

UNDERSTANDING THE EXPERIENCE OF PARAPROFESSIONAL SUPPORT IN THE  
VETERANS TRANSITION NETWORK: WHAT HELPED AND HINDERED

by

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## **Abstract**

**Background:** Paraprofessional support is a widely used intervention with military populations, although the mechanisms underlying its effectiveness are not fully understood. The Veterans Transition Network (VTN) offers group programming for military veterans experiencing challenges transitioning back to civilian life. Initial research has suggested it has beneficial outcomes for participants. Former participants of the VTN are trained as paraprofessionals and help deliver the program. The involvement of paraprofessionals is considered integral to the VTN, although little is known about how their role impacts the group participants.

**Methods:** This study uses the Enhanced Critical Incident Technique (ECIT) method to understand how participants in the VTN experienced paraprofessional support and identify what helped and hindered this process. Eight graduates of the VTN were interviewed using an interview protocol that elicited helpful and hindering aspects of the paraprofessional role, and they were asked to suggest resources or process (i.e. Wish List items) that they might have liked to see in regards to the role of the paraprofessionals. Data analysis resulted in 19 categories, comprised of 182 Helpful, 37 Hindering, and 18 Wish List incidents.

**Results:** Helping categories highlighted the importance of shared experience and the role the paraprofessionals played in quickly building trust, supporting and coaching, and bridging differences between the clinicians and the group members. The paraprofessionals were integral to the group process in that they set norms for group behaviour, and modelled the group processes by going first in group activities. Hindering incidents related to lack of training, the perception that paraprofessionals were caught between the clinicians and the group members, issues of rank, and social distance between paraprofessionals and group members. Wish List

items included training initiatives, matching paraprofessionals with group members based on common factors such as age and military experience, more social time with paraprofessionals, meeting the paraprofessionals beforehand, and better follow-up. The findings are congruent with previous literature on paraprofessional support and shed light on additional mechanisms that are the result of the unique nature of the VTN therapeutic intervention. Recommendations for training are made that may contribute to the effectiveness of paraprofessional support in the VTN.

## **Preface**

Ethics Approval was obtained from:

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## List of Terms and Abbreviations

**Course:** The 100 hour VTN program is referred to as a course. *Course* and *program* are used interchangeably in this study.

**ECIT:** Enhanced Critical Incident Technique

**Group members:** Refers to those who were engaged in the VTN course

**Military personnel:** The terms military personnel, soldiers, veterans, and service members are used interchangeably to refer to individuals who serve, or have served, in the military.

**OSI:** Operational Stress Injury

**Paraprofessional Support:** In the context of this study, paraprofessional support refers specifically graduates of the VTN who are now assisting the professional facilitators in the delivery of the VTN. Participants often refer to the paraprofessionals as *paras* in the quotes used in the results section.

**Participants:** Refers to the eight individuals that participated in this study.

**Peer Support:** Is the term commonly used to refer to individuals who provide support services to individuals who share similar experiences and challenges. In this study, the term *peer support* will be used interchangeably with the term *paraprofessional support*.

**TE:** Therapeutic Enactment

**PTSD:** Posttraumatic Stress Disorder

**VTN:** Veterans Transition Network. This term refers to the national network that provides service to military personnel, and also to the group-based programming that is offered (formerly known as the Veterans Transition Program) to individuals in the network.



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## **Dedication**

This work is dedicated to my beloved nieces Sadie Elizabeth and Amelia Rose

## **Chapter One: Introduction**

Fifteen years ago, I was diagnosed with bipolar disorder and substance dependence. A severe psychotic episode landed me in the psychiatric ward, and my long journey of recovery began. I was raised by a Father who suffered from severe mental illness. He was more often than not disoriented, depressed, agitated, paranoid and suicidal. It was a difficult way to grow up, and no wonder that I turned to a rather wild way of living--playing in a rock band, abusing substances--punctuated by extreme low moods and eventually, an exhilarating, terrible, dangerous mania. My experience of psychosis introduced me to a disempowering identity—that of a mental patient.

It wasn't until 2011 that healing on the deepest level occurred for me. I was hired to start a peer support program for the patients at the BC Forensic Psychiatric Hospital. This population live with many challenges including severe mental illness and a history of trauma. Some have committed tragic, high-profile crimes. As a result, their freedoms are greatly restricted, and the structure of the environment is one that dehumanizes them. They exist behind locked doors, and can only speak with their caregivers through a thick glass panel. Some live in seclusion with little human contact.

As I researched and began performing the role of a peer support worker, I witnessed an incredible transformation. The patients warmed under the mattering climate (Amundson, Harris-Bowlby and Niles, 2005) that I created and the therapeutic friendship that I offered them as a true equal. Patients thought to be belligerent, untreatable and even psychopathic were thanking me, appreciative of my efforts. Not only did I see growth and recovery in the patients, but the redemption and inner transformation I personally experienced was profound. Their love and acceptance meant so much to me and I too, blossomed in a new way. Peer support works, as

evidenced by the fact that services run by and for people with mental health issues now outnumber professional interventions two to one. (Goldstrom et al., 2006).

Concurrently with my involvement at the Forensic Psychiatric Hospital, I was attending the Counselling Psychology program at UBC. There, I was exposed to the Therapeutic Enactment (TE) process and Dr. Marv Westwood's work with the Veterans Transition Network (VTN). Veterans were very different than forensic patients, yet they experienced crippling symptoms and challenges when they returned from active duty. I became interested in what made the VTN so effective.

The VTN offers group therapy to veterans across Canada who have experienced Operational Stress Injuries (OSI). A typical program includes 100 hours of group therapy and psychoeducation. It assists soldiers to transition from a military environment back into civilian life. The program involves various phases which focus on building communication skills, regulating emotions, and trauma resolution. A typical program involves about eight to twelve soldiers and is facilitated by two clinicians, and two former participants in the program, who have been trained as paraprofessionals. The primary intervention of the VTN uses TE as a form of trauma repair that involves the re-enactment of the traumatic events and draws from elements of traditional psychodrama, gestalt therapy, schema and script theory, and object relations theory (Westwood and Wilensky, 2005). As soldiers re-enact the traumatic events they have experienced in the line of duty, they complete, in the parlance of the VTN, the unfinished business of the past and "drop their baggage."

Although there has been little research on the VTN to date, a mixed methods study (Westwood, McLean, Cave, Borgen, and Slakov, 2010) demonstrated that participants of the program experienced a reduction in trauma-based symptoms and depression, and demonstrated

an increase in self-esteem. Similar findings were recently reported by Cox et al. (2014). Qualitative interviews with former participants of the VTN helped highlight aspects of the program that the soldiers found particularly helpful. One of the identified areas was the inclusion of paraprofessionals in the group therapy model. Soldiers who participated in the VTN reported that they felt an increased sense of trust and validation from the paraprofessional support. The role of the paraprofessionals is considered an essential aspect of the program (Westwood et al., 2010), and the program is billed as, “soldiers-helping-soldiers.”

In recent years, Veterans Affairs in the US and Canada are emphasizing the importance of mental health and are making efforts to support veterans in transition. They too, have introduced extensive programming which is based on the idea of “vets-helping-vets.” The Operational Stress Injury Social Support Initiative was developed in 2001 to meet the needs of Canadian military personnel who were suffering from OSI. They identified the effectiveness of peer support, and noted significant cost savings that resulted when personnel were supported by peers (Richardson, Darte, Grenier, English, & Sharpe, 2006). The Department of National Defence also recognizes the role of peer support in theatre, stating that mutual support of fellow soldiers is “crucial” to keeping troops healthy during active deployment (Canadian Dept. of National Defence, 2012).

The Defense Centres of Excellence for Psychological Health and Traumatic Brain Injury (Money et al., 2011) completed an environmental scan and identified numerous peer based programs for veterans across the country and documented their effectiveness. In addition to developing best practice guidelines for the provision of paraprofessional support in military populations, they drew attention to a significant lack of research and noted that key studies have methodological issues that limit their generalizability. Additionally, the documentation of

veterans' experience of peer support is largely anecdotal. They state that, "available research does not take into account the individual's point of view, which may shed light on additional benefits of peer support or suggest improvements (Money et al., 2011, p. 8)." This suggests that further exploration of how veterans perceive peer support is crucial, considering the wide scope of practice, and the large costs of untreated OSI.

Recently, four suicides were completed by members of the Canadian Armed Forces in the space of three weeks (Tucker, 2014). These events have drawn greater attention to the issue of military suicides and highlighted the need for greater mental health services for soldiers and veterans transitioning to civilian life.

### **Statement of the Problem**

Veterans with OSI and/or PTSD suffer a range of negative effects that impact their quality of life. Little research has been done on the VTN, through a preliminary outcomes study suggests that it has positive effects on the well-being of soldiers who participate in the program. The role of paraprofessionals is considered an important part of the program which contributes to a sense of safety and trust. Peer Support as a modality is widely practiced, and can even be considered a guiding principle in the care of veterans (Money et al., 2011), but the research is still sparse.

Although Peer Support is successfully and widely used in veteran populations, the models commonly used (e.g. one-to-one mentoring, general support groups) differ significantly from the role paraprofessionals play in the VTN, who participate in active treatment and the process of trauma repair. Therefore, a thorough exploration of how participants in the VTN experience the paraprofessional support offered in the program can contribute to a broader understanding of the peer support intervention, and may result in more effective delivery of the

VTN as they continue to expand their services nationally. Whether in the context of the VTN, other veteran peer support initiatives, or in civilian community settings, the mechanisms of the peer support relationship are not fully understood and represent an unmet need. This thesis will explore the experience of receiving paraprofessional support in the VTN, in order to understand the essence of this complex phenomenon, and the impact that it has on participants. In doing so, we hope to contribute to the development of the paraprofessional intervention for veterans who struggle with unresolved trauma and challenging transitions back to civilian life.

### **Purpose of the Study**

The purpose of this study is to discover how graduates of the VTN experience the role of the paraprofessionals who supported them in the program. Specifically, we hope to discover what was helpful about their role, and what aspects of the paraprofessional role were less helpful. We also want to solicit feedback on what they might like to see in regards to the paraprofessional intervention in the future. We aim to develop a more complete understanding of the mechanisms of the paraprofessional role in the VTN, and contribute to the sparse literature on the subject of peer support in veteran populations. Recommendations for training and development of the VTN paraprofessionals will be made based on the findings.

### **Research Questions**

What helps and hinders the experience of paraprofessional support in the VTN? What resources, processes or services do you wish you had in regards to the paraprofessional aspect of the VTN?



## Chapter Two: Review of the Literature

*“Military Service is unlike any other human experience. No one knows more about the issues facing a soldier--in combat or on the home front--than a fellow service member.”*

*buddytobuddy.org*

Upon their return from active duty, many military personnel suffer from post-traumatic stress disorder (Friedman, Warfe, & Mwiti, 2003). PTSD may develop when individuals have been exposed to a traumatic event that involves fear, helplessness, and horror (American Psychiatric Association, 2000). The intensity of combat-related trauma is directly related to the severity of the psychiatric injury (Keller, Greenberg, Bobo, Roberts, Jones, and Orman, 2005).

Veterans are routinely exposed to such events and may experience acute symptoms, such as restlessness, irritability, confusion, paranoia, and exaggerated startle responses as a result (Soloman, Laor, and McFarlane, 2007). If these symptoms persist long enough, PTSD may be diagnosed. Symptoms of PTSD include re-occurring intrusive thoughts of the incidents, hypervigilance, flashbacks, and hyperarousal (American Psychiatric Association, 2000). Veteran Affairs Canada completed a survey of over 2700 veterans. Of those who responded, 15% had PTSD, and an additional 10% had sub-syndromal PTSD symptoms (in Grenier, 2002). Substance use and depression are also experienced by up to 80% of veterans with PTSD (Foa, Keane and Friedman, 2000). Accordingly, veterans with PTSD are at greater risk for suicide and accidental deaths than both civilian populations and military personnel who do not suffer from PTSD (Buckley, Green, and Schnurr, 2004). Suicide rates in the U.S. military continue to increase, with 22 suicides per 100,000 soldier in 2009 (Braswell and Kusher, 2009).

The phenomenon we now know as PTSD was first identified after the Vietnam War, as returning soldiers manifested debilitating symptoms related to their experience of combat

(Richardson et al., 2006). However, the medical community had some understanding of the condition as far back as 1678, when Johannes Hofer noted, “continuing melancholy, insomnia, loss of appetite, anxiety, cardiac palpitations, stupor, and fever”, in Swiss mercenaries living in France. This condition was labelled, *nostalgia*, and then *shell-shock* in the aftermath of WW I (Richardson et al., 2006)

Lt. Col (Rtd.) Stephane Grenier was exposed to significant trauma as a result of his service in Rwanda, Haiti, Bosnia, and Afghanistan. In his search for personal recovery, as well as those of his colleagues, he conceptualized combat-related trauma as an injury, commensurate with physical wounds sustained in the theatre of war. Building on the work of Dr. Allan English, Grenier coined the term Operational Stress Injury (OSI), which was widely adopted in the military community in Canada. OSI is not a formal diagnostic or legal term. Rather, the intent is to destigmatize painful symptoms that might be perceived as weak in the hypermasculine military culture, as well as to indicate that wounds sustained in combat can be psychological, as well as physical (Grenier, 2012). According to Grenier (2012), the causes of OSI relate to a combination of experiences in four areas: trauma, fatigue, grief, moral conflict.

In military populations, experiences of *trauma* in active combat might include witnessing deaths, dealing with human remains, land-mine accidents, and other war-related atrocities (Westwood et al., 2010). Considered a “wear and tear” injury, *fatigue* develops from accumulated stressors in combat, or in a stressful transition to civilian life. Considered a “loss injury”, complex *grief reaction* occurs in response to traumatic events, as a result of losses such as deaths, impaired relationships, or a loss of innocence.

*Moral conflict* is the most pervasive and complex cause of operational stress injuries. When a person's sense of right or wrong is in conflict with the activities they must undertake in the line of duty, a difficult-to-resolve moral conflict can result.

These psychological factors that occur in the face of traumatic events also have a significant impact on our physiology and the structures of the brain (Bremner, 2006) leading to a complex injury that affects the whole person in idiosyncratic ways. Although mental health difficulties that develop as a response to trauma are multi-factorial, a lack of social support has been found to be one of the most predominant risk factors in the development of traumatic stress. (Brenwin, Andrews, and Valentine, 2000). Thus, Grenier (2012) suggests peer-based social support is an effective antidote to the isolation of living with an OSI.

### **Peer Support**

Peer Support is an intervention based on a dynamic set of principles which may be interpreted differently in various settings. However, it is universally understood to be, “the giving of assistance and encouragement by an individual considered equal (Denis, 2003, p.323).” Equality, in this sense refers specifically to a shared experience, such as various health conditions, or unique occupations. As a result, peer support may be considered a unique type of support that cannot be provided by family, friends, or health care providers (Veith Sherman, Pellino and Yasui, 2006)

Sunderland, Mishkin, and the Peer Leadership Group (2013) outline a spectrum of peer support interventions ranging from an informal, reciprocal relationship, to more formalized “intentional” relationships where the paraprofessional is embedded in institutional multidisciplinary settings such as psychiatric emergency rooms. Community clinical settings also employ peer workers to assist with group counselling, or provide other services to clients as a

full member of mental health teams. In these more formalized interventions, paraprofessional support is a complement to, but not a replacement for, traditional clinical treatment.

Paraprofessionals are increasingly being integrated into professional health services in the areas of medical health care (Dennis, 2003), forensic mental health (Livingstone, Nidjam-Jones, Lapsley, Calderwood, & Brink, 2013), community mental health (see Goldstrom et al., 2006), and veteran populations (Money, 2011; Resnick & Rosenheck, 2008).

The provision of peer support to people with mental health issues has demonstrated small, but promising effects on outcomes. It is designated as an evidence based intervention by the Centre for Medicaid in the US and is covered by Medicaid in many states (West, 2011). Studies to date suggest that Peer Support Services are effective in reducing days of hospitalization, and resulted in improved social functioning, increased hope and the subjective sense of validation, empathy, acceptance, recovery and empowerment (Repper and Carter, 2011). Studies on depression have shown that peer support can be as effective as CBT (Creamer et al., 2012). Benefits to the recipients of peer support include credible information about the challenges faced, positive role modelling, reduced stress, a sense of hope, and encouragement (Veith et al., 2006).

### **Mechanisms of Peer Support**

Solomon (2004) has identified psychosocial processes that are the foundation of the paraprofessional intervention. Firstly, the *social support* that the peer provides is generally experienced as meaningful and helpful. Secondly, the peer has *experiential knowledge* that only those in the unique culture share. Thirdly, peers act as a role model of healthy recovery from the presenting issue. Another important aspect of the peer support process is the *helper-therapy*

*principle*. That is, in providing peer support to others, the paraprofessional experiences further healing as a result of their contribution to their peers.

A study of peer support provider relationships by Veith et al. (2006), further investigated and identified key mechanisms of the peer support relationship. Participants found the peer provider to be the most *credible* source of information, more so than clinical staff, books, and the internet. They valued the *experiential knowledge* of the peer provider, and the sense of *equality*, *acceptance*, and *mutuality* that they experienced in the relationship. Peer providers were effective in *normalizing* the experience of their clients through self-disclosure of their shared experiences.

### **Peer Support in Veteran Populations**

Peer Support is widely used among military populations both informally and formally. It is offered to veterans retired from military services as well as those in active deployment. Recognizing the intense stress involved in military service, administrators have promoted a culture where service members rely on each other for support (Canadian Dept. of National Defense, 2012; Money et al., 2011). Service members are more willing to reach out to another service member for help (Money et al., 2011), and Keller et al. (2005) identified that military populations are significantly more likely to approach a peer (37%), than medical personnel (16%), chaplains (12%), or mental health care providers (10%).

Peer programming for military populations usually take the form of support groups, direct one-to-one mentoring. Peers also can act as educators, and sometimes work as part of a clinical care team, liaising between professionals and the client (Money et al., 2011).

In Canada, the Operational Stress Injury Social Support program was created in 2001 as a joint initiative of the Department of National Defense and Veteran Affairs Canada. It employed peer support workers with operational stress injuries to increase the level of social support to

active service members or military veterans, with the goal of reducing their OSI symptoms, improving their functions, and increasing their quality of life. (Richardson, et al., 2006).

The Canadian Armed forces embraces the role of peers as part of its Road to Readiness and Mental Health Continuum Model. “Most soldiers say that they made it through the deployment because of their buddies. Providing basic peer support is crucial to keeping each other healthy during deployment. Peer Support does not need to be complicated and it is not therapy. Sometimes the simplest interventions are the best.” (Canadian Dept. of National Defense, 2012 p.11).

As of 2005, VA in the US is offering Peer Support Services at approximately one-third of all VA facilities (Kymalainen et al., 2010). The paraprofessionals are veterans with a history of mental health issues who work to engage and support veterans who are receiving services. They share their experiences of having “been there”, and model insight, social skills, and promote hope.

Both the British and US armies have put peer-driven initiatives in place as a preventative measure to reduce harm and prevent the development of PTSD. They employ paraprofessionals to assist in identifying and referring soldiers to appropriate clinical care. The program aims to normalize OSI and destigmatize help-seeking (Keller et al., 2005).

Although there has been very little research documenting outcomes in paraprofessional support with military populations, an important quasi-experimental study looks at two different cohorts of veterans that received peer support services (Resnik and Rosenheck, 2008). The study measured a number of outcomes such as personal recovery, confidence, and self-efficacy, general empowerment, global functioning, substance use, and symptom severity. The results of this well-designed study demonstrated significant improvement in the domains of general

empowerment, confidence and global functioning. Kymalainen et al. (2010) conducted interviews with military paraprofessionals. They reported that the peer support they provided to veterans with PTSD was beneficial; they perceived that paraprofessional services helped veteran clients engage in treatment and cope better with their symptoms.

Money et al., (2011) reviewed 15 peer-based military programs in the U.S. and Canada. Their findings identify key ingredients of effective paraprofessional support that echo the findings in community-based peer settings. *Social Support* is thought to be a primary factor in peer support, and there is significant evidence to suggest that peer based social support is a protective factor against the development of PTSD and other problems related to OSI (King, King and Fairbank, 1998; Solomon and Mikulincer, 1990). Paraprofessionals have greater *credibility*, due to shared military experience. *Trust* is a very important component of military based peer support, as demonstrated by Chinman et al. (2008), who demonstrated that veterans trusted peer support workers more than hospital staff. *Confidentiality* is also a key ingredient in military peer support, as service members are known to be reluctant to come forward for help if they perceive their information might be shared with the military administration. Lastly, *easy access* to support is an important component of the paraprofessional support among military populations. Fellow service members may be more easily accessible in theatre, or in the community following their transition.

Military personnel often suffer in isolation due to the stigma involved in reaching out for help. Military personnel may perceive seeking help to be shameful, and fear that receiving help through military channels could end their career (Keller et al., 2005). Additionally, soldiers have reported that they fear how their peers would perceive them if they came forward about their

mental health symptoms. Unfortunately, the fear of stigma presents a major barrier in the treatment for PTSD (Westwood et al., 2010).

Some suggest that Peer Support seems to be especially effective as an intervention with groups that have a distinct culture, feel marginalized, and are resistant to professional mental health services (Everly, 2002). These groups may include psychiatric patients, first responders such as police, paramedics, corrections officers, and military personnel. Soldiers represent a group that, as a result of their active duty, have had significantly different experiences from the civilian population, many of which are experienced as extremely traumatic.

### **Veterans Transition Network**

The VTN is a highly successful group-based program that assists military personnel with their return to civilian life (Westwood, Black, and McLean, 2002). This transition can be a difficult time when veterans may experience emotional distress, vocational problems, impaired personal relationships, and an overall experience of *reverse culture shock* (Westwood, 1999).

Currently, the VTN offers 100 hours of group programming. Initial group sessions focus on communication, skill building, effective listening, group cohesion and trust. Trauma repair-the most crucial phase of the program-is addressed in the middle. Final group sessions reinforce the gains participants have made, and there is a focus on setting goals for the future. Group members also receive assistance in addressing vocational issues they may be facing (Westwood et al., 2002).

The success of the program is demonstrated not only in reduced symptoms and quality of life (Westwood et al., 2010) but also in an unprecedented 100% program completion rate (Cox et al., 2014). We propose that the success of the VTN is based on a number of factors: the small group format; the efficacy of the trauma repair therapeutic interventions, the cross-cultural



competency used to engage participants, and the inclusion of paraprofessionals in the delivery of the program.

According to Sipprelle (1985), *small group formats* are experienced as more helpful than individual treatment, as military personnel find benefit in learning from and interacting with their peers. Another factor contributing to the success of the VTN, is the *efficacy of the therapeutic interventions* employed in the group setting. Guided Autobiographical Life Review is used to share structured personal narratives involving important aspects of group members' lives and traumatic events they may have experienced. This sets the stage for TE, an active form of trauma repair. Key events in the life of the group members are re-enacted allowing catharsis, resolution, and cognitive integration (Westwood et al., 2002). Both TE and Guided Autobiographical Life Review are well suited to use in military populations to treat OSI (Westwood, 1999; Ragsdale, Cox, Finn, and Eisler 1996). Although the multifaceted processes of TE are beyond the scope of this paper, suffice it to say that correct implementation of this powerful intervention requires a high level of training and skill.

Furthermore, the VTN is appealing to veterans because the facilitators view working with military clients as a *cross-cultural competency*. They cater to military culture by using language that is task-oriented and stays away from the feminine-nurturance model (Powell, 2006). Masculine vernacular is used which avoids terms like treatment or therapy. Instead, reference is made to meetings and conversations. Emotionally-based terms are replaced with things like skills, resources, tools, and goal-setting (Westwood, Kuhl and Shields, 2012). Westwood, et al. (2012), are aware of the importance of being sensitive to the unique needs of this hyper masculine culture that values self-discipline and strength. Military values such as courage,

commitment, loyalty, service and integrity are promoted as a form of engaging participants in an unfamiliar therapeutic process.

Finally, the high retention rates in the program may be in part due to the use of paraprofessionals in the delivery of the group therapy model. These paraprofessionals are graduates from previous programs who have benefitted from their involvement. They are trained and supervised by the professional facilitators. The paraprofessional training involves the acquisition of basic and advanced counselling skills, such as clarifying, paraphrasing, and empathy. They learn about the basic group process, structure, and rationale of the VTN, and are taught to assess for risk of harm to self and others.

The VTN reports that paraprofessional support is vital to the program, and the mechanisms can be presumed to be the same as those identified by other organizations that offer peer support (see Money, et al., 2011). For example, the paraprofessionals in the VTN also provide role modeling and social support, assisting others to open up emotionally. Their presence builds trust in the group process, which allows the enactment to unfold in a therapeutic way. Those who have “been there” may be more effective in engaging the VTN members and contributing to group cohesion. However, we still don’t know the extent to which the paraprofessionals are an important part of the positive outcomes we see in the VTN or if there are additional mechanisms which underpin its ability to engage new participants and have therapeutic outcomes.

As previously mentioned, peer support in veteran populations is limited to common models such as general support groups, one-to one peer mentoring and peer education. The VTN is completely unique, in that peers are incorporated into active trauma treatment utilizing a

complex intervention. Therefore, the type of peer support offered in the VTN is markedly different from other military peer-based programs and bears further examination.

## **Chapter Three: Methodology**

### **Critical Incident Technique**

The Critical Incident Technique (CIT) was developed by Flanagan in 1954 as a broad, flexible approach to look at a range of phenomena with a view to analyze effectiveness, helpful or harmful aspects, and successes and failures. (Butterfield, Borgen, Maglio, and Amundson, 2009). CIT emerged as a research method in World War II, when it was used by the U.S. Army Aviation Psychology Program, to recruit and classify personnel. The method was largely used by industrial and organizational psychologists, but as Flanagan refined the developed the method, it saw wider use in various disciplines such as counselling, education, medicine, and social work. CIT is appealing and useful because it is conceptualized as an adaptable set of principles, rather than a rigid protocol (Butterfield, Borgen, Amundson, and Maglio, 2005). Five steps in the CIT methodology were outlined by Flanagan (1954). Initially, the researchers articulate the aims of the activity or phenomenon that is being studied. Secondly, plans are made and parameters set. Data is then collected, and analyzed for Critical Incidents (CIs) that are either Helpful (HE) or Hindering (HI). Lastly, the findings are interpreted and reported (Butterfield et al., 2005).

Qualitative methodology is a rich tradition that offers many strategies for inquiry and options for research design (Cresswell, Hanson, Plano-Clark, and Morales, 2007). Traditional quantitative methodologies seek to draw factual conclusions that apply to a whole population, while qualitative research is more concerned with understanding the multi-faceted context in which participants live (Haverkamp, 2005), and the meaning they ascribe to their personal experiences (Creswell, 2014). CIT is considered a type of qualitative design, as it uses language gleaned from open ended-questions as the primary form of data. The research takes place in a natural setting. The interpretation of data results in a written description that conveys a holistic

picture of the participants' perspectives (Creswell, 1998). Although the CIT method is firmly embedded in qualitative traditions, it has characteristics that set it apart as a distinct approach. For example, questions are targeted to elicit the "critical incidents", that is, factors that contribute to, or hinder the experiential or concrete phenomenon under study. Unlike other qualitative methods, CIT categorizes incidents into themes, in ways that are somewhat quantitative (e.g. operational definitions of categories, required percentages of response rates to define categories). Therefore, CIT is a particularly valuable method due to its adaptability to a wide range of study topics, but also because it employs both qualitative and quantitative approaches in the data analysis and interpretation.

### **Evolution of the Method**

Researchers at UBC considerably advanced the CIT model by introducing mechanisms that increased the validity of the method and added the Wish List items (WL) as part of the interview protocol (Butterfield et al., 2009). These enhancements were formally acknowledged by changing the name of the methodology to the Enhanced Critical Incident Technique (ECIT).

In addition to eliciting HE and HI factors of the subject under study, the WL items seek information from participants about things (people, resources, information, supports) that they wish they had at the time of their experience. The nine credibility checks include: audiotaping the interviews, ensuring fidelity to the interview protocol, employing an additional expert to extract CI and WL items from the data, documenting exhaustiveness, tracking participation rates, participant cross-checking, the solicitation of expert opinion, and establishing theoretical agreement (Butterfield et al., 2009). These enhancements to the original CIT protocol significantly improve its validity and reliability, and contribute to its appeal as a comprehensive qualitative research method.

## **Participants**

### **Participant recruitment and selection**

A document advertising the study was designed and sent to former graduates via the VTN electronic mailing list (see Appendix C). Seven participants contacted the researcher and were screened by email or phone. One additional participant was the result of a personal referral from the Primary Investigator, Dr. Marv Westwood. Participants had all been active in the military and faced difficulties in their transition back to civilian life. Seven participants fully met the inclusion criteria as they were recent graduates of the VTN and did not have experience providing paraprofessional support. The final participant did disclose that he had acted as a paraprofessional on one-ten day retreat in 2012, but had not been involved with the VTN since that time. He was asked to answer the questions based on his original experience as a regular participant in the VTN in 2010. Responses that referred to his direct paraprofessional role (limited to WL items) were excluded from the study.

### **Participant demographics**

All Participants were male and of Caucasian heritage. They ranged in age from 29-57, with the mean age being 44 years old. All participants had some college education and had studied academics or trades. Two participants had completed Bachelor of Arts degrees. Seven participants were retired from the military. Of these, three had been retired for approximately 20 years, and four had retired from military service in the last five years. The eighth participant was still currently active in the military. Six of the participants served in Afghanistan, one served in the Rhodesian army, and one did not participate in active combat. Three participants worked in occupations such as emergency nursing, trades, and policing. Two were students, two were retired, and one was still active in the military.

## **Procedures**

### **Interviews**

All interviews were conducted in English. Five of the eight interviews were conducted in the research offices at UBC. The other three participants were interviewed at a convenient location of their choosing that was adequately quiet and comfortable. All interviews were audio recorded, and some minimal notes were made to indicate points of interest or developing themes in the participants' words. An interview guide was developed (see Appendix A) which clarified the object of the study and elicited HE, HI, and WL items. Informed consent was obtained (see Appendix B) by all participants after the researcher reviewed the purpose of the study, the procedures used to ensure confidentiality, the limits of confidentiality, and the possible risks and benefits of the study. Contact information for both the research team and the UBC ethics board was provided as per the BREB guidelines.

Consistent with the ECIT method, participants were asked a number of questions to provide context and background information. These opening questions elicited information about participants' military experience, the emotional and psychological issues they faced in their transition back to civilian life, and how they came to be involved in the VTN.

Participants were then directed to think about the paraprofessionals in the VTN program they attended and identify helpful and hindering aspects of their role. At times, the researcher would use prompts or ask the participants to elaborate on their statements. Participants were also asked about process, resources, or other things that they wished were a part of the paraprofessional role in the VTN (i.e. WL items). The researcher used paraphrasing, summarizing, and empathetic reflection to fully clarify and capture participants' responses. When the interview was completed, participants were provided with the contact information of

the Primary Investigator and encouraged to contact him or the VTN co-ordinator for follow-up if needed.

### **Data analysis**

Seven of the eight interviews were transcribed in full and one interview was transcribed using a targeted approach. Following the guidelines of Flanagan (1954), three transcripts were chosen at random and analyzed. A highlighter was used to initially identify CIs and WL items that were supported by examples. Notations were made on the transcripts. In a separate document, CIs and WL items were listed, along with participant quotes. After the CI/WL items from the three randomly selected transcripts were coded, the initial categorization process began. Once the preliminary categories were established, the other five were coded according to the new categorization scheme. In some cases, new categories emerged until exhaustiveness was reached. During the process, descriptions of the categories were developed, some overlapping categories were merged, and others were established as distinct categories after much consideration. The recommendations of Butterfield et al. (2005) and Flanagan (1954) were taken into consideration during this process. They suggest categorization should be guided by how the data will be eventually used. In this case, the data is intended to shed light on the mechanisms of the paraprofessional support intervention in the VTN. Also, the data may be used to make recommendations for training and program development in the VTN. Therefore, HE categories were largely organized in order to ascertain the mechanisms by which the intervention was helpful, and the HI/WL items were categorized in ways that could be used to make further recommendations to the administrators of the VTN



After all interviews were fully coded, categorized and counted, fresh copies of the transcripts were analyzed to ensure consistency in the extraction process and the accuracy of the numbers of CI/WL items and participation rates.

### **Rigour**

Qualitative methods are typically not thought to have the same rigour as quantitative approaches, however, there are many ways of addressing validity in qualitative research, and Cresswell (2014), suggests that validity can be a strength in qualitative research as long as accuracy is established in the view of the researchers, participants, and audience. The ECIT method has rigorous and specific steps to establish trustworthiness and credibility. Studies have established that the ECIT method is reliable and valid based on saturation, comprehensiveness, reliability measures (e.g. inter-rater reliability & test-retest reliability), and construct validity (Butterfield et al., 2009). The department at UBC has developed a protocol to follow which integrates the following credibility checks.

#### **Audiotaping interviews**

All interviews were audiotaped in order to ensure an accurate account of the participants' data. The resulting transcripts were used to complete the extraction of HE, HI, and WL items. Audiotaping interviews contributes to the descriptive validity of the study, as it establishes the accuracy of the qualitative data. (Butterfield et al., 2009).

#### **Exhaustiveness**

Exhaustiveness is an important concept in the ECIT as it ensures that, to the greatest extent possible, all CIs and WL categories have been established, and no new information is likely to emerge (Butterfield et al., 2009). Although it is possible that new categories could have emerged with additional interviews, especially in regard to idiosyncratic WL items, it is likely that most

major themes regarding the experience of the paraprofessional role in the VTN had been mined. This is demonstrated in the lack of new HE and HI themes after the first few interviews. Also there was moderate to high participation in most categories, and considerable consistency of responses across interviews.

### **Independent extraction of CIs**

An independent judge reviewed three transcripts and extracted CIs and WL items. His work was then compared to that of the researcher. A handful of questionable CIs were briefly discussed and 100% concordance was reached.

### **Placing incidents into categories**

The same independent judge placed the above CIs into the existing categories. Again, 100% concordance rate was reached, with no disagreements about how the incidents should be categorized.

### **Participant crosschecking**

All participants were emailed a transcript of the interview, which had been scrubbed of irrelevant information or identifying details. All participants were asked to review the transcripts and reflect further on the following questions:

- What was helpful about the paraprofessional role in the VTN?
- What was hindering (or not helpful) about the paraprofessional role in the VTN?
- What would you have liked to see (e.g. resources or processes) as part of the paraprofessional role in the VTN?

They were invited to add or remove anything from the interview transcript, and to clarify any responses. The participants were also given the categories that were relevant to their interview. They were invited to comment or make suggestions on the categories. Four participants

expressed that they were happy with their responses and had nothing further to add. Two participants responded with additional WL items. Two participants did not respond to the follow-up email.

### **Participation Rate**

In the ECIT method, at least 25% participants must endorse a category before it can be included in the results. Should a category fall below a 25% participation rate, it may be included in the results if it is considered to contain information relevant to the study. All categories formed had at least a 25% participation rate. Five categories had a 75-100% participation rate. Eight categories had a 38-63% participation rate, and six categories had a 25% participation rate. An additional category emerged which had a 25% rate. However, this category was not included in the formal results, as it involved too great an inference on the part of the researcher.

### **Expert opinions**

The categories were reviewed by two experts, one being a graduate student and the other being the Primary Investigator. Both have comprehensive knowledge on the topic of paraprofessional support and the ECIT methodology. Both confirmed the usefulness of the categories, and felt that they were congruent with what is currently known about paraprofessional support in the VTN.

### **Theoretical validity**

The results strongly reflected and confirmed theoretical concepts in the existing research in the area of Peer Support. This is outlined in the discussion section, along with new insights that emerged as a result of the unique group intervention offered by the VTN.

### **Ethics**

A number of ethical issues are apparent in this study. The participants may be vulnerable to relapse of symptoms when discussing traumatic events of their military history, or the TE

process. As many military personnel fear being stigmatized (Westwood et al., 2012) for seeking help, it is vital that their anonymity be protected. Also, because the VTN is so small, the participants might feel the need to withhold important information that could affect valued relationships or impact their ability to participate in the VTN.

These concerns were mitigated by an extensive process of informed consent with the participants (see Appendix B) which conveyed the risks of the research (e.g. the emergence of PTSD symptoms). The benefits, such as assisting the cause of the VTN and other veterans who have experienced trauma, were also made clear. Participants were provided contact information of VTN administrators/and or paraprofessional supports and encouraged to call if necessary. The researcher was transparent about the measures that will be taken to protect anonymity. This included separating demographic information from the transcripts. Each participant was assigned a numeric code. Documents containing participant information were kept in locked cabinets, and electronic documents were housed on a password-protected server.

## Chapter Four: Results

From the eight interviews, a total of 237 incidents were identified. Of these incidents, 182 were identified by participants as helpful aspects of paraprofessional support, 37 incidents were considered hindering aspects, and 18 Wish List items emerged. The total number of incidents were sorted into 19 categories: Nine that were helpful, five that were hindering and five Wish List categories. The categories were thoughtfully named to mirror the participants' worldview and the essence of the information they provided. Each category will be fully explored, beginning with the Helpful.

### Helpful aspects of the paraprofessional role in the VTN

The nine categories identified by participants as helpful aspects of the paraprofessional role in the VTN are described in rank descending order, beginning with the categories that were endorsed by the most number of participants (see Table 1).

**Table 1**

#### Helpful Aspects of the Paraprofessional Role

Category of Incidents	Number of Incidents	Number of Participants
	<i>182 Helping Incidents</i> <i>N (%)</i>	<i>N=8</i> <i>N (%)</i>
Paving the Way	33 (18%)	8 (100%)
Trust & Credibility	28 (15%)	7 (88%)
Supportive Role	25 (14%)	7 (88%)
Shared Experience	29 (16%)	6 (75%)
Bridging the Gap	14 (8%)	6 (75%)
Setting Norms	13 (7%)	5 (63%)
Nuts and Bolts	11 (6%)	5 (63%)
Quick & Easy on the Uptake	15 (8%)	5 (63%)
The Coach Approach	14 (8%)	4 (50%)

**Table 2**

**Participant Endorsement of Helpful Categories**

<b>Category</b>	<b>Participant ID</b>
Paving the Way	001; 002; 003; 004; 005; 006; 007; 008
Trust & Credibility	001; 003; 004; 005; 006; 007; 008
Supportive Role	001; 002; 004; 005; 006; 007; 008
Shared Experience	001; 002; 003; 004; 006; 008
Bridging the Gap	001; 003; 004; 005; 006; 008
Setting Norms	001; 002; 005; 006; 007
Nuts and Bolts	001; 002; 004; 006; 007
Quick and Easy	001; 002; 003; 006; 008
The Coach Approach	001; 002; 004; 007

**Category 1: Paving the Way (33 incidents; 8 participants; 100% participation rate)**

All participants described actions on the part of the paraprofessional that involved “leading by example,” or “getting the ball rolling” which were experienced as helpful. This included going first in performing difficult tasks such as self-disclosing emotional content in the Guided Autobiographical Life Review or the TE.

He exposed a little bit about himself, shall we say, about his injury and about what happens with him...and that brought down some of those barriers...the safety of being able to do it because someone else has gone before you, so you're not the first one putting your foot on the bolt.

Another participant concurred,

And once the para brings it [the emotion] out well then other people start to bring it out.

You bring it out. And all of a sudden you go-ok-we're all normal.

A third said,

One para went first and related his most traumatic experience so he set a good example that he was willing to go into that much depth about that scary an experience.

One participant spoke to the importance of the paraprofessionals modelling the therapeutic tasks of the group.

And they're demoing it, and you see the raw emotion on them, and how they deal with it differently, they take you to the deep, deep bowels of where you don't want to go.

Another participant said,

The paras provided an example of how to do it...providing an example for people to watch and then emulate themselves, which facilitates the whole process and the Doctors can stick to doing the doctoring stuff.

In other cases, *Paving the Way* referred to the fact that the paraprofessionals had completed the VTN course in the past, which helped participants move forward into the process.

They did the program, and they said they still struggled with [OSI] but they got tools, they're working through it...most of the guys [group members] don't want to go down that road, but because these guys did it, and they could talk about it, and both of them were at a point in their life where they could share.

One participant summed up the importance of *Paving the Way*,

If it wasn't for the para sort of diving in and being an example as we're sitting in the group, and the psychologists asks us a question or asks us to do an activity, without the paras jumping in first, I would say you're not getting the full benefit.

Paving the way was the only category that was endorsed by all participants. The VTN course may be considered something of a perilous mission by the group members, and as such, they experienced the paraprofessionals willingness to lead them through the group process as extremely helpful.

**Category 2: Trust and Credibility (28 incidents; 7 participants; 88% participation rate)**

Although trust was a by-product of other helpful factors such as setting norms or shared experience, *Trust and Credibility* emerged as a theme in its own right. Simply by being present, paraprofessionals were seen as credible, and this contributed to increased trust that engaged group members. In military culture, soldiers rely on each other, and the ability to trust their fellow soldiers is critical. One participant said:

You don't show weakness...[you ask yourself] can I trust this guy in this situation where I need to critically trust him?

Another participant noted, "To be honest, I wouldn't have even touched the process if it wasn't for knowing one of the paraprofessionals."

The perceived credibility of the paraprofessionals impacted the way group members felt about the VTN program.

Obviously the process could not have been that bad if they were back to it, not only to help out, but to continue to participate in everybody else's process.

Another participant expressed the same sentiment:

They had come back because they believed in what this program had done. So that showed—it increased my trust. It worked for them, so I was willing to give it a bit more of a go that maybe I would have if I didn't have them there.

Another participant, recently retired from a long military career, reported it was helpful when that the paraprofessionals conveyed an implicit message:

This is a process that works...and trust me a brother in arms. You can express yourself here safely and it won't come back to bite you.



One participant noted, “Their role was critical. Without them, it doesn’t jive. There’s no credibility.” One participant noted that having trust was “integral” to the process saying,

When you see the fact that the paraprofessionals have trust in those Doctors... if I like this paraprofessional and they trust [the doctors], well maybe it’s not so wrong that I trust them.

At times, when paraprofessionals displayed their own emotional vulnerability it had a positive impact on the participants. “It’s all part of that trust, and breaking down some of the barriers.” Overall, participants trusted the paraprofessionals and saw them as credible. This helped them accept and engage in the VTN program.

### **Category 3: Supportive Role (25 incidents; 7 participants; 88% participation rate)**

Almost all of the participants identified critical incidents that indicated that the paraprofessionals played an important supportive role in the group process. This included interpersonal support such as listening, understanding, validating emotions and experiences, normalizing, providing reassurance and expressing curiosity about the experience of the mindset of participants. One VTN graduate said,

He wanted to find out more in talking to me...he was trying to understand [my experience]...and that helped because I explained where my angsts were, and my concerns, and [where] my thought process went...it helped me.

One participant noted that a paraprofessional expressed appreciation for his contribution to the group, despite the difficulty of engaging in the work

...and they came up afterwards and said—you know, you did a really good job, and thanks for doing that...it helped [me] a lot.

The supportive role the paraprofessionals was experienced as meaningful within the group process, for example, when a group member became overwhelmed and had to leave the room.

And one of the paras would go out and walk you around the block, talk to you about it, and [they] understood the process.

Informal socializing was identified as supportive and important to some participants.

We'd sit and chat...they spoke a lot about themselves, and asked questions about my training. So, just the communication—it's a very, very important part of our day.

In some cases, the support offered by the paraprofessionals was very practical, such as giving rides to participants who did not have a car.

Two participants identified the act of "presence" being helpful to them.

The role is huge...just to be there, be themselves, be present...not just in the physical sense, but in every aspect.

In the supportive role, paraprofessionals displayed a range of behaviours that were experienced as helpful to the participants. These included basic and advanced counselling skills, such as empathizing, active listening, and other caring behaviours. Sometimes the support was more practical. In other cases, simply being present in the group setting or in a social context was experienced as supportive and meaningful.

**Category 4: Shared Experience (29 incidents; 6 participants; 75% participation rate)**

Participants strongly endorsed shared experience with the paraprofessionals as a helpful factor. Shared experience included military experience in general, as well as specific experiences in theatre, such as tours of duty in Afghanistan. The concept of shared experience extended to phenomenon such as emotional states, personal issues, a military mindset, and having previously completed the program.

One participant referred to shared military experience as,

Boots on the ground...you know there is a common thread, regardless of whether he was infantry or whether they were armoured, or whatever their background was--the fact that they wore the uniform, did the job, and can speak from that point of view.

The shared experience and mentality created a feeling that the paraprofessionals were “brothers in arms”, which contributed to the safety necessary to engage participants in the group process.

For example, one participant felt that those in military culture tend to deal with personal issues in a similar fashion “We bury ourselves in other ways...so the paras could speak about that.”

Another aspect of the shared experience was reflected in common humour,

So we took these digs at each other...the sense of humour, some of it was fairly dark, because that’s how we deal with it.

Shared experience also manifested itself in the use of vernacular which increased comfort levels.

When a paraprofessional spoke about issues he faced with his family during his transition, one participant was very responsive saying,

You hear some of the problems they’ve gone through, and you say-wow-that’s exactly what I’m experiencing. And to hear somebody talking about it...I see it from a different point of view now, and it really helped me.

It was noted by a couple of participants that there was considerable variability in experiences despite the commonalities between the paraprofessionals and the group members. These differences usually had to do with differing geographic areas where they had served or being employed by different branches of the military. However, this was directly addressed by the paraprofessionals, according to one participant.

[The paras said] we’re all here, we all have different experience, but they’re all similar.

Another participant concurred saying, “At the end of the day, they’re all the same, and they all walked in the same dirt.”

Therefore, despite the differences in life experiences noted by some participants, the cultural commonalities between the paraprofessionals and the group members superseded any differences in military service.

One participant astutely noted the difference between the professional facilitators and the paraprofessionals in regards to shared experience.

[The psychologists’] background is from what they’re read, what they’ve experienced third hand. Where [the paras] you accept because they had issues, or are still dealing with issues, and have a similar experience-not so much experience in what occurred to bring you there, but the experience of what you’re feeling at that point.

The same participant further identified the shared experience of PTSD as being meaningful.

It’s not so important...what happened to you that created the issue...what happened to me...the [shared experience] is the things that occurred with respect to the PTSD...having experienced real fear...at an intense level that makes you want to throw up.

He also identified the primary shared experience between the paraprofessionals and the group members as,

Failing to deal with this [PTSD] on your own. ‘I’m weak because I’m here’ ....and all of a sudden you see someone [the para] that is willing and has an experience and talks about that, and you go ok, that’s normal.

One participant summed up the impact of shared experience:

I think what I appreciated the most [about the paras] was they were able to speak from their own experience ... it always helps to have somebody who's gone through the experience themselves there, to relate to, to show you that it is a safe environment—to put your mind more at ease.

The paraprofessionals in the VTN shared a wide range of life experiences and a similar mindset as the participants. This shared experience contributed to a sense of safety. Participants felt they were among those who understood what they were going through, and the paraprofessionals helped normalize some of the painful issues they were dealing with as part of their OSI.

**Category 5: Bridging the Gap (14 incidents; 6 participants; 75% participation rate)**

Several participants identified that the paraprofessionals bridge the gap and act symbolically as a liaison between the clinicians and the group facilitators. The “gap” seemed to refer to a lack of trust due to a different mindset, or a power differential based on the participants’ previous experience of hierarchy in the military. One participant referred to the clinicians as “headsheds.” Another participant put it,

You’re apprehensive when you’re seeing the establishment, the instructors, the bosses—and the rest of the group members...Whereas the paras kind of bridge that, and that was key.

One participant spoke to the inherent distrust that group members initially feel toward the clinicians and the group process.

I hate to say it but there’s a standoffishness there. I mean having a lot of PhDs in the room, and then a bunch of [military] guys. They [the paras] just connect, I think. So I definitely think that the paras helped to bridge that gap.

Another participant expressed a similar sentiment:

The fact that they really liaise with the staff...it's almost like you're on the course, and [the psychologists] are the instructors...you don't want to share too much with the instructors because you're all trying to get through this course...[The paras] kind of bridge that gap. They tell the clinicians how the soldiers feel and what they do.

The paraprofessionals also help to bridge the gap by facilitating the acceptance of the clinicians into the group milieu.

It's the psychologists that have to be accepted by the group, right? And without the group accepting them, they wouldn't get anywhere. The paras facilitate that acceptance.

Another participant commented on how the bridging aspect of the paraprofessional role contributes to group cohesion:

By having the paras there I think it really helps to sort of bridge that gap and in a way even [i.e. equalize] and create that circle into a group.

The concept of bridging strongly emerged as a helpful factor that facilitated the group process.

The presence of the paraprofessionals brought the two "sides" together, despite a cultural bias on the part of participants to see the clinicians as "instructors", "bosses", or the "establishment."

The paraprofessionals were able to clearly understand the mindset of both the clinicians and the participants, and communicate that to both sides, thereby facilitating the group process.

#### **Category 6: Setting Norms (13 incidents; 5 participants; 63 % participation rate)**

Some participants identified 'setting the norm' as pivotal in the process of recovery. By setting the tone of what behaviour was acceptable or not, the paraprofessionals acted as a gauge to assist the group to enter the process of the process safely.

I think one of the greatest positive things that their function performed was they set the norm for acceptable behaviour. They set the norm for how the participants should interact and react.

Norms the paraprofessionals set included how much to disclose, what kind of humour was appropriate, how to give feedback, and how to reflect on the disclosures of others. Setting the norms around feedback was particularly important to one participant who noted:

[They demonstrated] how to provide it. What was acceptable to discuss with respect to how it made them feel, how it may have reflected on them...how the feedback was actually structured, like actually how to say it and what order, and the scope you could touch on.

Setting the norms for the group helped to facilitate the therapeutic tasks of the course,

They make it safer to do, they make it easier, they make it a norm...it's a gauge, an ability to say—I can go here without feeling criticized, or without feeling ashamed.

At times, paraprofessionals acted in the role of enforcing the norms and maintaining discipline among the group participants.

He kind of helped keep the discipline, like Army discipline per se...this process is here for a reason. It would have been different coming from a counsellor.

Paraprofessionals also set norms in regards to an acceptable level of emotional involvement in the therapeutic process.

So to have this guy who was a rough, tough Sergeant, throwing out the orders, stand up there and come to the brink—come to tears, then, ok-it's allowed.

The perception that the paraprofessionals set clear norms for acceptable behaviour in the group setting was experienced as very helpful by the participants. Once the norm was effectively set, they could more fully engage in the group process due to an increased sense of safety.

**Category 7: Nuts and Bolts (11 incidents; 5 participants; 63% participation rate)**

Participants identified that the paraprofessionals' presence was helpful as they pulled their weight and contributed to the smooth facilitation of the program. In some cases these were administrative or logistical tasks and in other cases the paraprofessionals helped with aspects of the group process. One participant said, "I could ask them about time, pace and agenda, they were there to help with small groups." Others noted that paraprofessionals helped with homework and explained the process of group therapy. One participant expressed appreciation for the paraprofessionals work saying,

Getting coffee and running around and doing all those menial sorts of tasks is logistically required. Somebody has to do all that...It's best that it's not one of the participants, and the Doctors are busy enough, but I think that role is fundamental.

Other logistical tasks that the paraprofessionals did which contributed to the smooth running of the group were making sure the rooms were ready, completing the check-in process, and organizing the contact emails. The paraprofessionals also helped with the nuts and bolts of the TE process. One participant noted that on a few occasions, a group member became overwhelmed and had to leave, "and one of the paras would go out and walk you around the block."

The presence of the paraprofessionals allowed all members of the group to have their needs attended to. Overall, participants were aware of how much the paraprofessionals contributed to the smooth functioning of the VTN, and valued the operational duties they performed.



**Category 8: Quick and Easy on the uptake (15 incidents; 5 participants; 63% participation rate)**

It was often mentioned by the participants that trust and safety were built more quickly and easily because of the presence of paraprofessionals. One participant explained, “It makes an easier transition for that trust, or it makes the acceptance of that trust come quicker.”

Another said, “I would have [done the TE] because I felt I owed it to the program, but without the paras there it would have been so much harder.”

One participant mentioned how important it is to engage group members quickly in a time-limited program such as the VTN.

So I think without them you’d probably have it [trust] but it would have taken much longer to fully engage in the process—therefore not utilizing all the time that we have. Another participant referred to the “immediate engagement” that occurred as a result of the paraprofessional involvement. This ability to transition the group quickly and easily into a cohesive whole is vital for a course that must treat into unknown territory in a short span of time.

**Category 9: The Coach Approach (14 incidents; 4 participants; 50% participation rate)**

In addition to a supportive role that involved traditional nurturing approaches such as listening, understanding, validating, and reassuring, the paraprofessional sometimes played a more active role that was experienced as helpful by the participant. This involved a range of skills such as encouraging, coaching, advice giving, and at times, challenging the participant to push into unfamiliar terrain. The word *encouragement* was mentioned several times by participants, who experienced this aspect as helpful, “They were there to encourage, because they’d done it before.”

One participant explained,

You don't want to expose yourself...and [the paras] are there saying-you know what-you've got to go there...they're always there to kind of coax us through stuff. They're more of a coach...because they've lived it.

The same participant recalled being pushed through difficult emotions,

The paras they'd almost have your back and say-you gotta own your shit, as hard as it is, if you get through this, it's removing a lot of weight.

The coaching approach contrasted nicely with the softer supportive role, and included a range of more *active* supportive behaviours that were experienced as helpful by participants.

### Categories that describe the hindering aspects of the paraprofessional role in the VTN

The five categories identified by participants as hindering aspects of the paraprofessional role in the VTN are described in rank descending order, beginning with the categories that were endorsed by the most number of participants (see Table 3). Participants were very reluctant to identify hindering factors, and would sometimes try to retract or soften their statements afterward. This is a reflection of their esteem for the paraprofessionals that they worked with. However, participants were encouraged to share hindering factors, as it could benefit the VTN programming in the future.

**Table 3**

#### Hindering Aspects of the Paraprofessional Role

Category of Incidents	Number of Incidents <i>42 Hindering Incidents</i>	Number of Participants <i>N = 8</i>
	<i>N (%)</i>	<i>N (%)</i>
Lack of Training	8 (19%)	5 (63%)
Neither Fish nor Fowl	9 (21%)	3 (38%)
Rank	8 (19%)	3 (38%)
Individual Differences	6 (14%)	3 (38%)
Aloof	6 (14%)	2 (25%)

**Table 4**

#### Participant Endorsement of Hindering Categories

Category	Participant ID
Lack of Training	002; 004; 006; 007; 008
Neither Fish nor Fowl	001; 004; 006
Rank	001; 002; 004
Individual Differences	001; 002; 005; 007
Aloof	001; 002

**Category 1: Lack of Training (8 incidents; 5 participants; 63% participation rate)**

This category refers to certain aspects of the paraprofessional's behaviour that were experienced as hindering by participants. These included actions such as giving feedback insensitively, pressuring a participant to disclosure information they weren't comfortable with, or speaking negatively about the group facilitators. These diverse behaviours potentially speak to a lack of training or ongoing supervision for the paraprofessionals. One participant noticed that a paraprofessional in his group was much more likely to give advice, "which could have been annoying or frustrating, but we knew his intentions were good."

Another participant described feeling ashamed when he received feedback that was experienced as too harsh.

They'd mentioned the boundary at the start of the program, but I was a bit overwhelmed and I stepped over one of the lines and he reminded me where the line was...He said, "You went too far." He firmly reminded me where the line was.

The participant appreciated being reoriented to the norms of the group, but the perceived harshness of the feedback as an added stress in a situation he was already experiencing as overwhelming due to his PTSD.

One participant noted that over the course, a paraprofessional would vent on occasion to the group members about interpersonal challenges that he was having with the clinicians or a fellow paraprofessional. The participant was somewhat reluctant to share this hindering event, saying,

The only reason I bring it up, especially when you're about two-thirds the way through the process, you're pretty vulnerable to everything, you're also very acute. Perception

wise...and right away you listen for it. So they have to be careful about how they do that.

..and they weren't doing anything evil, it was just something that slipped out.

One deeply traumatized participant, who had very little experience with therapy, was affected when he felt pushed to write about a traumatic incident he didn't want to share with the group.

I had a few things I wanted to write about, and some things I didn't want to approach, and I spoke about it with him, and he said, "oh no, you shouldn't do that [avoid talking about the incident], you should be writing about it." I regretted talking to him about it, and thought I should have just kept quiet.

This participant did approach the clinicians, who reassured him that he did not have to disclose anything he wasn't ready to, and they said they would address the issue with the paraprofessional.

The fact that a paraprofessional missed two days of the course due to work obligations was noted by one participant.

It was difficult not to have the two of them there to rely on, because they both kind of fed off of each other...If he'd missed earlier in the process it might have been more detrimental...you probably need two [paraprofessionals] at a minimum.

The participant acknowledged that illness is inevitable, but felt that the paraprofessional could have prioritized the program over work obligations, with enough notice.

These varying behaviours, which could be considered "unprofessional", can have a significant impact on the participants when they occur. However, these missteps are fairly easily resolved with training guidelines and ongoing supervision.

**Category 2: Neither Fish nor Fowl (9 incidents; 3 participants, 38% participation rate)**

The paraprofessionals were thought by some participants to effectively *Bridge the Gap* between the group participants and the clinicians. However, when the paraprofessionals did not navigate this delicate balance effectively, their role was experienced as hindering. One participant described them as being *Neither Fish nor Fowl*; that is, they were neither clinicians nor group members. Another participant put it, “they’re damned if they do, and damned if they don’t.” Similarly, another said:

They were technically part of the establishment, but because they were there as a para, even though they were there to support us in that role, they weren’t one of the six of us. This was noticeable at the end of the day when the clinicians and paraprofessional debriefed.

That definitely blackened the lines, and then they were part of the staff...you treat them as one of the guys but they’re really not...through [the paraprofessionals] relationship and rapport [with group participants] they’re privy to stuff that the clinicians wouldn’t be...and sometimes there’s the fear that they’re sharing that.

This speaks to an erosion of trust that can occur when there is a perceived division between the two “camps” and the paraprofessionals can be perceived as being aligned with the staff. Conversely, when the paraprofessionals are perceived as being too aligned with the group participants, their role was also experienced as hindering.

Sometimes you could see them almost getting back into it themselves, as a member of the group. They have to be able to gauge correctly, when to start backing off and just let the group go.

It would seem it is important for the paraprofessionals to enter into the group process, without appearing to become reliant on it, which can be disconcerting for participants. At the same time, they cannot appear to be too aligned with the clinicians.

This category speaks to the issue of role confusion. That is, paraprofessionals can feel torn between two different alliances and uncertain about how to behave. As a result, the effectiveness of the paraprofessional intervention is diminished.

### **Category 3: Rank (8 incidents; 3 participants; 38% participation rate)**

Differing ranks between paraprofessionals and group members emerged as a hindering factor that was mentioned by two participants. Although shared military experience was generally an asset, it was difficult for some members to feel comfortable due to a cultural mindset that favours hierarchy.

One of the guys was particularly still Army-like...it sent some of the guys' hackles up because it brought them back to being in a hierarchical structure.

Part of the reason that the issue of rank was hindering was that participants were reluctant to share emotional vulnerability with someone of a higher rank.

The Master-Corporal-Sergeant does not want to tell the Warrant Officer that he's got an issue...you don't want to tell your superiors you've having difficulties.

Another participant from the same cohort described,

One of them reminded me of a Sergeant I had, and my instinct was dislike of him...[He was] brusque...'do it this way-do it that way-shout at the guys-throw the orders around', and I immediately got my back up.

However, both participants noted that this concern lessened as the program progressed. "As I got to know him, I really appreciated his input."

It is interesting to note that after three days together, the issues of rank and hierarchy became less of an issue.

Once we got from the hierarchy to “I’ve been on the ground, and that’s my experience, it [the paras military experience] became an asset.

Military culture had an impact in other subtle ways, which might not have been apparent to the professional facilitators. For example, one participant spoke to certain norms around eating meals. It may be important to be aware of issues like rank and other norms that are second nature to the veterans. If they are not sensitively addressed, they can be experienced as hindering factors.

**Category 4: Individual Differences (6 incidents; 3 participants; 38% participation rate)**

Although not necessarily a hindering factor per se, some participants mentioned that individual differences in character and approach could potentially be hindering if there was not a good fit between paraprofessionals and group participants. One participant did not feel close to the paraprofessional and noted, “it was as much of a personality difference as anything else.” Another participant made a similar statement saying that his experience of the paraprofessional role, “depended largely on their personality.” He noted that he had a good connection with one paraprofessional, but not the other. A third participant echoed the same words, “it’s so dependent on the individual”, that is, whether or not the paraprofessional is experienced as helping or hindering.

Although a good fit is not always possible, these sentiments were common enough among the study participants that it may be worth considering what constitutes a good fit, and work towards minimizing this potentially hindering factor.



### **Category 5: Aloof (6 incidents; 2 participants; 25% participation rate)**

Two participants noted that the paraprofessionals seemed aloof outside of the group context, which was experienced as hindering. “I felt that they were a little aloof, that they wanted to try to keep the professional distance a bit.” The same participant wondered if the paraprofessionals were guarded because they were protecting themselves from the vulnerability they were feeling inside. Another participant referred to the lack of socializing as,

...A little bit of a hindrance...because socializing did get you to talk a little bit more about things...spending time socially helps break down barriers we had.

Both these participants had identified that they experienced socializing with paraprofessionals as helpful, and therefore, perceived aloofness or emotional distance from the paraprofessionals as hindering to their experience of the course.

### **Other**

Additionally, the issue of paraprofessional vulnerability was raised as a hindering factor by one participant. Although not endorsed by enough participants to be considered a category, the comments of the study participant are worth considering. It was felt that the paraprofessional’s vulnerability contributed to a lack of safety in the group, noting, “he [the para] still gets agitated, and his guts would be playing up.” Although the participant was quick to clarify that showing some vulnerability is a good thing, he warned that a vulnerable paraprofessional might lead a new group member to feel that the program wasn’t effective. The participant joked [in imitation of a hypothetical vulnerable paraprofessional], “Hey Guys! I went through the program too and I ended up...what the fuck?”

The participant reflected that if he was a paraprofessional, “I don’t know if I would have that same vulnerability on my sleeve.” These comments speak to the need for a paraprofessional

to have experienced a certain level of recovery, in order to provide safety and leadership to those in the group.

### **Participant Wish List items**

Participants identified five WL items in regards to the paraprofessional role in the VTN. These are: Recruitment and Training, Follow-up; Matching; Socializing; and a Meet and Greet session.

Two participants identified *Recruitment and Training* as important WL items. One participant said that a paraprofessional who was well trained adds value to the process. He felt, “extensive knowledge” in group content and process was vital to the provision of good paraprofessional support. Another participant elaborated:

The para training may not be enough. Perhaps more training could be beneficial to paraprofessionals to better understand their roles and understand how to provide feedback within the group...so they truly understand how much meaning what they say carries. Because their input is held in higher regard than the input provided by other members of the group.

Another issue identified related to the recruitment of paraprofessionals.

You have to be very careful of who you put in there [as a paraprofessional]. It could really make or break things. Even just their general demeanour. That sets the tone [because the paraprofessional is] someone you’re looking to. If someone you’re looking to is an asshole, for lack of a better word, you’re kind of screwed from the get go.

This same participant claimed that he had been asked to be a paraprofessional by the VTN, and found the recruitment process to be disconcertingly casual. These WL items mentioned by two

participants, both of whom had extensive and very recent military experience, speak to the importance of clear guidelines for the recruitment and training of paraprofessional staff.

Two participants reported that adequate *Follow-up* was something they wished they had more of in their involvement in the VTN. While participants reported that while immediate follow-up was provided, long term follow-up was experienced by some as inconsistent or lacking. One participant said,

Afterwards I got 3-month, 6-month, and 12-month follow-up, that's usually phone or email. I would suggest something that might be more intimate follow-up.

The participant was aware that it might be difficult logistically to get everyone together, but he reiterated that there should be "better follow-up." Another participant was more specific in suggesting a follow up day course,

Just to refresh the tools, kind of check in and see where everybody is at, how they're coping...just to see where they are...You have kind of a refresher...we do it all the time in the Army. You always do your weapons test every year, and you refresh your First-Aid.

He echoed the sentiment that it might not be feasible to get participants from geographical areas all together. Both acknowledged that staying connected with paraprofessionals and other group members was positive and important, although one participant did acknowledge that it was "asking more of your paraprofessionals" to provide ongoing follow up. It would seem that there is follow-up provided at intervals (possibly for research purposes), although this may be experienced as somewhat impersonal. Some paraprofessionals and VTN graduates do stay in touch, but this may be an organic, rather than a formalized process. Overall, study participants

requested more organized, consistent, and intimate follow-up to reinforce the learning and the relationships they built in the VTN.

The category of *Matching* flows from the *Individual Differences* mentioned as a hindering factor by some participants. To a large degree, matching refers to selecting group members based on their similarity of experiences, and the how recent their tenure in the military was. The concept of matching could also be extended to paraprofessionals, to minimize the impact of a poor fit between paraprofessionals on the group members. Two participants mentioned that they thought matching paraprofessionals and group members on variables such as age and type of military experience was something they would like to see in the VTN program. Although this did not emerge particularly strongly as a WL list item, it is worth bearing in mind, so that individual differences between paraprofessionals and group members may be reduced in future.

Paraprofessionals who were perceived as being aloof were considered hindering to some participants. Similarly, increased *Socializing* was mentioned as something two participants wished they had more of, and would like to see more of in the future. One participant said simply, “I would have liked to spend more time with them.” The other reported that he would like to spend time with the paraprofessionals, “even if it’s just the social aspect of getting together and having a drink.” These participants identified the importance of socializing while on course, and wished to maintain social ties with the paraprofessionals after the ten-day program was completed.

Two participants, both of whom attended the same VTN ten-day program, suggested that a *Meet and Greet* with the paraprofessionals would have been beneficial.

Everything that happens there [in the group] happens fairly fast. It might have been a good idea to meet the paraprofessionals beforehand.

The other participant elaborated,

The only thing that could have made a [positive difference] is if there had been a meet and greet type thing, maybe a couple of days before, or the weekend before, just an afternoon to meet who's going to be the players.

Both of these participants felt that a meet and greet beforehand might break the ice in advance, so that the valuable time on the course might be used more efficiently.

## Chapter Five: Discussion

The results strongly support what is known about the mechanisms of paraprofessional support in the literature. This contributes to the validity of the existing literature on the topic, and affirms that the paraprofessional role is a distinct intervention that is common across populations and settings. However, the VTN is a very unique form of group trauma repair, and the findings uncover some aspects of the paraprofessional role that are unique to the therapeutic method and the veterans who participate.

*Shared experience* is the foundation of the peer intervention, and is what differentiates it from professional interventions and general social support. This shared experience was critical to participants who felt safe among those who had similar life experiences and a similar mindset. The paraprofessionals and the group members shared a range of experiences, such as exposure to combat-related trauma, symptoms of PTSD, interpersonal and vocational difficulties, and a sense of failure at not being able to overcome these challenges on their own. Shared experience was critical in the group milieu, as participant felt understood and less alone. The sense of camaraderie as, “brothers in arms”, resulted in a therapeutic space where they did not have to self-censor and the healing could begin. The shared mindset of the paraprofessionals and the group members, reflected in a tendency to react emotionally in certain ways, was also helpful and normalizing.

The success of peer support as demonstrated in randomized trials and quasi-experimental studies (Solomon, 2004) is thought to be due to this element of shared experiences. However, shared experience cannot simply be implicit. The personal experiences of the paraprofessionals must be shared, or the benefit of experiential learning will be lacking in the process (Money et al., 2011). In the VTN, this shared experience was both *implicit* and *explicit*.

A shared mentality was *implicit* in the sense of humour and vernacular used among the paraprofessionals and group participants. Additionally, the shared military experience of the paraprofessionals was sometimes implicitly expressed during the more active parts of the group process. Although not mentioned in the results, two participants alluded to the paraprofessionals' ability to act as a "switched on" group member resulting in an enhanced ability to role-play, tune in to the mindset of the participant, or "bring them back" when they noticed the group member was disassociating.

The sharing of personal experiences via self-disclosure is the more *explicit* method. Several participants mentioned the importance of the paraprofessionals sharing their personal experiences, including specific traumatic events and transition-related challenges. Self-disclosure is used very judiciously, if at all, in professional counselling interventions. However, it is one of the most important tools of the paraprofessional support provider. Although, the paraprofessional uses self-disclosure much more frequently than the professional, it must be applied with equal care. The goal of self-disclosure is to communicate shared experience in a way that is helpful. Sharing personal stories and coping strategies leverages shared experience to promote healthy recovery. However, limits to self-disclosure do apply. Excessive self-disclosure can damage the paraprofessional alliance if it is long-winded or inappropriate (Lapsley, 2012). A delicate balance must be struck between self-disclosure that promotes therapeutic friendship, and self-disclosure that becomes boring or a burden to the participant.

Overall, shared experience is undoubtedly a critical factor in veteran paraprofessional support. Having similar experiences contributes to a sense of social cohesion (Money et al., 2011), therefore, shared experience must be fully leveraged in the VTN to maximize group cohesion, safety, and engagement in the therapeutic process.

Trust was identified as an important component in paraprofessional support in the VTN, as participants headed into unfamiliar emotional terrain. The findings of this study confirm that veterans trust paraprofessionals more than traditional medical personnel (Chinman et al., 2008). Rotter and Stein (1971) outline the key ingredients of a trusting relationship as feeling: a) that the other person is honest; b) that the other will not take advantage; and c) that the other has credible knowledge. The military culture and experience that veterans share with the paraprofessionals are likely to result in the assumption of their honesty, and the paraprofessionals are perceived to be less likely to have an agenda, than the “establishment.” They also know how to navigate transition-related challenges and life with PTSD, as demonstrated by their involvement with the VTN as paraprofessional support staff.

The result is that a sense of trust is rapidly established. Several participants pointed to the helpfulness of the paraprofessionals’ presence in that trust was developed quickly and easily. In a time limited program such as the VTN, the ability to form trust quickly is imperative.

Money et al. (2011), note that trust and credibility are integral to building helping relationships, and that the presence of paraprofessional support contributes to a beneficial *environment of credibility*. Participants did not trust the clinicians or the therapeutic process itself, but because the VTN was endorsed by the paraprofessionals, reluctant group members were willing to give it a try.

The paraprofessionals also have first-hand knowledge of the common challenges faced, something professionals only know through formal education (Veith et al., 2006). This puts the paraprofessionals in a unique position to translate knowledge to group members in a credible way. Overall, the paraprofessionals contributed to the environment of credibility that helps to make the VTN a successful program.



*Paving the Way* was a category that was endorsed by all participants. It spoke to the importance of the paraprofessional having walked the same path, which made it easier for the group members to move forward. This ties nicely into the concept of role-modelling, considered an important mechanism in paraprofessional support (Solomon, 2004). Typically, role modelling provided by a peer supporter takes place over a period of time, as the client engages in ongoing group work or a one to one buddy relationships.

The role modelling described in the literature relates to the ongoing process of recovery. Traditional veteran peer support initiatives are embedded in a psychosocial model of personal recovery (Chinman et al., 2008; Resnick and Rosenheck, 2008). The personal recovery model was conceptualized by Anthony (2003) and has blossomed into an international guiding principle in health care delivery (Slade, Amering, and Odes, 2008). The most current definition conceptualizes recovery as a self-directed, dynamic process of pursuing health, wellness, and the fullness of personal potential as defined by the individual themselves (SAMHSA, 2011). The typical veteran paraprofessional lives by example and models a healthy recovery from the injuries and mental health challenges they have in common with their clients.

Due to the unique nature of the VTN, the role-modelling occurs in the context of the time-limited nature of the 80-hour program. Although there was some data that spoke to the paraprofessional having gone down the road of recovery in terms of PTSD, for the most part, *Paving the Way* referred to the paraprofessional having previously completed the program. Most importantly, *Paving the Way* referred to the paraprofessional “leading by example” by actually going first in the group process. This made it significantly easier and safer for participants to venture into unfamiliar terrain such as disclosing traumatic incidents, expressing vulnerability, and the TE work.

The supportive role that the paraprofessionals played was highly endorsed by participants. Although they generally did not frame it in terms of supportive acts, they spoke of feeling heard, understood, and validated by paraprofessionals. These are commonly used counselling micro skills that are crucial to the paraprofessional role (Lapsley, 2012). Social support is considered perhaps the most important factor in the peer support intervention across a variety of populations (Money et al., 2011; Solomon, 2004, Veith et al., 2006) and is a crucial protective factor in those with PTSD (King et al., 1998; Solomon and Mikulincer, 1990). The importance of social support cannot be overstated.

Although study participants may not have consciously recognized they were recipients of social support, they nevertheless identified commonly identified aspects of social support as being helpful to the paraprofessional intervention. Interestingly, the VTN has gone to great lengths to appeal to the masculine culture of the military personnel who engage in the program, and they consciously steer away from traditionally feminine models of counselling that may alienate a hyper-masculine population (Westwood et al., 2012). However, within the safe context of an *environment of credibility*, typically feminine ways of support are appreciated and necessary. In fact, at times when paraprofessionals ventured outside of these gentle forms of support, such as excessive advice giving, their interventions were experienced as hindering by group members.

More active forms of social support such as encouraging, coaching, information giving, coaxing, and challenging were also considered a helpful part of the paraprofessional intervention in the VTN. This type of active support is well within the purview of the paraprofessional, whose role is dynamic and broad. Veith et al. (2006) suggest that this may extend to activities like mentoring, advice giving, practical support and goal setting. These typically masculine forms of

support were appreciated by participants, and interventions such as “challenging” may be more likely to be well received when delivered by a paraprofessional, who is perceived to be more credible. If these more active forms of social support are delivered artfully, they can be very effective and aligned with the goal-oriented, task focused nature of the “course” and the military population.

Going forward, it might be worth noting that both masculine and feminine forms of support are important. An over-emphasis on masculine ways of helping might contribute to a societal bias toward overvaluing the masculine. Presenting the therapeutic process in ways that appeal to military clients, and creating an environment of credibility with the presence of paraprofessionals is critical to engagement. However, once trust and safety is established, the opportunity presents itself to deliver interventions that integrate both masculine and feminine ways of being in a way that expands the internal and external worldview of the group members.

The category *Setting the Norm* is a helpful aspect of the paraprofessional role which is unique to the VTN group program. Because it is an intensive, time-limited therapeutic process, that is unfamiliar to participants, the norm setting provided by the paraprofessionals was vital to ensure safety in the group. While *Paving the Way* refers to going first in the therapeutic process, *Setting the Norm* refers to both explicitly and implicitly informing group members the proper way to behave. These included things such as what type of humour was appropriate, how to give feedback, and what level of self-disclosure was appropriate. In a military culture which strongly endorses conformity, this setting of norms was needed for participants to regulate themselves in an environment that was, at least initially, considered foreign territory. The credibility that the paraprofessionals had with the group members also allowed them to also enforce these norms at times, if needed.

Participants expressed appreciation for the *Nuts and Bolts* logistical tasks that the paraprofessionals completed over the 80 hour program. Whether these involved menial tasks, or assisting with aspects of the group process, participants were aware of the important contribution that that paraprofessionals made to the smooth running of the program. This contribution existed outside of the unique offerings of the paraprofessional role (e.g. shared experience). The identification of Nuts and Bolts as a helpful aspect of the paraprofessional role may speak to participants' military mindset. On a course there is much to be done, and as a team, people do what it takes to get the job done. The contribution that the paraprofessionals make to the logistical aspects, as well as the therapeutic process, in the VTN is immeasurable.

*Bridging the Gap* is an important part of the paraprofessional role that was identified by participants. When participants see themselves as inhabiting a different world than the professionals, a gap results that the paraprofessionals are in a unique position to bridge. This process took various forms, some subtle and some more overt. According to two participants, the paraprofessionals facilitated the acceptance of the doctors into the group. In the time limited group process, success is contingent upon the buy-in of the group. The paraprofessionals serve to bridge the cultural difference between participants and the doctors by contributing to the environment of trust and credibility. If the paraprofessionals believe in the clinicians, the group members are more likely to follow suit. Participants feared that the doctors might not understand the unique issues they face as military personnel, and the paraprofessionals acted as a go-between. At times, it was noted that the paraprofessionals were aware that the group was reluctant to move forward in the therapeutic process and had to communicate to the clinicians that the group was not ready.

Although what entailed *Bridging the Gap* was not always concrete, it spoke to a cultural gap, which only the paraprofessionals could close. This is a noted phenomenon in peer support, especially in mental health where clients can feel a great deal of suspiciousness toward clinicians (Lapsley, 2012). Peer Supporters play an important role in assisting reluctant clients to engage and bridge them into needed treatment (Money et al., 2011). Certainly, several participants, especially those who had a longer tenure or were more recently in the military, saw the clinicians as authority figures. As such, the clinicians were initially worthy of distrust, and were only reluctantly employed by group members. In a time-limited intervention such as the VTN, this gap needs to be addressed immediately, in order to quickly engage group members in the program.

Clinicians also rely on the paraprofessionals to communicate the mindset of the participants, as aspects of the military culture may be present, but not obvious to civilians. Bridging the Gap is a critical aspect of paraprofessional support, and one that was strongly endorsed as helpful. However, bridging the perspectives of the clinicians and can be a complex task that requires a lot of flexibility from moment to moment. In order to be successful in this, the paraprofessional must be able to hold multiple truths at once in a compassionate way. As instances arise where the peer supporter is called to bridge the gap, conscious awareness and reflection will assist them in taking the right approach (Lapsley, 2012).

As important as *Bridging the Gap* is, the other side of the coin is the *Neither Fish nor Fowl* phenomenon, which was identified as a hindering factor by some participants. At times, the paraprofessionals did not navigate this terrain with enough delicacy, and were “caught between divided loyalties.” The paraprofessionals were at times perceived as having a somewhat unholy alliance with the clinicians, and it was feared that the paraprofessionals could share information

that group members feared could be used against them. The paraprofessionals may also be under some perceived pressure from the clinicians, who may have set guidelines around appropriate behaviour and “boundaries” which must be adhered to. If the paraprofessionals socialize excessively with participants, they may be perceived by the clinicians as violating this boundary. If the paraprofessionals behave, even subtly, in a way that conveys any distrust of the clinicians or the therapeutic process, the collective environment of credibility is impaired. If one or both camps perceive the paraprofessionals to side with the other, they may be considered unprofessional by the professionals, and too professional by the participants. This is indeed, as one participant put it, “a tough spot” and one that takes considerable delicacy to navigate. The answer lies in a dialectical mindset, of holding the perspectives of both the clinician and the client simultaneously. The paraprofessionals are legitimate and effective healthcare providers, who have therapeutic skills, and are trained to deliver a powerful intervention that artfully uses self-disclosure and shared experience to have a meaningful impact on participants. They have also been in the shoes of the clients, and understand what it is like to be on the receiving end of care. Paraprofessionals ideally are, “Experts at not being an expert (Repper and Carter, 2011 p. 396).” The complexity and delicacy of this role requires supervision from a skilled supervisor, who is knowledgeable about the peer support intervention (Lapsley, 2012).

Several study participants identified that they experienced the paraprofessionals as *Aloof*. This was experienced as hindering, as they enjoyed socializing with the paraprofessionals. There was some suggestion that the paraprofessionals were directed to leave the participants to themselves when not in group. Yet, Grenier (2011) rather humorously refers to *chit-chat* as one of the more important tools in the arsenal of the paraprofessional. Indeed, *chit-chat* was a major component of forensic peer support (Lapsley, 2012), as it took pressure off the clients to engage

in onerous mental health related conversation, contributed to a relationship of equality, and built therapeutic rapport.

The *Neither Fish nor Fowl* phenomenon and the reluctance to socialize identified in the *Aloof* category both speak to the issue of role confusion, a topic that has generated considerable concern in peer support practice and literature. This seems to stem largely from a professional mindset that clings to proper boundaries as a lynchpin of ethical and effective therapeutic practice. However, unclear boundaries and lack of skill can have a negative impact on the recipients of paraprofessional support. Paraprofessionals who are not trained to navigate this role confusion can experience emotional strain in work settings, and may damage relationships with clients as well as professionals (Lapsley, 2012). Role confusion can lead to unfortunate problems in clinical settings. For example, at times clinicians may influence peer supporters to adopt approaches that are too professional, which diminishes their unique peer perspective (Resnick, Armstrong, Sperrazza, Harkness, and Rosenheck, 2004). Conversely, in some settings, peer supporters experience egregious inequalities, including poor pay, not enough support and supervision on the job, and lack of access to facilities such as staff bathrooms or client files.

Clear boundaries are indeed important in the peer support relationship, as they create safety and stability for all parties (Money et al., 2011). Again, the delicate dance of the paraprofessional is highlighted, as support providers must be dissolve barriers between themselves and their clients, in order to promote closeness and trust, yet reinforce boundaries so they do not become overly involved in the lives of those they serve (Bacharach, Bamberger, and McKinney, 2000). Ultimately, each setting in which a paraprofessional provides care is unique, and appropriate boundaries must be established in that context. There are no easy answers, but peer support relationship embedded in clinical settings typically have clear guidelines, which

discourage the fostering of dual relationships, while still promoting some reciprocity between the peer support provider and the client.

*Paving the Way* was strongly endorsed by participants as a helpful factor of the of the paraprofessional role. Paraprofessionals led by example, and also set norms around how far to go emotionally. Demonstrated emotional vulnerability was a key part of this process. Yet, paraprofessionals who showed too much vulnerability were experienced as hindering by participants. Vulnerability is a powerful tool in the arsenal of the effective paraprofessional (Lapsley, 2012), but like self-disclosure, it must be used judiciously in the service of the client. When the paraprofessional became so vulnerable that they could not act in a leadership role, the effectiveness of the paraprofessional intervention was impaired. The group milieu became less safe, and the paraprofessional lost credibility as a role model of recovery.

Appropriate vulnerability sets a good example for the participant to access the deepest parts of themselves, and realistically reflects a journey of recovery that is not linear, and one that may involve ongoing suffering and therapeutic work. However, when a paraprofessional becomes emotionally overwhelmed, their state of mind becomes a burden on the participant. While this may go unnoticed should it occur temporarily in a time limited setting, a paraprofessional who is not yet resilient enough to withstand the selfless giving and potential re-traumatization in TE, may not be ready to offer paraprofessional support to other individuals with OSI. Overall, vulnerability is an important tool if it is used consciously and appropriately, but only if the paraprofessional has full control over this powerful healing intervention.

*Individual Differences* was a category mentioned by a number of participants. While not clearly a hindering factor, it was acknowledged that some paraprofessionals would not be a good fit for every group member, and in some cases, study participants had not meshed well with the



paraprofessional in the VTN program they attended. This is unavoidable of course, especially since part of the paraprofessional role is to be authentically themselves in a reciprocal supportive relationship. Clinicians are not always a good fit for their clients either, although they are trained in specific ways of relating that mitigate personality differences to the greatest extent possible. Training, experience, and supervision will assist the paraprofessional to adjust themselves to the needs of those they support, while simultaneously maintaining and radiating their authentic presence in the context of the group process.

Issues related to *Rank* was mentioned by two participants. Although shared military experience was vital to their engagement, they had difficulty opening up to paraprofessionals because they were unused to admitting personal problems to those who were of superior rank in the military. Also, some participants feel bitter toward the military, despite their immersion in the culture. If a paraprofessional isn't careful to clarify that rank is not of any consequence on the VTN course, participants can be triggered by memories of a less than supportive military milieu. This issue is easily remedied by directly addressing it at the beginning of the VTN course, in order to clarify that rank has no bearing in the group process or in the interpersonal relationships that form there.

The *Lack of Training* implicit in some of the hindering behaviours mentioned by study participants are easily addressed through comprehensive and consistent training and supervision. Interestingly, training emerged as the most frequently mentioned WL category. Training and recruitment are essential in paraprofessional interventions across populations and settings, and efforts are being made to standardize Canadian federal guidelines for best practice, training and recruitment (Sunderland et al., 2013) of peer support providers.

Participants also wished for more formalized *Follow-up*, which speaks to their engagement in the VTN program. The “refresher” course suggested by one individual sounds like an excellent idea, although resource intensive. Organized social groups that are integrated into formal follow-up procedures may also meet the needs of some participants who expressed as wish to socialize more with the paraprofessionals after course ends. However, involving the paraprofessionals in further VTN duties may be asking too much of them without offering additional incentives. Currently, paraprofessionals currently get their expenses covered, but do not receive compensation.

*Matching* was mentioned by some participants as a process they would like to see in place, which may help to minimize the individual differences experienced as a hindering factor. Matching might manifest in ways such as placing paraprofessionals in a group with members of a similar age, or those who are more thoroughly steeped in military culture. For example, someone with a life-long military career might do well with a higher ranking paraprofessional who had a gruff manner. A group member who had been retired from military service and worked as a civilian for over twenty years, might do better with a paraprofessional who was more sensitive to civilian culture.

Two participants suggested a *Meet and Greet* session with the paraprofessionals beforehand would be beneficial in order to make the most out of the formalized group time. While this may be ideal, it is another resource intensive WL item, especially if group members hail from differing geographic areas. An alternative suggestion is to involve paraprofessionals in some of the pre-program phone contact, as it gives them the chance to start the engagement process before the group actually meets.

One WL item was not included in the results because it was only mentioned by one participant. He wished that the paraprofessionals had shared more theoretical knowledge about PTSD. While this idea may not appeal to all participants, it is common practice for peer supporters to provide information about the condition they share with their clients (Veith et al., 2006; West, 2011; Lapsley, 2012). When a paraprofessional effectively translates theoretical knowledge through the lens of their lived experience, the result can be a powerful story which is transformative for those who hear it.

## **Recommendations**

### **Training**

The paraprofessionals may benefit from more formal or comprehensive training. Typically, peer support training in veteran populations is quite involved and multifaceted (Chinman, Shoai, and Cohen, 2010; Money et al., 2011), even though the modes of delivery (basic support groups; one to one buddy visits) are much less complex than the VTN program model. Although communication skills, group processes, and suicide risk assessment are currently part of the VTN paraprofessional training, additional information related to the nature and impact of trauma, and the delicate nature of the peer support intervention, especially in regard to things such as role confusion, may be important to convey. Most veteran peer training programs have a formal study curriculum, recruitment policies (see Chinman et al., 2010 p. 272), and documented paraprofessional competencies. These must be demonstrated before a paraprofessional can move into direct client care. Supervised practicum hours and ongoing supervision by a clinician who has expertise in the paraprofessional model, may be able to more sensitively and accurately guide a paraprofessional to do the greatest work possible. The

development of a formalized training manual, clear recruitment guidelines, and supervision requirements for VTN paraprofessionals are recommended.

### **Greater alignment with paraprofessional principles and practices**

The VTN is an incredibly effective and unique model of care that is highly valued by the graduates who have attended the program. The program has changed many lives, and undoubtedly saved many lives as well. As this study has demonstrated, the paraprofessionals play a critical role in the delivery of the VTN course. Traditional veteran peer support initiatives are strongly aligned with the guiding principles of the personal recovery model (Anthony, 2003) and it may be of interest to become familiar with these principles in order to speak a common language with other paraprofessionals. The Mental Health Commission of Canada has developed comprehensive best practice guidelines and outlines paraprofessional competencies designed to create consistency in peer supported programming across Canada (see Sunderland et al., 2013). The Defense Centre of Excellence (Money et al., 2011 p. 25), have outlined *33 critical competencies* for military paraprofessionals which include cultural competence, managing crisis and emergency situations, peer support principles (e.g. instilling hope; being a role model); paraprofessional ethics, boundary issues and dual relationships; recovery principles and tools; managing internal and external stigma; and knowledge of various psychiatric conditions.

Clinicians are expected to have mastered certain competencies, which are outlined by accreditation bodies. Although the nature of paraprofessional support is by nature informal, it is also a powerful intervention, especially when embedded in a clinical setting. Although peer support best practice guidelines and competencies might not be a perfect fit for the paraprofessional support offered in the unique therapeutic and philosophical context of the VTN,

it is nevertheless important to be familiar with common principles of peer support and align the training with them as much as is deemed necessary.

### **Compensation for VTN paraprofessionals**

Although resources are always scarce mental health programming, it is important to validate the contribution the paraprofessionals make to the VTN by compensating them, at least somewhat, for their hard work and the added value they bring to the program. It is an unfortunate trend that peer support workers are often underpaid (Chinman et al., 2008) or not paid at all. If at all possible, it is suggested that funding be found to provide some compensation to the paraprofessionals who do such a wonderful job helping to implement the VTN program.

### **Limitations**

A number of limitations to this proposed study are evident. Firstly, due to a small sample size and the qualitative nature of the inquiry, the findings only reflect this particular time and place, and may not necessarily be generalizable to other types of peer interventions and/or civilian populations. This study can only suggest themes that could provide a rationale for more extensive research in the area. Secondly, it may be difficult for the participants to fully tease out the peer intervention from the professional intervention or other aspects the program when recollecting their experience of the VTN. This is a common limitation in the area of peer support research (Money et al., 2011). Thirdly, researcher subjectivity may be a limitation, as the results were filtered through my own experience of providing peer support and my life experience as a civilian. Fourth, the interview fidelity check laid out in the ECIT protocol was not adhered to. If in fact the interview was not delivered correctly, the results may have been affected. Fifth, a number of participants were in the same cohort and the helpful and hindering aspects they reported may reflect an individual paraprofessional rather than a general trend in the VTN.

Lastly, although it is likely that exhaustiveness was reached, it is possible that more themes, especially idiosyncratic WL items, might have been unearthed if more interviews were conducted.

## **Conclusion**

Paraprofessionals are indeed in a tough spot. They must delicately align with both professionals and participants, bridging a sometime perilous gap. They must be vulnerable, but not too vulnerable. They must be social able and friendly, but not overstep boundaries considered important in the provision of health care. As one participant said regarding paraprofessional support, “The concepts are simple, but extremely complex to understand and to put into practice.”

The paraprofessionals make a critical contribution to the therapeutic milieu by engaging clients quickly and fully, and maintaining an environment of credibility. They complete tasks that are important to the smooth functioning of the group program. Yet, while they are valued by both clinicians and group members, to date the academic literature on the VTN has not paid particular attention to the vital importance of their contribution.

This study demonstrated that both the helpful aspects and hindering paraprofessional support provided in the VTN is commensurate with what is known about peer support in the literature. These relate to various types of social support, trust and credibility, the importance of shared experience, and the benefits and perils of bridging the gap. We were also we able to gain a greater understanding of how participants experienced paraprofessional support in the unique context of the VTN course. These themes included leading by example and setting norms in an unfamiliar therapeutic process, and challenges related to rank which hindered the group process. This study also was able to provide, based on the literature and on the wishes of participants,

recommendations that may contribute to the further development of this engaging, effective, and healing program.

Although a qualitative study can only speak to the experience of a few participants, and is not generalizable, it can nevertheless point the way to further research and avenues of inquiry. Future research could investigate how paraprofessionals experience their role in the VTN program, as it has been demonstrated that peers derive numerous benefits from supporting others (Moran, Russinova, Gidugu, Yim, and Sprague, 2012; Solomon, 2004). Also, it might be interesting to explore the synergistic interaction between the clinicians and the paraprofessionals, as they bring complementary gifts and skills to the therapeutic process.

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## Appendix A: Interview Guide



Educational and Counselling  
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Education

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### INTERVIEW GUIDE

#### Understanding the Experience of Peer Support in the Veterans

#### Transitions Network: What Helps and Hinders

Sara Lapsley, B.A.

Participant Number:

Interview Start time:

Date:

Interview End time:

#### *Demographic Information*

Age\_\_\_\_\_

Gender\_\_\_\_\_

What is your current military status?

Level of Education\_\_\_\_\_

Cultural Background\_\_\_\_\_

#### *Establishing Context*



- Tell me a little bit about your experience in the military and what it was like transitioning back to civilian life.
- How did you become involved in the Veteran's Transition Program
- Looking back, how were things emotionally and psychologically for you before you entered the program?

### *Soliciting Critical Incidents (What helped or hindered)*

Think back to your time in the VTN program.

A) Describe how you experienced the role of the paraprofessionals in the program.

What was helpful about their presence?

What was hindering about their presence?

Further open-ended questions will act as probes for further information:

- Exactly what was helpful about paraprofessional support
- What went on before and after?
- What impact did this have on you?

B) Specifically in the TE portion of the VTN program, how did you experience paraprofessional support?

- How did that help or hinder the TE process?

### *Soliciting Wish List items (resources or processes they would have liked to be there for them)*

- Is there anything you can identify that you wish would have been a part of paraprofessional support in the VTN?
- Are there any improvements you could suggest based on your experience of paraprofessional support in the VTN?

### *Debriefing*

After the interview is complete, the participant will be given an opportunity to ask any questions or raise any concerns they have.

A request for a second interview will be made, so they can look over the transcription of the first interview and given the opportunity to clarify.

Participants will be assessed for any signs of emotional distress and contact information for the VTN program and encouraged to call if they should experience any discomfort after the interview.

# Appendix B: Participant Consent Form



Educational and Counselling  
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## **PARTICIPANT CONSENT FORM**

### **UNDERSTANDING THE EXPERIENCE OF PARAPROFESSIONAL SUPPORT IN THE VETERANS TRANSITION NETWORK: WHAT HELPED AND HINDERED**

**Principal Investigator:** Marvin J. Westwood, PhD

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604-822-6457

**Co-investigator:** Sara Lapsley, BA

The university and those conducting this study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This form and the information it contains are given to you for your own protection and to ensure your full understanding of the procedures, risks, and benefits of participating in this study.

**Purpose:** The purpose of this study is to understand how participants in the Veterans Transition Network (VTN) experience paraprofessional support in the context of the 10-day program offered by the VTN.

**Study Procedures:** The study will involve an interview with the co-investigator that will last about 1.5 hours. It will be audio-recorded and will take place at the UBC campus in a private office in

the Department of Education You will be contacted afterwards to review the transcription of the interview and given the opportunity to clarify your responses.

## **Confidentiality**

Your confidentiality will be respected. We will not share the information you give us with anyone else. As a participant you will be assigned a unique study number. Your name and study number will be saved on a master list of participants, which will only be accessed by the PI and the co-investigator. Your name and study number will never appear together on any document; all the information we collect from you (i.e. demographic form, interview data) is completely anonymous. Only the authorized PI and co-investigator will have access to these materials. We will take the following steps to ensure your confidentiality.

- All documents will be identified by a study number and kept in a secure filing cabinet in the Veterans Transition Network research office.
- All electronic records will be stored on a secure password protected network of the Provincial Health Services Authority.
- Any information that identifies you will be stored separately from your study responses.
- Any reports, papers, or thesis resulting from this research will not include your name or any other identifying information.

## **Limits to Confidentiality Agreement**

Confidentiality is guaranteed unless you are judged to be a serious danger to yourself or another person, including children, adults, and elderly persons. In this case, information gathered during the study may be shared with another professional only to the extent necessary to prevent harm. The researchers will not release any information you provide during the interview unless required by law.

## **Risks**

Owing to the sensitivity of the topic, you may experience some distress or discomfort discussing combat related trauma and the difficulties experienced transitioning back to civilian life. **Participation in this study is voluntary.** You do not have to answer questions you feel uncomfortable about, and you can withdraw from the study at any time. Declining to answer certain questions or withdrawing from the study will not affect your ability to receive services or remain involved in the Veterans Transition Network. Should you experience any distress we encourage you to contact PI Dr. Marv Westwood who can be reached at 604-822-6457 or at marvin.westwood@ubc.ca

## **Benefits**

Participants may contribute to better services and provision of paraprofessional for fellow veterans who participate in the Veteran's Transition Network programming in the future.

**Contact for information about the study**

If you have any questions about the study, please contact co-investigator Sara Lapsley at [slapsley2@forensic.bc.ca](mailto:slapsley2@forensic.bc.ca) or 604.724.8787 or Dr. Marv Westwood at 604-822-6457 or [marvin.westwood@ubc.ca](mailto:marvin.westwood@ubc.ca)

**Contact for concerns about the right of research subjects**

If you have any questions, concerns, or complaints about your treatment or rights as a research participant, you may contact the research subject information line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to [RSIL@ors.ubc.ca](mailto:RSIL@ors.ubc.ca)

## Appendix C: Study Recruitment Poster



**a place of mind**

THE UNIVERSITY OF BRITISH COLUMBIA

**WE ARE LOOKING FOR GRADUATES OF THE VTN WHO WOULD BE  
INTERESTED IN PARTICIPATING IN THE STUDY:**

### **Understanding the Experience of Paraprofessional Support in the Veterans Transition Network: What Helped and Hindered**

Principal Investigator: **Dr. Marv Westwood**, Department of Education 604-822-6457 or [marvin.westwood@ubc.ca](mailto:marvin.westwood@ubc.ca)

Co-investigator: **Sara Lapsley**, BA, M.A (Candidate) Department of Education

**We are looking for 10-12 graduates of the VTN program to discuss the impact that paraprofessional support had on their experience of the program.**

If you decide you would like to participate, the study will involve an interview with the co-investigator that will last about 1.5 hours. It will take place at the UBC campus in a private office in the Department of Education and be audio-recorded. You will be contacted afterwards to review the transcription of the interview and given the opportunity to clarify your responses. All information will be kept strictly confidential.

We will pay you \$10 at the time of the interview to cover the costs of parking on the UBC campus, or transit to and from the UBC campus.

If you are interested in participating, please contact co-investigator Sara Lapsley at [slapsley2@forensic.bc.ca](mailto:slapsley2@forensic.bc.ca) or 604.524.7703 or Dr. Marv Westwood at 604-822-6457 or [marvin.westwood@ubc.ca](mailto:marvin.westwood@ubc.ca)