes of an existing or new, broader theme. For example, concerns about career loss and affecting future job opportunities were both turned into sub-themes of the "career concerns" theme.

Once five interviews were coded, a second researcher (Callista Forchuk) selected one of the five interviews at random to code independently. The researchers then met to discuss results of their coding, in which they agreed on most identified themes. After the nine interviews were coded, the codebook was sent to four other researchers involved in the project who had already read all the interviews. They provided feedback reflecting the grouping of themes and sub-themes. The team then met to discuss their feedback and ensured that we reached a final agreement on the organization of all themes and sub-themes. Once we reached agreement, phase 5 was completed in which themes were described, clearly defined, and named. The following section provides the descriptions of all identified themes.

CHAPTER 3: RESULTS

3. Results

Below are descriptions of all identified themes, concerns, and barriers associated with mental health support in the CAF.

3.1. Confidentiality concerns

The most prominent perceived barrier to mental health support in the CAF involved confidentiality concerns. Specifically, many participants indicated that if a soldier decided to seek help for mental health concerns, this information would be disclosed to their chain of command or peers. One participant surmised that any individual inevitably gives up some confidentiality when they join the military. Three participants also expressed the belief that confidentiality was not possible in the military, and another believed that if they had sought help, they would have no control over what would be shared from their session. Overall, these concerns resulted in hesitation in terms of help-seeking or disclosing any personal information when receiving help.

When asked whether confidentiality was possible in the military, one participant captured the beliefs of the majority of interviewees well by stating, "… you're never going to have an entirely confidential system because I mean that's just the way the military is, everybody's got your records, well not everybody but I mean your records are available to those who need to make decisions so you can't have it so that – or if you've got a mental health problem you can't be deployed, we're just going to put 'You can't be deployed' we're not going to say why" (Man, 40).

Relevant to the theme of trust, many participants mentioned that their chain of command and those in the higher ranks often encourage them to seek help and insist that their information

will be kept private. However, most participants expressed that this felt performative, such that their chain of command would say that their information was protected and not follow through on their word.

When discussing moral injury specifically, interviewees expressed that they would keep the details of the event brief out of fear that the information would get out. Some expressed that they would never discuss moral injury in a military mental health support situation. This is likely because the potential repercussions of events that lead to moral injury can be more severe than with PTSD as they are sometimes legally ambiguous. Therefore, soldiers would not want their chain of command or peers to learn about the event.

3.1.2. Participant Understanding of Confidentiality

Most participants had a strong understanding of what confidentiality should involve (i.e., the physician does not share any information without the informed consent of the client). Still, however, all but two participants posited that this was not actually possible in a military mental health setting due to important obligations to protect soldiers' safety and ensure the success of missions. Specifically, the practitioner needs to determine whether a soldier is able to safely participate in certain missions. To do so, they may need to discuss with an individual's chain of command to determine what is required of the soldier in a mission. Most participants indicated they would be very careful with what they disclose because they do not know what information will be shared and what implications this could have for their career and personal lives. It is important to note that the confidentiality concerns lead to more extreme behaviours when discussing moral injury. This was the only instance in which participants indicated they would either not discuss the morally injurious event at all or choose not to seek help for their moral

injury altogether out of fear that their chain of command would learn about the morally injurious event.

The main issue surrounding confidentiality reflects the general lack of transparency from both the healthcare providers as well as military leaders concerning what remains confidential and what is permitted to be shared to an individual's chain of command or military leaders. However, this issue is not an easy one to solve because of the distrust that many individuals have within the military; they do not believe the military leaders when they are told they can seek help without repercussions.

3.1.3. Cannot Disclose Operational Security Information

Two interviewees disclosed that they were not permitted to discuss certain parts of their missions as they signed a non-disclosure agreement (NDA). These participants were unsure whether discussing operational details with their practitioner would be a breach of their NDA. In this case, participants were unsure of their own confidentiality guidelines.

3.1.4. Routes of Confidentiality Breach

Many routes associated with confidentiality breaches were identified. Below is a description of the ways in which participants believed confidentiality could be broken.

3.1.4.1 Implied. Most participants reported the belief that their chain of command could infer information about their mental health through the information on "chits" provided by doctors outlining the soldier's medical limitations and work restrictions or the physical health of the individual. Specifically, if a soldier receives a chit during a doctor's appointment indicating no physical ailments but is instructed to take time off, it is assumed that they are seeking mental health support. In addition, if a soldier is physically healthy but attends routine doctor's appointments, the chain of command may assume these are therapy sessions.

3.1.4.2. Word of mouth. Eight of the nine participants expressed concern that confidentiality was broken through word of mouth. Three participants believed this to be the case because the military is a small, tight knit community. As such, individuals may overhear practitioners discussing a client in their office, thus making confidentiality difficult or impossible. Alternatively, many participants believed that practitioners may discuss details of their client's mental health with a friend over drinks. This friend could then relay this information to the client's chain of command. More directly, a few participants indicated that their boss asked or pressured the practitioner to provide them with the client's session notes.

When asked how confidentiality could be broken through word of mouth, an interviewee responded: "Because when people – even medical professionals – are dealing with disturbing information, they will often talk about it with their colleagues, sometimes just to get it off their chest, on what they heard because you can hear some pretty disturbing things" (Man, 62).

3.1.4.3. Medical file. Four participants expressed concern that the details of any mental health support sessions would appear on their medical file. They believed that, even if they were assured confidentiality, the chain of command could gain access to this file if they so desired.

3.1.4.4. Government access to medical file. Another participant expressed the belief that any government organization could access the details of a client's medical files. Therefore, if they were to apply to work at a government job upon release, they may not be hired because the organization would surmise that they are a "mental case" [participant's own words]. Although it is not clear whether this is true, the belief motivated this individual to refrain from seeking help for mental health concerns.

3.1.4.5. Investigation. This route of confidentiality breach was only described when discussing instances of moral injury. Participants expressed concerns about sharing information

surrounding morally ambiguous situations that could involve legal repercussions. Participants reported that they would be hesitant to discuss information with their practitioner that involves moral wrongdoing committed by the client due to fear of a potential investigation. Similarly, if they witnessed another individual engaging in behaviours viewed as morally wrong, they would still be hesitant to disclose this to a practitioner, as an investigation may be opened, and the practitioner could share information from their session.

3.2. Stigma

The apparent lack of confidentiality reveals itself as a much larger issue when considering the stigma surrounding mental health that exists in the military. If the stigma that mental health concerns make an individual weak did not exist, it is possible that an individual's chain of command would be more accepting if they found out a soldier is seeking help. Six participants expressed that seeking help made them feel weak or that they were concerned that others would perceive them as weak: "People don't like generally to be painted with that brush of having PTSD. In many peoples' minds, it's a sign that you're weak" (Man, 62).

Two Veterans expressed the belief that the older members of the military perpetuate this stigma. The older members of the military both held and reinforced the beliefs that mental health issues make an individual weak and unfit to be a soldier: "You still have a lot of guys, the old boys club – we call them dinosaurs – that haven't really been able to evolve or adapt to the new line of thinking. So even though the top chain of command in the Canadian Armed Forces says, 'Mental health is a problem, and we encourage people to seek help,' there's a lot of old guys that still have that belief system that they've had for 20 or 30 years" (Man, 51). One interviewee made the point that these older members make decisions regarding soldiers' careers, as they are higher up in the ranks: "The problem is the older generation, the ones that would be in superior

rank to where I am, or I was, they're grooming the next generation of leaders. And they are picking likeminded individuals. And they are shaping them to behave in the same way they do. And I experienced that firsthand" (Man, 40). This may reinforce the stigma surrounding mental health for future generations.

The stigma surrounding mental health can also influence how and individual is treated by their peers and chain of command. One participant described how a peer was ostracized after expressing concern following a morally injurious event to their chain of command "So trying to address moral injury through the chain of command was almost impossible. From a peer perspective I know this individual was absolutely ostracized for coming forward because of what he thought that was morally incorrect that was going on. He was ostracized by some of his peers. The ones that were friends with the bosses or pushing these policies" (Man, 40).

3.3. Career concerns

This theme reflected participants' concerns about both current and future career prospects. Participants were reluctant to seek help not only because they believed it could put their current career on hold, but also because they were worried about limiting future opportunities, such as promotions within the military or obtaining government employment once released.

Participants also expressed their fears about falling behind their peers. These individuals may judge their own adequacy regarding their career using social comparisons.

Describing the reasons underlying their career concerns, participants believed they would be labelled as "mental cases" [participant's own words] if it was revealed they were receiving mental health support, and that subsequently, they would not be chosen for promotions or hired for government positions upon release. There were also practical concerns in which they may be

required to take time off from work or must decline a mission due to their mental health, thus impeding their career progress.

One participant expressed that career implications could also be a function of a soldier's relationship with their chain of command: "So the issue I find today is if you are well-liked by the chain of command and you have a mental health issue then they will work with you. If you are not well-liked by the chain of command and you have a mental health issue, then you're out the door basically" (Man, 51). If an individual has a trusting relationship with their chain of command, they are more likely to aid this individual in obtaining the help they need. However, this participant indicated that if an individual's chain of command does not think highly of them, they would find a reason to release them from the military. Relatedly, another participant went to receive help for mental health concerns and was "cashiered out of the army" [participant's own words]. This individual experienced career loss firsthand as a result of seeking mental health support.

3.4. Trust

The importance of trust was identified in over half of the interviews. Many participants expressed that they did not trust that the military in general or any military practitioners were genuinely trying to help them.

3.4.1. Lack of Trust in Military

Seven participants conveyed a fundamental lack of trust in the military. In fact, many stated that they would never discuss anything personal with military leaders or their chain of command as they do not trust that their information will be kept private. When discussing moral injury specifically, one participant even expressed they would not discuss the trauma until the event which caused it was long over because of their absence of trust. "I am not going to go talk

to anybody about it until the procedures are complete, because I'm not going to give them any more ammunition than I have to. Because if I've made the choice to do something morally questionable, I've done it for what I consider to be justifiable reasons, and because I don't trust the system I'm not going to help them out to try and put me out to try to gain political capital on it, right?" (Man, 50).

Some participants also expressed a belief that the military would not try to adequately resolve an individual's mental health issue. They perceived the military's primary goal as pushing soldiers to become fit enough to return to work almost immediately or ushering them out of the army if they displayed any signs that they required longer, less straightforward treatment.

Although the military may have adequate mental health resources available, participants also expressed that they did not trust that all members would abide by the appropriate confidentiality protocols. Many participants expressed hesitation to disclose personal information when seeking help for mental health concerns due to the assumption that if their chain of command accessed their medical file, they would not use that information as they were supposed to. These participants perceived their chain of command as weaponizing access to soldiers' medical files.

For most participants, their lack of trust stemmed from directly experiencing or hearing stories about the repercussions of seeking help for mental health concerns. For instance, one participant expressed that not only did they not receive adequate help when seeking mental health support, but they also suffered severe career consequences. This individual now advises soldiers to keep their issues to themselves, explaining that it creates more harm than good.

3.4.2. Lack of Trust in Military Practitioner

Five participants expressed concerns related to trust in their mental health practitioner. Notably, one participant indicated that they do not believe in anything that a military mental health practitioner says and expressed that they have had several experiences in which a practitioner would say one thing and do another. When asked if there was anything a practitioner could say or do to gain their trust, one participant stated "…I simply do not believe anything that comes out of their mouths … they violated that trust and what they've said. They've broken those promises and I'm not prepared to believe anything, knowing the fact that they have exceptions" (Man, 44). Two participants also expressed a belief that military practitioners are not actively trying to help soldiers resolve their mental health concerns, but instead attempt to identify a reason to have them released from the military.

Three participants stated that they would only be comfortable seeking help from a trusted individual and clarified that it would be difficult for them to trust a military mental health practitioner. They further stated that their level of openness within a treatment setting depended heavily on how much they trusted their practitioner. In terms of developing trust, one participant stated that they would only feel comfortable if the practitioner was recommended to them by a peer. The other two stated that they would only talk to friends or family about their issues, suggesting that they would never trust a military practitioner.

3.5. Fear of investigation

This theme primarily emerged when discussing moral injury. Interviewees were asked whether and how they would seek support after experiencing potentially morally injurious events in which they did something morally wrong, they witnessed someone do something morally wrong, or they felt betrayed by their unit or chain of command. Most participants reported concerns that a morally-ambiguous act executed by the participant or another individual may be

illegal or against rules of engagement. In this case, participants reported that they would be careful when discussing these events with a practitioner. If they were the ones who performed the morally ambiguous act, they would not provide details to a practitioner for fear of legal repercussions. If they witnessed another individual performing a morally ambiguous act, they would wait until any decisions were made in terms of repercussions before discussing the issue in a mental health setting. However, if they were to discuss the event in a mental health support scenario, they would refrain from naming the perpetrator to avoid involvement in any legal proceedings surrounding the event. In both cases, the concerns reflect the potential for disclosure of information that could lead to an investigative process and legal repercussions.

For instance, when asked if participants would disclose details of an event to a practitioner in which they did something morally wrong and it was causing them severe distress, one participant stated: “I’m trying to stay as vague as possible. Because like there are so many things that you could do morally wrong in a situation like that. In the back of your head, like you try to get out like whether you did the right thing or not, because you’re questioning your morals. But, at the same time, you know in the back of your head that if you did something morally wrong there is a good chance that it’s also illegal, or it goes against the rules of engagement or something else. So, you’re going to be thinking like, “OK, if I do come out with this am I going to be in trouble?”” (Man, 34).

3.6. Accessibility and Adequacy of Support

This theme relates to the ease of accessibility for mental health treatments. First, only one participant expressed time constraints as a barrier to mental health support. When they were actively serving in the military, they did not believe they had enough free time to see a therapist

regularly; when they were released, their therapist was 45-60 minutes away, indicating that attending sessions required a significant time commitment.

3.6.1. Active Military

One participant reported that seeking and receiving help in the military is much more procedurally straightforward than when individuals are released from the military. The sick parade, where soldiers can access medical and mental health support, is easily accessible to those on base. Conversely, five participants expressed that there was a lack of available resources for mental health support in the military. Specifically, they mentioned that the wait times were too long to receive the required help.

Another participant mentioned that they would be more comfortable seeking help outside of the military while they are still actively serving, but that seeking help outside of a military setting is made difficult.

Two participants expressed that the level and effectiveness of support an individual receives strongly depends on their chain of command. Related to stigma, many participants expressed that some older members of the military believe that issues with mental health are synonymous with being weak, and therefore, do not believe that any individuals should seek help. These individuals likely will not actively work with soldiers in their chain of command to obtain help for mental health concerns.

Two participants expressed that the mandatory post-mission mental health check-in is inadequate. One participant stated that they did not have enough time between missions to recover from mental health issues before starting another mission. Another participant expressed that the military's "12-step program" does not work for everyone, suggesting that a more inclusive and adaptive system should be developed and implemented.

3.6.2. Released

One participant mentioned cost as a barrier, stating that it is expensive to seek help when released as it is not funded. Two participants further expressed that the process to seek mental health support when released from the military is unclear. Transitioning from a meticulously planned environment with appointment reminders within the military to becoming fully autonomous when released is difficult. Specifically, they expressed that it is difficult to know where to seek help for mental health concerns and identified issues surrounding wait times. There is also a fundamental lack of awareness of available support systems. CAF Veterans are not provided with information upon release regarding where to seek help for mental health issues. Relatedly, one participant expressed that there are quite a few great resources for mental health support upon release, but that CAF Veterans are not made aware of such resources.

3.6.3. Prefer separation of military and mental health support

Two participants mentioned they would prefer if the mental health support system was kept separate from the military. For instance, it would be beneficial to use mental health practitioners who do not report to the military and who work off base. However, this is a fundamental system change that would be difficult to implement quickly.

3.7. Understanding of mental health

3.7.1. Chain of Command

Treating mental health concerns is not as straightforward as treating physical ailments. It is not always immediately clear how to treat these issues. For this reason, it can be difficult to establish an effective treatment plan for soldiers who are struggling. For example, some soldiers may require only a few days off to recover, while others may need a more intensive program. One participant mentioned that this leads to an overabundance of caution and skepticism of their

abilities. For instance, A soldier may have a minor mental health concern and only require a few days off to recover. However, since this may not be clear right away, the practitioner may state that the soldier is unfit to perform a mission because they are still unsure how these mental health concerns will affect the soldier. As well, if a soldier's chain of command learned that their soldier has sought mental health support, they may choose to assign the soldier to mundane tasks as they are also unsure how these mental health concerns would affect the soldier. This can lead to career repercussions that may not be necessary if that individual could still function at work while seeking mental health support. Some interviewees further believed that if the individual is considered for a promotion and they seek mental health support, the chain of command may select another "healthy" individual because they perceive them as more capable. One participant outlined what they believed the chain of command's thought process to be when making the decision to replace a soldier who expressed mental health concerns: "We'll talk to them. You know what? It seems kind of uncertain. We'll still make sure they get their course at some time when they seem more certain. But for now, we're going to go send this other person who we could be certain is going to go on this course and be, you know, continue to be an asset to us as a service member" (Man, 37).

3.7.2. Military Mental Health Care System

Two participants expressed that there may be a lack of knowledge surrounding mental health within the military health care system. They believed that mental health problems were treated as though they were physical ailments. The practitioners want to find a "quick fix" to heal an individual in four to six weeks: "You know, the CAF wants to treat mental health like it's a broken bone. You put it in a splint and six weeks later guaranteed you're good to go. And there is

a fundamental lack of recognition that it's not always that simple" (Man, 40). This is not always a reasonable response for individuals struggling with their mental health.

In addition, two participants stated that they did not possess background knowledge reflecting mental health, but they knew that they needed support and assumed the practitioner would use their own knowledge to treat them. However, in both cases, they were only given time off and told nothing was wrong. One participant went on to struggle for years until they found out they had PTSD when they were released. Evidently, more education surrounding mental health would be useful throughout the military to ensure individuals receive the appropriate support.

3.8. Military Culture

Throughout the interviews, it was apparent that a culture exists in the military that is counterproductive to mental health support. Eight of the nine interviewees mentioned issues related to this military culture. This likely stems from the stigma that seeking assistance for mental health reasons implies that you are weak. Six participants communicated that there was pressure to deal with difficult emotions privately. Most of these participants expressed that they were constantly being told to "suck it up" and "soldier on." This reinforcement led to a normalization of self-medication, in that many soldiers chose to use substances and avoid their mental health concerns instead of confronting them head on. This leads to consequences for both the individual's well-being, as well as their relationships: "It's as a veteran our entire career we're kind of told to suck it up and, you know, soldier on and all that stuff. Which is all well and good, but we tend to push stuff down and at some point, it affects relationships whether it be your friends or family or significant other" (Man, 51). Similarly, when discussing moral injury, another interviewee stated "We, as service members, your loyalty is to your troop mates first.

And it's weird, like, we have this weird wall of silence, right? So, that weighs heavily into something like that…I joined the forces in '86 and we were told, you know, even if you do something ugly, you're supposed to, you know, get drunk, wipe some dirt on it, and carry on" (Man, 53).

There is also a pressure to focus the majority of an individual's time on their work, essentially discouraging work-life balance. However, one participant indicated that this is a difficult problem to resolve, as those in higher ranks had previously dedicated their lives to their job. These individuals are making hiring and promotional decisions and will, therefore, likely hire others who focus primarily on work and put their home life and mental health second.

On a positive note, five participants expressed that there does seem to be an active culture shift, such that soldiers and military leaders are trying to be more accepting and are increasing their understanding of mental health.

3.9. Identity as a soldier

This theme was reported in five of the nine interviews. Participants would identify a soldier and someone who seeks help for mental health concerns as mutually exclusive. In other words, there is a widespread belief that soldiers should not need to seek help because they are "strong".

Many participants stated that being a CAF member was not a job, but an identity. This makes the prospect of losing this job much more difficult and adds to the concern that seeking help for mental health concerns could result in job loss. These individuals then refrain from seeking help to maintain their self-worth.

One participant summarized this notion: "We don't get paid a lot and we love the job and, you know, you do things that are hard and you're proud of the fact you're doing it because you

want to and not because it's a lot of money involved or there's any other – there's a lot to do with how we portray Canada and how important it is for us to do our thing not for any other reason other than we give a crap about this country. So, anything that interferes with your promotions or – like, one of my jobs was I'm a military rescue diver. And it was a – it's called being a ship's diver. I would have been allowed to scuba dive if I wasn't mentally ill there. And that's part of your self-worth" (Man, 53).

Another interviewee stated that they went through such a negative experience seeking help through the CAF that they do not identify as a soldier anymore. This separation has allowed them to move forward in life easier and accept the help that they need. "…I've been in treatment for a number of years. I don't identify as a soldier anymore. And it has helped that I don't identify as a soldier anymore and that I'm able to move on with my life to a degree, but it's not gone. It's still there" (Man, 62).

3.10. Concerns about current relationships

There were two dimensions related to this theme: relationships with family, which served to facilitate help-seeking, and relationships with peers/troops, which hindered help-seeking or disclosure. Participants discussed seeking mental health treatment because they could see their social and home lives deteriorating and wanted to mend their relationships with family and friends. For these participants, the decision to seek help and mend relationships was more important than potential career implications associated with help-seeking: "And it took for me getting to the point where my marriage meant more to me than my career. To actually say all right, I'm going to get the help. Consequences be damned" (Man, 40). Some participants also stated that their family and friends encouraged them to seek help.

On the other hand, participants described their loyalty to peers or troops as one reason to refrain from seeking help. This was mentioned most often when discussing moral injury, as the potential implications can be more severe when disclosing morally injurious events. After having witnessed an individual do something morally wrong, many participants mentioned that they would be reluctant to disclose names when seeking help because they did not want to get someone in trouble. Stigma is also relevant to the "relationships with peers" dimension, as many participants expressed hesitation to seek help in fear that their peers would perceive them differently and consider them to be weak.

3.11. Concerns related to the practitioner

3.11.1. Skepticism Related to Practitioners' Understanding of Military

This theme is separate from "trust" because it relates to the belief that the practitioner will not understand what the soldier has been through. Whereas the trust theme involves concerns surrounding whether the practitioners want to help and will keep information private, this skepticism reflects the practitioners' knowledge and understanding of their career. Many participants expressed that they would prefer a practitioner who has had previous experience in the military to allow for a deeper understanding of the CAF Veteran's personal situation. For instance, when asked about what factors they consider when deciding to seek or utilize help, one participant stated: "I wanted to have [a practitioner] that had some sort of inkling and understanding of the military" (Man, 40).

3.11.2. Negative Experience with Practitioner

Two participants expressed that their resistance to help-seeking was due to a negative experience with a practitioner. A third participant reported that they did not receive adequate support when seeking help. This individual sought help for mental health concerns and was

given seven days off work; they only learned after they left the military that they were suffering from PTSD. The practitioner's lack of understanding of PTSD caused this individual to struggle without adequate help for years.

3.11.3. Willing to be Very Open with Practitioner

Three participants stated they were willing to be open with their practitioner when seeking mental health support. In these cases, they believed that the only way to receive adequate help would be to be as open as possible with their practitioner. The prospect of receiving the help they need was more important than their concerns surrounding confidentiality of their information.

3.12. Other

This domain includes all the points that were not described frequently enough to warrant their own theme.

3.12.1. Gender

One participant expressed that there was an added pressure as a woman to prove that they are just as strong and competent as the men. Relevant to stigma, there is a belief in the military that seeking mental health support makes you weak. Therefore, women are often hesitant to seek help due to fear that their peers already consider them weaker because of their gender.

3.12.2. Outside Stressors Minor in Comparison

One participant expressed that it is hard to accept mental health support once released as everyday stressors are "nothing compared to what they went through in the CAF".

3.12.3. Malingering

One participant mentioned the concern surrounding a malingering accusation, although they mentioned that this is more common for physical ailments. In the past, military members

often presented with fake injuries to get out of a mission that they did not want to do. Now, if an individual seeks help for a minor injury, they may fear that others will believe that they are faking it. The participant mentioned this could happen for mental health as well because it is an invisible ailment.

3.13. Moral injury

The themes that prevailed most when discussing moral injury were confidentiality, fearing investigation, and loyalty to peers. Most participants expressed that they would not want to be part of an investigation or experience any legal repercussions. These are concerns that were not apparent when discussing mental health help-seeking in general. The ambiguous legality of events that could lead to moral injury seems to be the main factor that drives CAF members to be more cautious about who they seek help from and what they disclose. Most interviewees expressed extreme caution when discussing moral injury because of their concerns about what would happen if their chain of command learned about the morally injurious event. This led some participants to avoid support for their moral injury altogether. It is evident that, while most of the barriers to mental health support are similar when experiencing PTSD or moral injury, moral injury leads to an abundance of caution and a difference in behaviours in which participants may be more likely to avoid help when experiencing moral injury versus PTSD.

CHAPTER 4: DISCUSSION

4. Discussion

The purpose of this study was to qualitatively examine confidentiality concerns and other barriers associated with seeking mental health support in CAF Veterans, as well as assess whether these concerns are amplified for those experiencing moral injury versus PTSD. Confidentiality concerns are often cited as a barrier to mental health treatment seeking and disclosure in the military (Hom et al., 2017). However, few studies go beyond merely identifying confidentiality as a concern. This qualitative investigation provided a detailed, in-depth description of the primary concerns associated with treatment-seeking and disclosure and yielded a more comprehensive understanding of why and how confidentiality is a concern.

Using thematic analysis, 11 main themes emerged, including the following: confidentiality concerns, stigma, career concerns, trust, fear of investigation, accessibility and adequacy of support, understanding of mental health, military culture, identity as a soldier, concerns about current relationships, and concerns related to the practitioner. Studies that investigate barriers to mental health in military populations have found similar results, such that stigma, confidentiality concerns, and military culture were identified as barriers to help seeking (Greene-Shortridge et al., 2007; Sharp et al., 2015; Zinzow et al., 2013). However, these studies did not differentiate between concerns related to PTSD and moral injury. The results of this study demonstrate differential help seeking behaviours and barriers when experiencing moral injury versus PTSD, demonstrating the necessity to separate PTSD and moral injury when researching help seeking behaviours. The possible legal repercussions associated with potentially morally injurious events influenced some individuals to refrain from seeking help for as long as possible. As well, the barrier of a fear of an investigation only emerged when discussing moral

injury. The following sections focus on how moral injury may influence these barriers, as well as the ways in which some major themes may influence other themes.

4.1. Moral Injury

This study was one of the first to separate moral injury and PTSD when exploring help seeking behaviours. When discussing moral injury, it was made clear that the legal ambiguity of potentially morally injurious events amplified the concerns that exist when experiencing PTSD alone. Because of this legal ambiguity, there was an added fear when experiencing moral injury that individuals would not only encounter career repercussions, but that an investigation may be initiated surrounding the event. In fact, discussions surrounding fear of an investigation only emerged when describing moral injury, supporting the notion that hesitation to seek and utilize help for mental health concerns in the military cannot be addressed by simply investigating these behaviours in general. This is consistent with previous research that found individuals with moral injury are sometimes reluctant to seek help for their moral injury due to potential legal implications (Williamson et al., 2021). It is important to separate PTSD and moral injury when investigating treatment seeking and utilization as they have differential motivators and outcomes for treatment seeking behaviours. This will aid policy makers in determining the best way to facilitate treatment seeking for moral injury specifically as CAF members and Veterans are less willing to seek or utilize support after experiencing moral injury compared to PTSD (Nazarov et al., 2021).

4.2. Confidentiality

Most participants expressed concerns surrounding the confidentiality of their information and these concerns likely influenced the emergence of other themes. Most notably, the majority of career concerns conveyed by nearly all interviewees could be by-products of confidentiality

breaches. The primary concern reflected the individuals' beliefs that peers, or their chain of command, would discover that they were seeking help and what they were seeking help for. They may then perceive them as weak and incapable of executing their job effectively, which would encourage their chain of command to make discouraging decisions about their career progress based on their misguided conceptions that this individual cannot do their job as well as someone without mental health concerns. The issue of stigma is also largely in effect here as these career repercussions seem to be a consequence of the chain of command classifying mental health concerns as weakness. In fact, research has identified that individuals in the military who seek help for mental health concerns are more likely to be discharged than those who do not, and individuals who sought help were more likely to be subject to medical board evaluations (Ghahramanlou-Holloway, 2019).

Interviewees also did not trust that their chain of command nor their practitioner would maintain the privacy of their information. These confidentiality-related trust deficits are not unwarranted, as studies have revealed that many military mental health professionals do not have a full grasp on the policies related to the disclosure of confidential information (Faustman, 1982, Jagim et al., 1978; Mengeling et al., 2014). If these practitioners are unsure of what they can and cannot disclose, it is possible that they may divulge information to their client's chain of command that should not have been shared.

Confidentiality is an even larger issue when dealing with moral injury, as this was the only instance in which interviewees stated they would refrain from seeking help altogether out of fear that the information shared in a session would be relayed to others. For example, one participant stated that if they were experiencing moral injury after engaging in behaviours that may be perceived as morally wrong, they would not share this information with practitioners,

friends, or family: “I don't think like if I did something wrong morally, like that went against my values; I would have a really hard time sharing that with anybody” (Man, 34). This is likely because moral injury can lead to feelings of shame and guilt. Shame, specifically, has been shown to lead to non-disclosure surrounding the cause of this emotion because of self-judgement as well as a fear of blame or judgment from others (MacDonald et al., 2011).

Evidently, confidentiality is a considerable issue when utilizing mental health support as there tends to be a lack of awareness by the soldiers surrounding what is and is not permitted to be shared with the chain of command. In addition, the chain of command may receive information based on a mental health support session that they should not have. If these confidentiality concerns were addressed by clarifying with the soldiers what can and cannot be shared from a mental health support session, this could greatly curtail some of the barriers to mental health support that are perceived by soldiers.

4.3. Stigma

Participants noted that there is widespread stigma surrounding mental health treatment-seeking and disclosure in the military. Many participants expressed that either they or others within the military believed that seeking or utilizing mental health support is synonymous with being weak. This is a commonly cited barrier to help-seeking in research on military populations (e.g., Green-Shortridge et al., 2007; McGuffin et al., 2021; Sharp et al., 2015).

This stigma could be the catalyst for many other themes that emerged. For instance, the military culture of “sucking it up” and “dealing with emotions privately” likely emerged because individuals were afraid to express their concerns for fear that they would be perceived as weak. To illustrate this, Sharp and colleagues (2015) conducted a systematic review that investigated the prevalence of stigma surrounding mental health in the military, as well as its influence on

mental health help-seeking. The authors found that the main concerns surrounding help-seeking reflected the notion that their leadership team would treat them differently and that they would be perceived as weak. These military members were most concerned with what others would think of them, suggesting that they are aware of the general negative beliefs surrounding mental health treatment-seeking in the military. This could also indicate that some of the themes related to relationship concerns may not have emerged if this stigma did not exist as these individuals' peers would not perceive them differently solely because of their mental health. This is also a by-product of confidentiality as these individuals are assuming that their peers and chain of command will know that they are seeking help. However, if this was confidential, their peers and chain of command would not be privy to this information.

Relevant to the *identity as a soldier* theme, many expressed that a crucial characteristic of a soldier is both internal and external strength. Therefore, this stigma associated with mental health being synonymous with weakness may lead to greater difficulty with acknowledging mental health concerns, as this runs contrary to their self-identity. This discrepancy could manifest into a cognitive dissonance within the soldier as their behaviours and beliefs do not match. To manage cognitive dissonance, individuals generally try to eradicate one of the factors causing the incongruity (McGrath, 2017). In this case, the soldier can either choose not to identify as a soldier anymore or convince themselves they do not need mental health support. Given that being a soldier is not only their identity but their job, the latter option of discounting their mental health concerns may be more feasible. Studies have also shown that after experiencing deployment, soldiers have a harder time separating their identities as soldier versus citizen (Vest, 2013). If one primarily identifies as a soldier, they will presumably be even less likely to seek help for mental health concerns, as this fundamentally goes against this identity.

Perhaps reinforcing the idea that these individuals are more than just soldiers would benefit CAF Veterans by normalizing mental health help-seeking and disclosure.

For individuals experiencing moral injury, this stigma could lead to even more severe implications, as they will likely already hold feelings of shame and guilt. Shame and guilt, paired with a self-stigma that they are weak for requiring mental health support could manifest into serious outcomes such as social isolation. Shame has been found to be associated with social disengagement and the desire to work alone (Chao et al., 2011). Therefore, an increase in feelings of shame can lead some individuals to social isolation which can be detrimental to their mental health (House, 2001). It is possible that the feelings of shame are amplified when paired with self-stigma as the individual is not only experiencing shame as a by-product of their moral injury, but they may also be ashamed of themselves for experiencing any mental health concerns.

4.4. Understanding of Mental Health

Throughout the interviews, it became clear that within the military, there is limited knowledge surrounding mental illness and how to treat these conditions. Perhaps with greater effort to increase knowledge surrounding mental health, the stigma that exists could dissipate. In fact, studies have shown that implementing mental health education programs decreases stigma related to mental health (Griffiths et al., 2014; Saporito et al., 2011). It is possible that if the individuals within the chain of command enhance their mental health knowledge, they may be less likely to make impactful career decisions based on one's mental health.

A lack of understanding of mental health paired with a skepticism of the practitioner could have detrimental consequences for an individual's well-being, as these Veterans are the least likely to seek or utilize help. Relatedly, Kantor et al. (2017) conducted a systematic review of studies investigating barriers to mental health utilization in both civilian and military samples

and found that a diminished understanding of mental health was one of the largest predictors of lower rates of help-seeking and utilization.

Understanding of mental health could be enhanced by implementing programs to increase military members' mental health literacy. This would likely help decrease the stigma associated with mental health in the military which could in turn curtail many of the other barriers that were identified in this study. It is important to note that the CAF implemented the "Road to Mental Readiness" (R2MR) program in 2008. The goal of this program being to educate military members about mental health as well as increase psychological resilience (Bailey, 2015). It is likely that most of our participants were not exposed to this program as most were enlisted long before it was implemented. Therefore, it is possible that mental health literacy has increased in the CAF since 2008 (Fikretoglu, 2019).

4.7. Limitations and Future Directions

Although the qualitative nature of this study allowed for a more in-depth investigation of CAF members' perceptions of barriers related to mental health help-seeking and disclosure, there are some limitations associated with this study that should be considered. First, when conducting interviews, the face-to-face nature could result in social desirability bias (Leggett et al., 2003). This is inherent in many qualitative interview-based studies. The virtual nature of our interviews may have mitigated the impact of social desirability, as participants had the option to turn off their camera during the interview. Still, this does not provide the anonymity that exists in quantitative research. It is possible that participants would be more open about their specific experiences if their responses remained anonymous. However, participants freely discussed both their positive and negative perceptions related to the military mental health care system, suggesting that social desirability was not a major issue.

Research bias is also inherent in all qualitative research, as the analysis and organization of the data depends largely on researcher interpretation. To mitigate this, the research team had biweekly meetings to discuss and review the interviews. Each member of the research team also read all interviews to familiarize themselves with the content. When coding began, the team continued to meet bi-weekly to ensure agreement based on the analysis and organization of codes.

Next, all but one participant indicated they were currently experiencing or had experienced mental health concerns previously. It is possible that our findings would have resulted in greater variability if we had interviewed more CAF Veterans who had never experienced trauma or mental health concerns at all.

Additionally, the average age of our sample was 47.78 years. This suggests that many of our participants had likely not been exposed to the R2MR program and may not have a strong understanding of mental health. Future research should target individuals who have been exposed to this program as different themes may emerge.

There was also less representation for women in the study, as most of the sample were men. Future research should recruit a greater number of women to gain more insight into their perspectives on mental health treatment-seeking and disclosure. Finally, individuals were free to participate regardless of their mental health status. It was hoped that doing so would allow us to obtain a more general picture of CAF members' perceptions surrounding treatment-seeking and utilization for individuals who did or did not seek treatment. Although, as mentioned above, most participants had experienced or were currently experiencing mental health concerns. Future research should, however, specifically recruit individuals exhibiting symptoms of moral injury

and PTSD to directly explore how their perceptions and experiences differ from those who have not experienced moral injury and PTSD.

It is important to note that the conversations surrounding moral injury did not emerge organically. Although we anticipated that interviewees would mention moral injury without prompting, most participants only made the distinction between moral injury and PTSD when asked directly. Future studies should include more in-depth qualitative investigations of moral injury to better understand individuals' experiences with the construct. Future research should also qualitatively evaluate perceived barriers to mental health help-seeking and disclosure among military mental health clinicians. This will allow for comparisons of their perceptions of mental health treatment with those of CAF Veterans'.

4.8. Conclusions

This study contributes to the understanding of CAF Veterans' hesitation to seek and utilize mental health support. Evidently, there are many barriers to mental health care within the military community. We also demonstrated that PTSD and moral injury have distinct motivators and outcomes associated with treatment-seeking behaviours. The legal ambiguity of PMIEs, as well as the feelings of shame and guilt associated with moral injury, can make it very difficult to come forward and seek support for moral injury.

When considering the emergent themes of the present study, it is evident that improving the clarity surrounding what remains confidential in a mental health treatment-seeking setting, as well as an increase in mental health literacy in the military could help mitigate some of the barriers and alleviate the stigma surrounding mental health. The results of the present study should aid policy makers in creating programs to help facilitate help seeking and utilization in the military.

References

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. (DSM-5)*

Anestis, M. D., & Green, B. A. (2015). The impact of varying levels of confidentiality on disclosure of suicidal thoughts in a sample of united states national guard personnel. *Journal of Clinical Psychology, 71*, 1023-1030.

Bailey, S. (2015). The Canadian Forces Health Services Road to Mental Readiness Programme. Medical Corps Int Forum, 2015(2), 37–48.

Begić, D., & Jokić-Begić, N. (2001). Aggressive behavior in combat Veterans with post-traumatic stress disorder. *Military Medicine, 166*(8), 671-676. https://doi.org/10.1093/milmed/166.8.671

Bonar, E. E., Bohnert, K. M., Walters, H. M., Ganoczy, D., & Valenstein, M. (2015). Student and nonstudent National Guard service members/Veterans and their use of services for mental health symptoms. *Journal of American College Health, 63*(7), 437-446. https://doi.org/10.1080/07448481.2014.975718

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bremner, J. D., Southwick, S. M., Johnson, D. R., Yehuda, R., & Charney, D. S. (1993). *Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam Veterans. The American Journal of Psychiatry*, *150*(2), 235-239. https://doi.org/10.1176/ajp.150.2.235

Bryan, C. J., Bryan, A. O., Roberge, E., Leifker, F. R., & Rozek, D. C. (2018). Moral injury, posttraumatic stress disorder, and suicidal behavior among National Guard personnel.

Psychological Trauma: Theory, Research, Practice, and Policy, 10, 36–45. https://doi.org/10.1037/tra0000290

Callebaut, L., Molyneux, P., & Alexander, T. (2017). The relationship between self-blame for the onset of a chronic physical health condition and emotional distress: A systematic literature review. *Clinical psychology & psychotherapy, 24*(4), 965-986.

Canadian Psychological Association. (2014). *Canadian Code f Ethics for Psychologists-January 2014*. Retrieved from https://cpa.ca/docs/File/Ethics/cpa_code_2000_eng_jp_jan2014.pdf

Chao, Y. H., Cheng, Y. Y., & Chiou, W. B. (2011). The psychological consequence of experiencing shame: Self-sufficiency and mood-repair. *Motivation and Emotion, 35*(2), 202-210.

Chapman, P. L., Elnitsky, C., Pitts, B., Figley, C., Thurman, R. M., & Unwin, B. (2014). Mental health, help seeking, and stigma and barriers to care among 3-and 12-month postdeployed and never deployed US Army Combat Medics. *Military medicine, 179*(8), 55-62.

Easterbrook, B., Plouffe, R. A., Houle, S. A., Liu, A., McKinnon, M. C., Ashbaugh, A. R., Mota, N., Afifi, T. O., Enns, M. W., Richardson, J. D., & Nazarov, A. (2022). Risk Factors for Moral Injury Among Canadian Armed Forces Personnel. *Frontiers in psychiatry, 13*, 892320. https://doi.org/10.3389/fpsyt.2022.892320

Faustman, W. O. (1982). Legal and ethical issues in debt collection strategies of professional psychologists. *Professional Psychology, 13*, 208-214.

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

Fikretoglu, D., Liu, A., Nazarov, A., & Blackler, K. (2019). A group randomized control trial to test the efficacy of the Road to Mental Readiness (R2MR) program among Canadian military recruits. *BMC psychiatry, 19*(1), 1-14.

Fisher, M. L., & Exline, J. J. (2006). Self-Forgiveness versus Excusing: The Roles of Remorse, Effort, and Acceptance of Responsibility. *Self and Identity, 5*(2), 127-146. https://doi.org/10.1080/15298860600586123

Frey, R. A. M. (2017). Ethical challenges for military psychologists: When worlds collide. *Ethics & Behavior, 27*, 283-296.

Ghahramanlou-Holloway, M., Koss, K., Rowan, A., LaCroix, J. M., Perera, K., Carreno, J., & Grammer, J. (2019). Retrospective and prospective examination of outpatient mental health utilization and military career impacts. *Stigma and Health, 4*(2), 143.

Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military medicine, 172*(2), 157-161.

Griffiths, K. M., Carron-Arthur, B., Parsons, A., & Reid, R. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World psychiatry, 13*(2), 161-175.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *The New England Journal of Medicine, 351*(1), 13-22. https://doi.org/10.1056/NEJMoa040603

Hom, M. A., Stanley, I. H., Schneider, M. E., & Joiner, T. E. (2017). A systematic review of help-seeking and mental health service utilization among military service members. *Clinical Psychology Review, 53*, 59–78.

Hook, A., & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of Clinical Psychology, 44*(3), 425-438.

House, J. S. (2001). Social isolation kills, but how and why?. *Psychosomatic medicine, 63*(2), 273-274.

Iversen, A. C., van Staden, L., Hughes, J. H., Browne, T., Greenberg, N., Hotopf, M., Rona, R. J., Wessely, S., Thornicroft, G., & Fear, N. T. (2010). Help-seeking and receipt of treatment among UK service personnel. *The British Journal of Psychiatry, 197*(2), 149-155. https://doi.org/10.1192/bjp.bp.109.075762

Jagim, R. D., Wittman, W. D., & Noll, J. O. (1978). Mental health professionals' attitudes toward confidentiality, privilege, and third-party disclosure. *Professional Psychology, 9*, 458-466.

Kantor, V., Knefel, M., & Lueger-Schuster, B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical Psychology Review, 52*, 52-68.

Leggett, C. G., Kleckner, N. S., Boyle, K. J., Duffield, J. W., & Mitchell, R. C. (2003). Social desirability bias in contingent valuation surveys administered through in-person interviews. *Land Economics, 79*(4), 561-575.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York, NY: International Universities Press

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war Veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29*(8), 695-706. https://doi.org/10.1016/j.cpr.2009.07.003

Lothen-Kline, C., Howard, D. E., Hamburger, E. K., Worrell, K. D., & Boekeloo, B. O. (2003). Truth and consequences: Ethics, confidentiality, and disclosure in adolescent longitudinal prevention research. *Journal of Adolescent Health, 33*, 385-394.

Macdonald, J., & Morley, I. (2001). Shame and non-disclosure: A study of the emotional isolation of people referred for psychotherapy. *British Journal of Medical Psychology, 74*, 1-21. https://doi.org/10.1348/000711201160731

Maltby, J., Macaskill, A., & Day, L. (2001). Failure to forgive self and others: A replication and extension of the relationship between forgiveness, personality, social desirability and general health. *Personality and Individual Differences, 30*(5), 881-885. https://doi.org/10.1016/S0191-8869(00)00080-5

McGrath, A. (2017). Dealing with dissonance: A review of cognitive dissonance reduction. *Social and Personality Psychology Compass, 11*(12), 1-17. https://doi.org/10.1111/spc3.12362

McGuffin, J. J., Riggs, S. A., Raiche, E. M., & Romero, D. H. (2021). Military and Veteran help-seeking behaviors: Role of mental health stigma and leadership. *Military Psychology, 33*(5), 332-340. https://doi.org/10.1080/08995605.2021.1962181

Mengeling, M. A., Booth, B. M., Torner, J. C., & Sadler, A. G. (2014). Reporting sexual assault in the military: Who reports and why most servicewomen don't. *American Journal of Preventive Medicine, 47*, 17-25.

Nazarov, A., Fikretoglu, D., Liu, A., Richardson, J. D., & Thompson, M. (2020). Help-seeking for mental health issues in deployed Canadian Armed Forces personnel at risk for moral injury. *European Journal of Psychotraumatology, 11*(1), 10.1080/20008198.2020.1729032

Nazarov, A., Fikretoglu, D., Liu, A., Thompson, M., & Zamorski, M. A. (2018). Greater prevalence of post-traumatic stress disorder and depression in deployed Canadian Armed Forces personnel at risk for moral injury. *Acta Psychiatrica Scandinavica, 137*(4), 342-354.

Nazarov, A., Jetly, R., McNeely, H., Kiang, M., Lanius, R., & McKinnon, M. C. (2015). Role of morality in the experience of guilt and shame within the armed forces. *Acta Psychiatr Scand, 132*, 4-19.

Nazarov, A., Plouffe, R., Forchuk, C., Trahair, C., & Richardson, J. D. (2021). *Beliefs about Confidentiality and Attitudes toward Disclosure of Moral Injuries*. Paper presented at the Australasian Conference on Traumatic Stress, Virtual.

Richardson, N.M., Lamson, A.L., Smith, M., Eagan, S.M., Zvonkovic, A.M. and Jensen, J. (2020), Defining Moral Injury Among Military Populations: A Systematic Review. *Journal of Traumatic Stress, 33*, 575-586. https://doi.org/10.1002/jts.22553

Saporito, J. M., Ryan, C., & Teachman, B. A. (2011). Reducing stigma toward seeking mental health treatment among adolescents. *Stigma research and action, 1*(2), 9.

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

Tanielian, T., Woldetsadik, M. A., Jaycox, L. H., Batka, C., Moen, S., Farmer, C., & Engel, C. C. (2016). Barriers to engaging service members in mental health care within the U.S. Military health system. *Psychiatric Services, 67*(7), 718-727. https://doi.org/10.1176/appi.ps.201500237

Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review, 32*(2), 122-138. https://doi.org/10.1016/j.cpr.2011.12.001

U.S. Department of Veterans Affairs. (2018). *VA national suicide data report 2005–2016: Office of Mental Health and Suicide Prevention– September 2018*. Retrieved from https://www.mentalhealth.va.gov/ docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_ 508.pdf

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-traumatic stress disorder in Canada. *CNS Neuroscience & Therapeutics, 14*(3), 171-181. https://doi.org/10.1111/j.1755-5949.2008.00049.x

Vest, B. M. (2013). Citizen, Soldier, or Citizen-Soldier? Negotiating Identity in the US National Guard. *Armed Forces & Society*, *39*(4), 602–627. https://doi.org/10.1177/0095327X12457725

Wampold, B. E., Imel, Z. E., Laska, K. M., Benish, S., Miller, S. D., Flűckiger, C., Del Re, A. C., Baardseth, T. P., & Budge, S. (2010). Determining what works in the treatment of PTSD. *Clinical Psychology Review*, *30*(8), 923-933. https://doi.org/10.1016/j.cpr.2010.06.005

Williamson, V., Murphy, D., Stevelink, S. A. M., Jones, E., Wessely, S., & Greenberg, N. (2021). Confidentiality and psychological treatment of moral injury: the elephant in the room. BMJ Mil Health, 167(6), 451-453.

Wisco, B. E., Marx, B. P., May, C. L., Martini, B., Krystal, J. H., Southwick, S. M., & Pietrzak, R. H. (2017). Moral injury in U.S. Combat Veterans: Results from the national health and

resilience in Veterans study. *Depression and Anxiety*, *34*(4), 340-347. https://doi.org/10.1002/da.22614

Xue, C., Ge, Y., Tang, B., Liu, Y., Kang, P., Wang, M., & Zhang, L. (2015). A meta-analysis of risk factors for combat-related PTSD among military personnel and Veterans. *PLoS ONE, 10*(3), 21. https://doi.org/10.1371/journal.pone.0120270

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

Zinzow, H. M., Grubaugh, A. L., Monnier, J., Suffoletta-Maierle, S., & Frueh, B. C. (2007). Trauma among female Veterans: A critical review. *Trauma, Violence, & Abuse, 8,* 384–400.

APPENDICIES

Appendix A

Recruitment emails

Email Scripts
For those who completed phase 1:

Subject line: New research study: Interview study about confidentiality and attitudes toward disclosure of moral injuries.

Good morning/afternoon/evening,

You may recall that you previously participated in an online research survey that examined your beliefs about medical confidentiality in response to hypothetical situations involving moral injury. At the end of that survey, you mentioned that you would be interested in being contacted for follow-up studies related to this topic. **We are inviting you to participate in a follow-up study,** which involves a virtual interview to discuss your thoughts and opinions on confidentiality and seeking help for moral injuries in the military.

Please see the study details below if you are interested in participating.

TO PARTICIPATE, we made it simple for individuals to complete the consent form online. CLICK HERE TO REVIEW LETTER OF INFORMATION AND CONSENT
[REDACTED] *A detailed Letter of Information and Consent is also attached to this email as a PDF file. If it is more convenient for you to sign the PDF form, please send the completed form to our research coordinator at* **[REDACTED]**

Study background:

Many current and former military members with OSIs do not seek mental health treatment. Several barriers to seeking care have been identified, however, one's beliefs about the privacy and confidentiality of medical details have not received the much-needed attention. Beliefs about the confidentiality of details shared during treatment may influence whether someone decides to seek help from a mental health professional. Confidentiality may be a critical barrier particularly in situations where individuals are struggling from distress related to moral injuries (i.e., where they believe they did something morally wrong or failed to do something, witnessed someone else do something morally wrong, or being deeply betrayed). More research is needed to understand how beliefs about confidentiality may influence help-seeking in military members and Veterans.

Study procedure:

You will be asked to participate in a virtual interview (via Cisco WebEx) in which you will be asked your thoughts and opinions about help-seeking and mental health service use in the military, as well as relevant barriers to these processes. You are not required to have sought out

mental health support in the past in order to be eligible for this study. We are interested in hearing opinions from everyone - regardless of whether you have sought treatment or not, or whether or not you have had mental health concerns or moral injury in the past. The duration of the interview can range between 30 minutes and 90 minutes, depending on the length of the discussion.

TO PARTICIPATE, we made it simple for individuals to complete the consent form online. CLICK HERE TO REVIEW LETTER OF INFORMATION AND CONSENT (https://redcap.lawsonresearch.ca/surveys/?s=L73KP3TJ8Y). *A detailed Letter of Information and Consent is also attached to this email as a PDF file. If it is more convenient for you to sign the PDF form, please send the completed form to our research coordinator at* **[REDACTED]**

Sharing the study with others:

If you are aware of other current or released CAF members who might be interested in participating, please send them the following study information link for this study: https://participaid.co/studies/dwpYge

If you have any questions or concerns regarding the interview, you may contact the **[REDACTED]**. Principal Investigator: Dr. Anthony Nazarov.

Thank you for your support.

For those who responded to media release / public advertisement:

Subject line: New research study: Interview study about confidentiality and attitudes toward disclosure of moral injuries.

Good morning/afternoon/evening,

You are being contacted because you previously reached out to our team at the MacDonald Franklin Operational Stress Injury (OSI) Research Centre to express interest in participating a research study **[REDACTED]** **[REDACTED]** We are happy to inform you that we are now recruiting participants for Phase 2 of this study, and we invite you to contact us should you wish to participate. Additional details are provided below.

Please see the study details below if you are interested in participating.

TO PARTICIPATE, we made it simple for individuals to complete the consent form online. CLICK HERE TO REVIEW LETTER OF INFORMATION AND CONSENT (https://redcap.lawsonresearch.ca/surveys/?s=L73KP3TJ8Y). *A detailed Letter of Information and Consent is also attached to this email as a PDF file. If it is more convenient for*

you to sign the PDF form, please send the completed form to our research coordinator at **[REDACTED]**

Study background:

Many current and former military members with OSIs do not seek mental health treatment. Several barriers to seeking care have been identified, however, one's beliefs about the privacy and confidentiality of medical details have not received the much-needed attention. Beliefs about the confidentiality of details shared during treatment may influence whether someone decides to seek help from a mental health professional. Confidentiality may be a critical barrier particularly in situations where individuals are struggling from distress related to moral injuries (i.e., where they believe they did something morally wrong or failed to do something, witnessed someone else do something morally wrong, or being deeply betrayed). More research is needed to understand how beliefs about confidentiality may influence help-seeking in military members and Veterans.

Study procedure:

You will be asked to participate in a virtual interview (via Cisco WebEx) in which you will be asked your thoughts and opinions about help-seeking and mental health service use in the military, as well as relevant barriers to these processes. You are not required to have sought out mental health support in the past in order to be eligible for this study. We are interested in hearing opinions from everyone - regardless of whether you have sought treatment or not, or whether or not you have had mental health concerns or moral injury in the past. The duration of the interview can range between 30 minutes and 90 minutes, depending on the length of the discussion. *A detailed Letter of Information and Consent is attached to this email.*

TO PARTICIPATE, we made it simple for individuals to complete the consent form online. CLICK HERE TO REVIEW LETTER OF INFORMATION AND CONSENT
[REDACTED] *A detailed Letter of Information and Consent is also attached to this email as a PDF file. If it is more convenient for you to sign the PDF form, please send the completed form to our research coordinator at* **[REDACTED]**

Sharing the study with others:

If you are aware of other current or released CAF members who might be interested in participating, please send them the following study information link for this study:
[REDACTED]

If you have any questions or concerns regarding the interview, you may contact

Principal Investigator: Dr. Anthony Nazarov.

[REDACTED]

Thank you for your support.

Appendix B

Letter of Information

LETTER OF INFORMATION AND CONSENT

Study Title: An Interview Study of Beliefs about Confidentiality and Attitudes toward Disclosure of Moral Injuries

Principal Investigator: Dr. Anthony Nazarov

[REDACTED]

Funding: Veterans Affairs Canada

Invitation to Participate

Individuals who have previous military experience in the Canadian Armed Forces (CAF) are invited to participate in a virtual interview exploring beliefs about the confidentiality of personal information when seeking mental health treatment and disclosing stressful events to mental health professionals. Of particular focus, the study will explore one's beliefs on whether experiencing certain types of stressful experiences, such as moral transgressions or morally distressing events, may be more challenging to disclose and seek help for.

Background/Purpose

Research has shown that mental health services are underutilized among military members and Veterans. Evidence also suggests that beliefs about the confidentiality of details disclosed during treatment may influence decisions on whether to seek help from a mental health professional. One type of psychological distress that may be experienced by military members is moral injury - the psychological distress in response to experiences that transgress personal moral standards. Moral injury is particularly concerning because individuals may not seek help due to perceived risk of career or legal repercussions. However, a lack of focused research on the role of confidentiality in help-seeking and disclosure for moral injury prevents a thorough understanding of its unique influence in help-seeking decisions. Given the importance of receiving adequate mental health care when it is needed, research is urgently needed to understand how beliefs about confidentiality may influence help-seeking in military members and Veterans.

Inclusion Criteria

- 18 years or older
- Must have a history of military experience in the CAF

Exclusion Criteria

- If unable to, or do not provide consent

Study Design/Procedures

Individuals with military experience in the CAF will participate in a virtual interview (via Cisco WebEx) in which they will be asked open-ended questions about help-seeking and mental health service use in the military, as well as relevant barriers to these processes. Questions will also touch on potential morally injurious events and how these events may influence the decision to seek help. It is not required that participants have sought out mental health support in the past in order to be eligible for this study. The interview duration may range between 30 minutes and 90 minutes. The interview will be recorded for transcription purposes. Only audio will be recorded to maintain confidentiality (video will not be recorded). Basic demographic variables will be collected.

Risks

There are some risks associated with participating in this study. Although this study asks questions about your beliefs and opinions, some of these beliefs may be your personal experiences in the military. This may cause you to feel uncomfortable or distressed. Should you feel discomfort or distress responding to the questions, you are free to refuse to answer any questions or withdraw from the study at any time without penalty. If you wish to speak to a mental health professional following participation in this study, please see the Mental Health Resources section below for more information. There are no other known or anticipated risks to you as a participant of this study. Please be advised that your participation in this study, or indeed any research, may involve risks that are currently unforeseen by Lawson Health Research Institute, St. Joseph's Health Care London, or Western University.

Benefits

There are no known personal benefits from participating in this study. However, our findings may allow clinicians, researchers, and policy-makers to determine whether specific policies and regulations should be modified to facilitate treatment-seeking and disclosure among CAF members and Veterans.

Voluntary Participation

Taking part in this study is entirely voluntary. You may change your decision to participate at any point throughout the study. You have the right to refuse to answer any questions, to stop the recording at any point during the interview, or to withdraw from the study at any point in time. Should you choose to withdraw, all data from your interview will be destroyed. Optionally, you will have an opportunity to be followed up for future research related to this study.

Compensation

You will be presented with the choice to receive an Amazon, Starbucks, or Tim Horton's e-Gift card in the amount of $25 CAD as compensation for your participation. The gift card will be sent to your email.

Confidentiality

The information in this study will only be used in ways that will not reveal who you are. You will not be identified in any publication from this study or in any data files shared with other researchers. Your identity as a participant in this study is confidential. All research data will be stored electronically on REDCap (password-protected research database behind Lawson Health Research Institute firewall) and on the St. Joseph's Health Care London network drive (behind institutional firewall). Contact information of potential participants enrolling from social media will be collected using the Lawson-approved survey tool REDCap (password-protected and encrypted). Audio recording of the interview will be saved for transcription purposes. Video will not be recorded. You will have a choice to either keep your camera on or off for the duration of the interview (if you choose to keep the camera on, the video of the interview will not be recorded). Audio recordings are not cloud-based and will be stored on the St. Joseph's Health Care London network drive (behind institutional firewall). Interviews will be transcribed verbatim (with identifying information removed), and copies of transcriptions will be stored as electronic data as described above. Interviews will be transcribed by Transcript Heroes. Transcript Heroes is a transcription service that St. Joseph's has a Master Technology agreement with. Audio and word files are transferred between St. Joseph's and Transcript Heroes using secure file transfer; no video files will be sent (only audio). Data will be stored for 15 years, as per Lawson Health Research Institute (London, Ontario) institutional guidelines. After 15 years, the data will be destroyed according to institutional guidelines at the time of data destruction.

First and last name, phone number, email, and city of residence will be collected and retained in order to schedule appointments, consent, differentiate participants, remuneration, and to inform them of future studies (only if they have expressed interest in receiving information regarding future studies). All personally identifiable information required for consenting, interview scheduling, and remuneration will be collected and stored electronically in REDCap; research data will only contain a participant ID. Identifiable data will remain confidential and accessible only to the investigators of this study. Research data may be shared with other researchers/statisticians/analysts through data sharing agreements approved by LHRI to confirm findings or provide analytical expertise; no directly identifying information will be shared.

Any data that may be published in scientific journals will not reveal your identity; however, anonymous de-identified quotations may be used. The contents of the interview described above will be used for purposes only in the context of this study. If you decide to participate, you are free to discontinue participation at any time without explanation to the researchers. Representatives of the Western University Health Sciences Research Ethics Board may require access to your study-related documents to oversee the ethical conduct of this study. Representatives of Lawson Quality Assurance Education Program may require access to your study-related records to ensure that proper laws and guidelines are being followed.

Given the nature of events potentially being discussed during the interviews, there are certain situations in which the investigators are mandated to report to authorities. If situations of child abuse and/or threat to self/others are disclosed in the interviews, then this

information will be shared with the relevant authorities. All other information discussed in the interviews will remain entirely confidential.

Rights as a Participant

You may skip any study procedures without penalty. You do not waive any legal right by completing this study.

Mental Health Resources

[REDACTED] (Veterans Affairs Canada Assistance Service) to speak to a mental health professional right now. This is a confidential and free service available 24/7 to Veterans, former RCMP members, their family members, or caregivers **[REDACTED]** **[REDACTED]**

Please note that this service is not for emergencies. If you have a medical or mental health emergency, call 911 or go to the nearest open clinic or emergency room.

If you have difficulties connecting with the listed resources, we invite you to connect with the MacDonald Franklin OSI Research Centre, who may assist in connecting with resources.
Email: **[REDACTED]**

Questions about the Study

If you require further information or have questions regarding this study, please contact: Luciana Brown, Research Coordinator, MacDonald Franklin OSI Research Centre, at
[REDACTED]
[REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact: St Joseph's Health Care London Patient Relations Consultant at
[REDACTED]

Consent

Please sign and date below if you consent to participate in this study.

Full Name: _____

Signature: _____

Date: _____

Please enter an email address where you wish to receive the e-gift card (Amazon card) as remuneration for participation in this study.

Email: _____

Appendix C

Interview guide

Confidentiality Interview Guide

Preamble

[Screenshare LOI]

Hello *[NAME]*. Thank you for participating in our study and for taking the time for this interview today.

I will provide you with a brief overview of what the interview will entail, and then we can address any questions you have before we begin. Overall, the duration of the interview should take approximately 1 hour. I will begin by asking a few administrative questions about your military service and treatment history and then we will proceed with the interview questions and we will finish up by asking you demographic questions. The interview questions will ask about your beliefs about disclosure in a mental health treatment setting, as well as some questions surrounding treatment seeking. If you do not feel comfortable answering a question, you do not have to answer and we can move on to the next question.

Everything you say in this interview will kept confidential and only accessible to approved investigators. The interview transcripts will be de-identified for analysis, so your name and any other identifying information will not be associated with your transcript.

The audio associated with this interview will be recorded for transcription purposes. The video will not be recorded.

Before we begin, do you have any questions about the letter of information, the interview, or the study in general?

We will now begin with the demographic questions. If you notice that I look off to the side during the interview, this is because I will be referring to the interview script to ensure that I don't miss anything.

[Refer to demographics questionnaire]
[Proceed to interview]

Treatment-Seeking Behaviour

I will start by asking about your experience with mental health treatment, if any.

1. What factors do you consider when deciding whether to seek mental health support?
    - **Probe**: Walk me through some advantages and disadvantages to seeking mental health support that you may consider prior to making a decision.
    - Who would you prefer to approach? Mental health professional, healthcare provider, chaplain, or someone else?
        - Why would you prefer to approach this person?

1. Can you walk me through the factors you would consider if you were still active in the military and considering seeking help?
    - **Probe:** You mentioned that as a Veteran, (travel cost; example) is a barrier to seeking help. How would this apply if you were active in the military? Are there any other factors you would consider when active that you would not have as a Veteran?
    - Who would you prefer to approach? Mental health professional, healthcare provider, chaplain, or someone else?
        - Why would you prefer to approach this person?

Disclosure

1. Can you think of any types of personal information that may be relevant to treatment that you would never share with the healthcare provider?
    - **Clarification:** Personal information might include anything related to your emotions, symptoms, and any traumatic experiences that you may have encountered during your service.
    - **Follow up**: Without going into specific detail, what about any information related to traumatic experiences you may have encountered during your service?
    - **Follow up:** Are there any circumstances in which you would disclose this information?

1. What kinds of personal information would you feel comfortable sharing with the healthcare provider?

1. Within the context of mental health treatment, including chaplain counsel, *who* would you feel more comfortable sharing personal information with, and who would you feel less comfortable sharing personal information with? Tell me more about that.
    - **Clarification:** This reflects actual disclosure of relevant personal information (not just seeking out a treatment option).

Moral Injury

Now I am going to provide you with some examples of events that someone could encounter in combat and ask how you think you might respond.

1. If you think you did something morally wrong and the experience was causing you mental distress, why would you or would you not choose to disclose this in a mental health support situation?
    - Is there a certain person you would prefer to disclose to? Like a mental health professional, healthcare provider, or chaplain in a military setting?

1. If you saw someone you know do something morally wrong and the experience was causing you mental distress, would you disclose this in a mental health support situation?
    - Why or why not?
    - Is there a certain person you would prefer to seek help from? Like a mental health professional, healthcare provider, or chaplain in a military setting?

1. If you felt betrayed during a mission and the experience was causing you mental distress, would you disclose this in a mental health support situation?
   Why or why not?
    - Is there a certain person you would prefer to seek help from? Like a mental health professional, healthcare provider, or chaplain in a military setting?

Confidentiality-Specific Questions

1. How do you define confidentiality in a mental health treatment setting?
2. What are your expectations about confidentiality in a mental health treatment setting?
3. How much does confidentiality play a role in your decisions to seek help? (Relative to other factors)

For the next questions I'd like you to think of confidentiality as:
A healthcare provider does not collect or use information about a client without the informed consent of the client, nor do they disclose information about a client to anyone other than the client without their written informed consent, except where the collection, use or disclosure is permitted or required by law (for example, child abuse). *ensuring convo is private and not used for any reason other than getting you help [definition derived from College of Registered Psychotherapists of Ontario]*

1. Do you believe full confidentiality is possible in a military treatment setting? Civilian setting? Why or why not?
2. How much does confidentiality defined this way play a role in your decision to seek help?
3. What are some ways you think confidentiality can be broken in a military treatment setting?

- How often do you think these things happen?

1. What is the military doing right in terms of ensuring military members are getting the help that they need while protecting their privacy?
2. What do you think could be done better?
    - **Follow up:** Why do you think this would help to protect their privacy while ensuring that they get the help they need?

Finishing up

Is there anything else you would like to add?

Now that you've completed the interview, are there any other questions you think I should ask future participants?

possibly mention research like "Bonar et al. (2015): "The most frequently cited barrier [for service members and Veterans] was not wanting treatment to appear on military records (42.9%), followed by embarrassment (31.0%), concerns that it might harm one's career (28.6%), concerns that the visit would not remain confidential (28.6%)," - discrepancy - and findings that people often go to civilian providers even while active

Phase one showed the likelihood for seeking help and disclosure was higher in the released condition compared to active what do you think about this?

Appendix D

Western Research Ethics Board (WREB) Approval letter

Trahair, C
Western University

Date: 25 May 2021

To: Dr Anthony Nazarov

Project ID: 118485

Study Title: Interview Study of Beliefs About Confidentiality and Attitudes Toward Disclosure of Moral Injury

Application Type: HSREB Initial Application

Review Type: Delegated

Meeting Date / Full Board Reporting Date: 08/June/2021

Date Approval Issued: 25/May/2021

REB Approval Expiry Date: 25/May/2022

Dear Dr Anthony Nazarov

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study**.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Interview guide - V1	Interview Guide	03/Mar/2021	1
Telephone Script - V1	Telephone Script	03/Mar/2021	1
Protocol - BELIEFS ABOUT CONFIDENTIALITY AND ATTITUDES TOWARD DISCLOSURE OF MORAL INJURIES - V3	Protocol	17/May/2021	3
Letter Of Information and Consent - V2	Written Consent/Assent	17/May/2021	2
Email Scripts for Interview - V2	Email Script	17/May/2021	2
Demographic information - V2	Other Data Collection Instruments	17/May/2021	2
Call for Participants (social media)_v3	Recruitment Materials	19/May/2021	3

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Confidentiality_Budget_Final	Study budget	22/Aug/2019	1
References for rationale - V1	References	28/Apr/2021	1

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB , except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health &

Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

[REDACTED]

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix E

Lawson Research Database Application (ReDA) Approval Letter

LAWSON FINAL APPROVAL NOTICE

LAWSON APPROVAL NUMBER: R-21-321

PROJECT TITLE: Interview Study of Beliefs About Confidentiality and Attitudes Toward Disclosure of Moral Injury

PRINCIPAL INVESTIGATOR: Dr Anthony Nazarov

LAWSON APPROVAL DATE: 8/07/2021

ReDA ID: 10921

Overall Study Status: Active

Please be advised that the above project was reviewed by Lawson Administration and the project was approved.

"COVID-19: Please note that Lawson is continuing to review and approve research studies. However, this does not mean the study can be implemented during the COVID-19 pandemic. Principal Investigators, in consultation with their program leader or Chair/Chief, should use their judgment and consult Lawson's research directive and guidelines to determine the appropriateness of starting the study. Compliance with hospital, Lawson, and government public health directives and participant and research team safety supersede Lawson Approval."

Please provide your Lawson Approval Number (R#) to the appropriate contact(s) in supporting departments (eg. Lab Services, Diagnostic Imaging, etc.) to inform them that your study is starting. The Lawson Approval Number must be provided each time services are requested.

Dr. David Hill
V.P. Research
Lawson Health Research Institute

Appendix F

Participant Interview Scheduling Emails

Sending LOI after contact info filled

Subject line: Participating in interview study about confidentiality and attitudes toward disclosure of moral injuries.

Good morning/afternoon/evening,

Thank you for your interest in participating in the interview study about confidentiality and attitudes toward disclosure of moral injuries. To enroll, we made it simple for individuals to complete the consent form online.

CLICK HERE TO REVIEW LETTER OF INFORMATION AND CONSENT
[REDACTED]

A detailed Letter of Information and Consent is also attached to this email as a PDF file. If it is more convenient for you to sign the PDF form, please send the completed form via secure file transfer (https://filesafe.lhsc.on.ca/safe/create) addressed to our research coordinator at **[REDACTED]**

Booking email

Subject: Scheduling your interview - Moral injury and Confidentiality Study

Dear Name,

Thank you for your interest in participating in the interview study about confidentiality and attitudes toward disclosure of moral injuries. The next step is to schedule a time that is best for you to complete the remote interview (via Webex). The interview should take anywhere between 45 minutes and 90 minutes.

We currently have these interview times available (all times are in EST):

[3-4 DATES THAT ARE AT LEAST 1 WEEK AWAY SO WE CAN CONTACT DOUG IN TIME

· Day, Month year at xx:xxam/pm

· Day, Month year at xx:xxam/pm

· Day, Month year at xx:xxam/pm

· Day, Month year at xx:xxam/pm]

Please let us know if any of these work for you.

Thank you,

[signature]

Confirmation email with Webex link

Sent directly from Webex. Paste the subject into the "topic" box and the contents of the email into the "description" box. See picture below for how invitation will look.

Subject: Interview - Moral Injury and Confidentiality Study

Hi [NAME],

We have scheduled your interview for [Day, Month, year at xx:xxam/pm]. Below is the Webex link for our meeting. You just need to click that link and enter the password at the time of your interview to gain access to the call.

I will send you a reminder email the [day of (*if interview in afternoon*)/ day before (*if interview in the morning*)] with the Webex link so it will be easy for you to find.

Please let me know if for any reason you are unable to meet at this time.

I look forward to speaking with you!

[Signature]

[REDACTED]

Reminder email (morning of or day before if interview in morning)

Subject: Reminder of your interview [today/tomorrow] for the moral injury and confidentiality study

Hi [NAME],

This is a reminder that your interview for the study about confidentiality and attitudes toward disclosure of moral injuries is [TODAY/TOMORROW at xx:xxam/pm].

Please click on the Webex link below and enter the password at our appointment time to gain access to the call. The interview duration is expected to be approximately 1 hour.

Please let me know if for any reason you are unable to meet at this time.

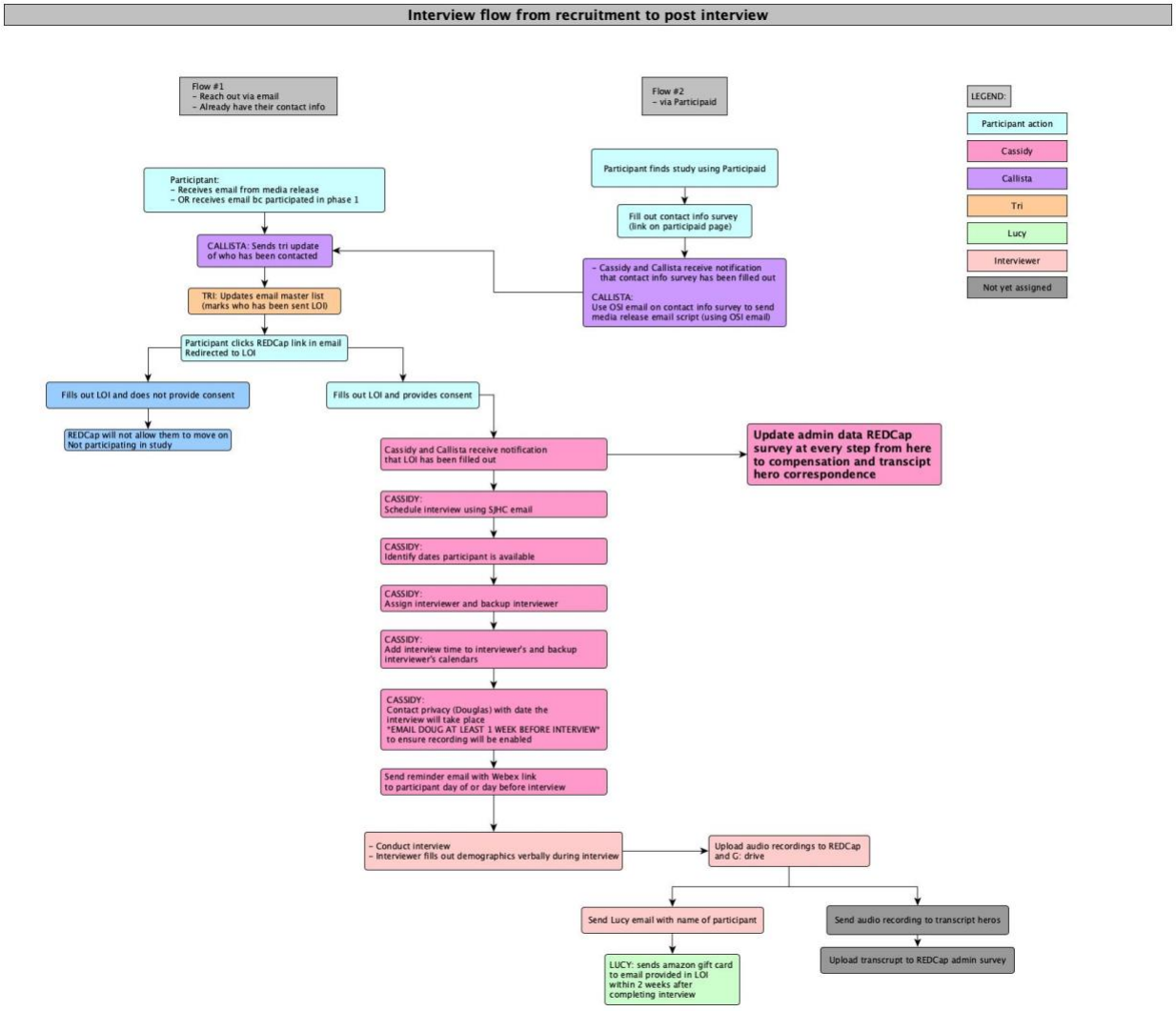
[WEBEX LINK]

Speak to you soon,

[SIGNATURE]

Appendix G

Interview Flow from Recruitment to Post Interview



CURRICULUM VITAE

Name: Cassidy Trahair

Post-secondary Education and Degrees:

Western University
London, Ontario, Canada
2020 – 2022 M.Sc.

Western University
London, Ontario, Canada
2015 – 2019 B.A.

Honours and Awards:

Western University
Dean's Honour List
2018 – 2019

Western University
Dean's Honour List
2017 – 2018

Related Work Experience:

Western University
Teaching Assistant
2020 – Present

Toronto Metropolitan University
Research Assistant
2019 – 2020

Research Contributions

Peer-Reviewed Journal Articles:

Trahair, C., Macdonald, K.B., Furnham, A., & Schermer, J.A. (In Press). Altruism and the Dark Triad. *Current Issues in Personality Psychology*.

Trahair, C., Baran, L., Flakus, M., Kowalski, C. M., & Rogoza, R. (2020). The Structure of the Dark Triad Traits: a Network Analysis. *Personality and Individual Differences, 167*, 7. http://dx.doi.org/10.1016/j.paid.2020.110265.

Conference Presentations

Trahair, C., Forchuk, C., Plouffe, R., Li, T., … Nazarov, A., (2022, October). *An Interview Study of Beliefs About Confidentiality and Attitudes Towards Disclosure of Moral Injury.* Poster to be presented at Canadian Institute for Military and Veteran Health (CIMVHR), Halifax, NS.

Trahair, C., Forchuk, C., Plouffe, R., Li, T., … Nazarov, A., (2021). *Beliefs About Confidentiality and Attitudes Towards Disclosure of Moral Injury.* Presented at 10th Research Consortium at Macdonald Franklin Operational Stress Injury Clinic.

Trahair, C., Saklofske, D., Plouffe, R., Kowalski, C., (2019, July). *Relationships Between Facets of Emotional Intelligence and Facets of the Dark Triad*. Poster presented at the International Society for the Study of Individual Differences (ISSID), Florence, IT.