

Understanding Operational Stress Injury Support Services from a Veterans

Perspective

By

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Abstract

With the recent combat in Afghanistan, Post Traumatic Stress Disorder (P.T.S.D.) is once again in the public eye. With this it has sparked researchers interested in P.T.S.D. and the experiences of soldiers post combat. However, much of this literature has framed P.T.S.D. as abnormal psychology versus a normal reaction to extreme violence. Further, the literature has concentrated on P.T.S.D. and not explored Operational Stress Injuries. As well, it has been stated that there has been an influx of soldiers and combat veterans seeking social services. This is an exploratory study that examines the narratives of five veterans for their perspectives of operational injury support services. The research is based on an anti-oppressive interpretative social science framework and narrative based qualitative interviews with five veterans residing in Southern Ontario. The findings revealed stories of the veteran's identity, the emotional impact of war, barriers to seeking treatment and facilitators to accessing services.

Each of these veterans spoke about their employment and culture and how this had an effect on seeking services. Many aspects of the veterans' stories were comprised of stigma and the impact it had on seeking treatment. Condensed with stigma, the structural barriers exacerbate the soldier's ability to seek culturally appropriate services in a timely fashion. Furthermore, these structural barriers do not solely impact the veterans in one area of their lives but have a ripple effect on all areas. Lastly, these veterans provided explicit service provisions that they believe would assist them and other veterans in the future. Not only do these men believe that individual support is important to them, but supporting their families also seems to be an important aspect of treatment.

Even with individual treatment each veteran talked about the importance of peer support, whether it was too informal or formal, and the role of peer support seems vital in a holistic culturally appropriate treatment.

Acknowledgement

First and foremost, I would like to thank and acknowledge the veterans who took their time to share their stories with me. I am honoured that I have had a chance to work with each one of these men and thank them for their openness and assistance with my thesis. I hope that this thesis represents and pays tributes to your stories.

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Chapter 1

Introduction

In Canada there is a lack of research on the experiences of veterans accessing mental health supports. This is not surprising given that there is a lack of research on all aspects of military life. The reasons for this include the high ethical clearance necessary to speak to men in the service, the confidentiality of research, and/or the reluctance of the military to speak to researchers about their culture. I experienced this as well and had some difficulty with recruitment for this study. Mental health issues in particular are challenging to research because of the military culture and stigma surrounding mental health. Regardless, I wanted to attempt to engage in an exploratory research study for my M.S.W. in order to contribute to research area from the perspective of the veterans themselves. Bringing in the voice of the Veterans is important because much of the literature does not allow room for this.

Introduction to Me

The military history in my family dates back to my maternal and paternal great grandfathers who both served in World War 1. I have also grown up in the military culture as my father served in the Canadian Armed Forces (C.A.F.) for most of my life. Furthermore, growing up I was in Navy League and Sea Cadets which further instilled the military culture into me. When I entered the social service field I worked predominantly in the mental health field. During this time the media was filled with stories of the C.A.F. being in Afghanistan and the impact of combat and returning home. I personally knew

many individuals still in the Army and a few that had just returned home from tours in Afghanistan's. A common theme that I seemed to be hearing when I spoke to these men was the reluctance to see social workers. This intrigued me and confused me as in my opinion social workers could be one of the most useful tools in a soldiers re-integration process or incidental recovery process. Since I was also in school during this time I started to focus many assignments and papers on the military. During my M.S.W. program I also took additional learning opportunities to assist me in understanding aspects of the issues further which included: Neuroscience and Social Work, Strategies to Resolving P.T.S.D., and a combat trauma lecture at Laurier University. My above journey has greatly impacted my passion and drive to complete my thesis on this topic.

Literature Review

Historically many labels have been used to describe the adverse reactions of soldiers to combat operational stress. Operational stress injury (O.S.I.) is a classification that describes irreversible and involuntary stress reactions as stress injuries, and a categorization for stress injuries has been suggested based on the nature of the causative stressor, dividing stress injuries into the broad categories of trauma, fatigue and grief (Figley & Nash, 2007).

An O.S.I. is also an umbrella term for any mental health diagnoses related to military service. Dealing with the issue of O.S.I.'s within the military extends beyond the realm of medical treatment. Although healthcare professionals play a crucial role in the delivery of healthcare to veterans there is also a need for improvement on the social and

educational aspects associated with O.S.I.'s (Figley & Nash, 2007). In more recent years, veterans can now access Operational Stress Injury Support Services (O.S.I.S.S.). These are services that veterans can use during or after his/her service in the military that will assist him with his mental health concerns.

In the beginning of my research I started by looking for literature that was available on the subject of veterans, the military population and post combat. Interestingly when I started looking for this literature in 2010 and it was sparse. Now, almost a year later, there are several more recent and relevant articles that I have been able to locate, illustrating to me that this is an area of recent development in the research field. A theme prevalent in military research highlights the demographics of the military; this is not surprising given that the military is now experiencing an influx of soldiers returning home from overseas with symptoms of mental health issues. These soldiers would be considered a combat veteran which is a term restricted to those veterans or current service men who have served in a combat zone.

Frequently a positivist approach is taken in the research literature that utilizes quantitative data, which has essentialized the experiences of the participants. This may be due to the high regard the Armed Forces put on evidence based practice and research (National Institute of Mental Health, 2002). Many research papers will combine this positivist view or use a critical social science approach as there are many suggestions and implications for practice and policy.

The literature review will provide an explanation of how the soldier's socialization through his employment, and the formation of cultural identity, impacts the process and perception of seeking treatment. Just because the soldier leaves the military does not mean the military leaves the soldier. The soldier identity is also present in the veteran population. In addition, much of the military combines veterans and military personnel into one category due to the similarities within the population.

1) Impact of Combat

There are long standing and ongoing issues that helping professionals must understand in order to effectively support the military and veteran population. Men and women who have been deployed to combat zones and military operations have always been affected by these experiences. There are many compelling reasons to believe that the human mind, very similar to the body, has a limited capacity to withstand external forces without suffering some type of damage. War zones hold a considerable amount of danger that is often recurrent and unpredictable.

There have been two views of causation for O.S.I. which are the psychological and biological. Humans, like most animals, react to danger in ways that promote survival, with the specific nature of the responses differing across individuals (Vasterling, Daly & Friedman, 2011). The two categories are the fight and flight responses, both involving biological changes that can help prepare a person in danger to take action (Vasterling, Daly & Friedman, 2011). When danger persists for days or months at a time, this can lead to a prolonged stress response which can take an emotional and physiological toll on the

soldier, at times result in an O.S.I. Now with all the advancements in science, the neuroscience research is also documenting that the brain physiology is being changed due to the traumatic experiences and portrays that there is truth to both theories. While psychological theories focus primarily on the way that mind is affected by traumatic experiences. Examining pre-traumatic psychological factors such as low self esteem and post traumatic reacts by self and others (Coon, Brown, Malik & McKenzie, 2005). Further, recent brain imagining studies place emphasis on the amygdale and hippocampus two brain structures (Coon, Brown, Malik & McKenzie, 2005).

One of the recurring themes in the literature on O.S.I. is the ability of traumatic events to shatter necessary and deeply held beliefs (Figley & Nash, 2007). Further, other themes in the literature demonstrate that veterans experience shame or guilt, dissociation, operational fatigue and grief as a result of the combat zone (Figley & Nash, 2007). The literature speaks to shame and guilt being toxic to self-esteem and the soldier's self-image. When the literature refers to dissociation they are representing a profound disruption in the capacity of the brain and mind to process and integrate information (Figley & Nash, 2007). This also represents the veterans' experience of distortions or loss in memory, freezing and flashbacks.

Operational fatigue is distinguished by persistent restlessness, irritability and anger, difficulty sleeping, tension and subjective anxiety, depression, decreased appetite, decreased ability to concentrate, easy fatigue and low energy, as well as tremors or other sympathetic hyperactivity (Figley & Nash, 2007). Lastly, grief is documented as a normal part of life; however, soldiers and veterans who participate in combat suffer extensive

loss. In addition, the soldiers have attachments that are infused with an intensity that parallels siblings or friends, and feel a sense of responsibility similar to what a parent feels for a child (Figley & Nash, 2007).

Other contemporary issues that the military and veteran population experience are homelessness, incarceration and suicide. It has been estimated that approximately 20% to 25% of all homeless individuals are veterans (Pryce & Shackelford, 2012). Sadly, 26% of veterans in federal prisons and 20% in provincial prison served in combat (Pryce & Shackelford, 2012). 53% of suicides in the general population are committed with firearms and 80% of all individuals who complete suicide were men (Ruzek, Schurr, Vasterling & Friedman, 2011). This statistic is important as the majority of service individuals are men and they generally have access to fire arms. Historically, this was not concerning because the military has usually had lower suicide rates than the general public. However, now the Army is reporting that its suicide rate has doubled since combat in Iraq and that the rate for death by suicide is high than the rate for death in combat (Pryce & Shackelford, 2012). Further, it is being suggested that the rate of suicide of soldiers and veterans has now surpassed the general public (Bossarte, et, al. 2012).

2) *Military Service and Culture*

i) *Military Service and Culture*

Culture has been defined as “all those things that people have learned in their history to do, believe, and enjoy (Bryan & Morrow, 2011). It is the totality of ideals, beliefs, skills, tools, customs and institutions into which each member of society is born”

(Bryan & Morrow, 2011). While there is a diversity of cultures, religions and ethnicities within the military, much of the literature views military as a culture distinct from civilian populations (Hall, 2011). It is also important to recognize that the way a person commonly understands the world they live in and the categories and concepts that they use are historically and culturally specific (Burr, 2003).

It has been recognized through literature, that military families have a distinct culture that differs from the rest of society. It has been stated that the culture of the Canadian military has more in common with other countries' military cultures than it does with its civilian counterparts (Bryan & Morrow, 2011). It must be acknowledged that there will be differences in a soldier's experience depending on the country they are from; however, the use of literature from other countries, especially the U.S, is valuable in order to gain a deeper understanding of Canada's Armed Forces' culture. It has been distinctly described as a closed society that has its own beliefs, symbols, social norms, code of discipline and justice principles (Knox & Price, 1995).

The military is a culture that values strength, resilience, courage and personal sacrifice while also holding an identity of elitism and superiority (Bryan & Morrow, 2011). It is expected that the men will have "mental toughness" and master stress without difficulty. This is illustrated from the description of basic training which was taken from the National Defence and Canadian Forces website: it explicitly states that basic training is to ensure that service men are mentally prepared for anything (National, Defence, 2011). Further, a cultural norm forms that emphasizes inner strength and self-reliance in order to "shake off" injury and illness (Bryan & Marrow, 2011). To understand the

military culture's worldview, mind-set, and historical perspective is essential in order to grasp the relationship between soldiers and their view of mental health.

When a soldier signs on to the military they are not just selecting a career, they are signing on to a different way of life. All soldiers go through basic training, which is a 13 week intensive course that is designed to teach them the skills he will need for his career and to "build strength of character" (National Defence, 2011). Basic training helps ensure that a soldier is physically and mentally prepared for any challenge (National Defence, 2011). Systematic basic training starts to shift a soldier's dependency from the family to the team (Hall, 2011). The formation of a soldier's identity starts to form and the men that work with the soldiers start to become a second family. Many soldiers will refer to the other soldiers in the troop as a "brotherhood" or "extended family" (Hall, 2011).

The military specifically trains its members to be able to work through stress, illness and injury on a continuous basis. The C.A.F. becomes a way of life through their training, the expectation of being available 24 hours a day seven days a week, high mobility, irregularity and temporary basis in their living situation (Knox & Price, 1995). Soldiers are also separated from their families regularly and isolated from civilian society, all of which continue the notion that the C.A.F. is a closed society (Knox & Price, 1995). Further there are several characteristics of the C.A.F. military culture: frequent separations and reunions, geographic relocations, residence in foreign countries, living by the "mission comes first" dictum, the need for members and their families to adopt to rigidity, regimentation and conformity, early retirement from a career in relation to civilians, rumors of loss or risk of death during missions, detachment from the

mainstream civilian world, work that usually involves travel, the social effects of rank on individuals, and the lack of control over pay, promotion and other benefits (Hall, 2011, Knox & Price, 1995, Burrell, Adams, Durand & Castro, 2006, Savitsky, Illingworth & DuLaney, 2009 & Kohen, 1984).

The military culture explicitly demands commitment of the service members regardless of personal cost (Drummet, Coleman & Cable, 2003). This is true as the activities associated with military life, ultimately surrounding the training of taking life and the exposure to extreme physical danger, serve to establish a unbridgeable gap between the military population and the civilian world (Fox & Pease, 2012). In addition, it is in great paradox that the C.A.F. soldiers stand as guardians to Canadian democratic values, but they do not live in a democracy themselves (Hall, 2011). The military world requires soldiers and their families to adapt to rigidity, regimentation and conformity (Hall, 2011). When most Canadian civilians would agree that they live in a democratic society, it can be a challenge to see that the very soldiers who stand for these democratic values live in an authoritarian, prescriptive and closed society.

As mentioned the literature speaks to the military culture being so distinct that service members share more traits in common with other service members from different countries than they do with their civilian counterparts (Bryan & Morrow, 2011). This may be due to the tactical methods employed to ensure that even in extreme conditions the units maintain social cohesion, loyalty and collective representation (Kirke, 2009).

3) *Military and Mental Health*

The military directly shapes the cultural attitudes and beliefs from a lens through which combat and operational stressors can either be filtered or magnified for individual soldiers (Nash, 2007). The veterans are trained to endure physical and physiological stressors from day one of the military training. This is due to the fact that combat stressor is used as a form of weapons in which the opponent targets the hearts and minds of individual opposing soldiers (Nash, 2007). Further, war itself is a stress in which the greater the intensity of combat, the greater the stress experienced by all soldiers. The idea of mental toughness is evident in the military in which there becomes an expectation of the ability to master stress without difficulties. This is embedded culturally and emphasizes inner strength and self-reliance in order to “shake off” injury and illness (Bryan & Morrow, 2001, Nash, 2007 & Hall, 2011).

As a result of vast improvements in medical skills and technology, current wars are producing far fewer deaths among soldiers. Many wounds that would have been fatal in previous wars are now being treated and the combat veterans are returning to duty or in most cases discharged from active duty leaving many still with invisible wounds (Pryce & Shackelford, 2012). They are referred to as O.S.I.'s and can range from post-traumatic stress disorder (P.T.S.D.), major depressive disorder and depressive symptoms and traumatic brain injury (Pryce & Shackelford, 2012). P.T.S.D. is the most commonly cited mental health concern with veterans and is an anxiety disorder that may develop among people exposed to traumatic events. The correlation between P.T.S.D. and military has been linked to the impact of traumatic events and experiences while during deployment in war zones (Ramchand et al, 2011).

Other mental health issues emerge in conjunction with, or independent of, P.T.S.D. Depression is the second most commonly studied mental health condition among soldiers and veterans (Ramchand et al, 2011). The military has now recognized the correlation between these mental health issues and deployment and requires combat veterans to complete a Post Deployment Health Assessment immediately after returning from overseas and a Post-Deployment Health Reassessment three to six months later (Ramchand et al., 2011). Both of these assessments are used to screen for mental health issues and assess if the individual is fit for duty.

Throughout history soldiers have sought to mitigate the intense emotions that combat evokes with substance. Stimulants are used to keep soldiers alert and opiates are taken to ease stress of pain (Pryce & Shackelford, 2012). This substance use can contribute to a longer term issue of an addiction. Also alcohol is frequently cited as being used to cope with the reintegration period when coming home. Alcohol use may continue for extended periods of time if the veteran is self-medicating, or masking their mental health symptoms (Nash & Figley, 2007).

4) Military Service Men and Service Prevision

Today there are a large number of soldiers diagnosed with an O.S.I. due to the conflict they experienced overseas. However, when considering the literature, a common theme is that the soldiers are reluctant to speak with a social worker unless it is absolutely necessary. Further, with the concerning statistic of service men and veteran suicide rates

having doubled since the recent combat overseas, there is a necessity for researchers to explore this areas as there is a gap in the available information.

In the early days of P.T.S.D. treatment was most commonly antianxiety and antipsychotic medication, which was primarily composed of tricyclic antidepressants and benzodiazepines (Garske, 2011). Now we have moved in many different directions when treating an O.S.I. Consequently, there are now methods being taken up in order to try and prevent the O.S.I. This is still done through pharmacology; however, there are also psychological approaches that include psychological debriefing, Cognitive Behavioural Therapy (C.B.T.), and Eye Movement Desensitisation and Reprocessing (E.M.D.R.) (Sharpeless & Barber, 2011). More recently, selective serotonin reuptake inhibitors have been used as the mainstay of treatment with exposure therapy, cognitive therapy and eye movement desensitization and reprocessing (E.M.D.R.) (Garske, 2011, Sharpless & Barber, 2011 & Richardson, Sareen & Stein, 2012). It has been stated that now the main goal when initiating treatment is stabilization in order to manage the acute symptoms and then improve the way the veteran is currently functioning (Richardson, 2009).

There have been relatively fewer studies of non-exposure based treatments. However, this does not mean they do not exist and there is no evidence that these treatments are less effective (Sharpless & Barber, 2011). Attachment based therapies have also been cited in the literature as types of treatment that are used post combat.

A unique study, *Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned from Defender's Edge Program*, took alternative strategies to

treatment when working with service men. This initiative took a non-traditional approach to a mental health program with veterans and strategized it to be a “performance enhancement program.” This was a program delivered to a group of soldiers that combined skills training and mental health treatment. Evaluative feedback from 192 program participants demonstrated high programmatic acceptability and feasibility suggesting positive success when circumventing the stigma with mental health program (Bryan & Morrow, 2011). This is one of the only non-traditional initiatives cited in the literature.

It has been stated that active-duty personnel and veterans with P.T.S.D. or any other O.S.I. seldom interact with a single practitioner; rather they work with multiple providers and interact with many different resources (Ruzek & Batten, 2011). This highlights that the actual treatment of veterans often takes sequentially through various elements of system care.

However, most research examines the effects of a lack of social support rather than on the positive effects social support could have on military members recovering from an O.S.I. (Figley & Nash, 2007). Further, there is even less research on the phenomenon that occurs when peer support is organized, formalized and proactively injected into an injured population such as the military and veteran population. Lastly, there is a gap in the literature regarding what veterans want when it comes to getting support for an O.S.I. This is what I hope to examine through my research.

Chapter 2

Methodology: Where my Story Meets the Veterans'

We all have narratives going on in our heads. Those that we say out loud, those that we hold private, and those that we are still creating. These narratives have a curiously strange power. They hold the power for a person to share their truth and another to interpret their own truth. I am hoping to study the veteran's narratives on O.S.I.S.S. This exploratory study uses a narrative approach to data collection and analysis. Narrative refers to a qualitative method that is a form of inquiry that assists in discussing and presenting data (Riessman, 2008). I have chosen this methodology as it allows the participants to tell their story. I believe that this is the best methodology to use for this as it allows the veterans to have self determination and tell me what they think is important and lead the interview process.

Prior to this study, I have had several conversations with veterans, each telling me similar themes with very different portrayals of their experiences with an O.S.I. and support services. I felt as if there was a gap in research and that the voices of the veterans were being lost in the literature. When I reflect on my theoretical framework which is an Interpretative Social Science and Anti-Opressive Framework, this methodology is very congruent as it provided veterans with the ability to choose what was important for them to share and allowed the veterans to discuss how their story was impacted by time and space. When deciding on a methodology, I wanted to engage in a process that supported participants in being able to tell their story. I wanted to ensure that each participant would

have a space to lead the interview in the direction that they thought was important. These veterans have made incredible sacrifices for their country and yet their voices were being silenced.

Theoretical Framework

i) Interpretative Social Science

My research represents an aspect of interpretative social science (I.S.S.) that examines the meaning participants create for situations that are embedded in the context of fluid social interactions (Neuman, 1997). The core of this theoretical methodology is that meaning is socially constructed and the value individuals place on the meaning is relative (Neuman, 2001). The whole premise to my research is to examine the meaning that the veterans have given to their experiences prior to and after an O.S.I. As well, human agency is evident as each of the veterans developed their own meanings and had the freedom through the interviews to make choices on what they would and would not share. Through listening and sharing parts of the veterans stories I hoped to create ‘verstehen’ which is defined as empathetic understanding, a deeper understanding with shared meaning (Neuman, 2011). Even though these veterans may have shared meaning, I still wanted to highlight the diversity within this meaning.

The interpretive nature of my study is examining the meaning that the veterans bring to O.S.I.S.S. Narrative and I.S.S. work well together as it allows the veterans to talk freely about a subject. It allows veterans to place the emphasis on the aspects of their

story that they find most meaningful. There is less direction or influence from the researcher on the topics during the interview.

Furthermore, by examining the literature, in combination with the veterans stories I hoped to shed some light on to the constructionist orientation of veterans. This is important as it provides an orientation towards social reality that assumes the beliefs and meanings that are present in social surroundings veterans create and fundamentally shape their reality for them (Neuman, 2011). By highlighting the existing literature on the subject this will allow the reader to understand some of the constructionist orientation of veterans.

ii) Anti-Oppressive Framework

An Anti-Oppressive Framework is characterized by promoting equity, inclusion, transformation, and social justice, as fundamental aspects of social work practice. This approach acts on a desire to eradicate the multiple forms of oppression and ensure equity for all social groups (Barnoff & Moffat, 2007). Anti-oppressive work is twofold; to provide practical frontline assistance to those who are injured by the oppressive social order, as well as engage in diverse efforts that are aimed at changing and transforming oppressive structures (Barnodd & Moffat, 2007).

In my research I used an anti-oppressive framework which identified an area of research where a social group was being silenced, and used a methodology that allowed their voices to be heard. Throughout the process I examined the perspectives of the individuals in relation to the structures that they utilized when seeking treatment

Methodology

i) Narrative Inquiry

Narrative inquiry provides a framework for interviewing participants, understanding the stories that the participants share with the researcher, and the process of disseminating the participants' narratives. Narrative methodology allows for a collaborative relationship between the participant and researcher to examine the meaning they made to their stories and how that fits within the meta-narrative which is the large narrative (Riessman, 2008). This method is appropriate for studying exploratory and small sample research studies. This is due to the requirement of attention to subtlety, nuance of language, who their attended audience is, organization of text, local context of production, and the circulating discourse that influences what can be narrated and how (Riessman, 2008).

Narrative inquiry is a qualitative methodology that provides a methodological framework for inquiry and data gathering that studies the participant's experience as a story (Hamilton, Smith & Worthington, 2008). This methodology has several prominent features: an interrelation or connected relationship among parts, a casual sequence of episodes to form a plot, it involves individuals or groups that engage in action and make choices, a selection process that emphasizes important versus less important parts, and a specific mix of time and place (Neuman, 2011). Narrative inquiry provides researchers with a way to think about and share experiences with the participants, while also

examining the meta-narrative, which is defined as an overall framework with master ideas and can organize the thinking of an entire population (Riessman, 2008).

The goal in narrative interviewing is to generate detailed accounts rather than brief answers or general statements (Riessman, 2008). Congruent with the Social Work Code of Ethics, self-determination and “starting where the client is” are two of the main premises within the interview structure (C.A.S.W., 2005). Giving up control of the fixed interview structure is meant to encourage equality. Generating narratives generally give participants longer turns at talk than are customary in ordinary conversations, as one story can lead to another (Riessman, 2008).

A) Recruitment

Due to the higher numbers of male combat soldiers and the exploratory nature of this research, only male participants were recruited for this study (Parks, 2008). For this study there were five male participants who lived within Southern Ontario and identified themselves as a veteran. The veterans had served in the Canadian Army for a period ranging from seven years to forty three years, and ranged in age from twenty four to eighty years old. One of the veterans was single, two were married, one was separated and one was widowed. These men had been post combat for a period of two years or more. These veterans had been using O.S.I. services for a period of just under a year and a half to seven years. The countries these combat veterans served out of included Afganistan (2), Germany (3), Cyprus, Syria, Israel, Lebanon, Egypt, Desert Storm Yugoslavia, Korea, Japan and of course Canada. The ranks of these veterans varied from

lowest to highest were: Corporal, Master Corporal, Sergeant, Captain and Chief Warrant Officer.

The recruitment process included emailing a recruitment poster (Appendix A), recruitment script (Appendix B) and information letter (Appendix C) to a service provided for veterans. This information was distributed to veterans that may be interested in participating in the study. Snowball sampling was also used as a recruitment strategy; however, each participant was required to contact me directly. If the participant had not received the information letter prior to contacting me, I e-mailed a copy to them. After this was sent to the individual a meeting time and place was determined by the participant and myself. Upon meeting with each participant, I went over the letter of information and consent form (Appendix C) which detailed the study and gave permission to withdraw at anytime. If the participant was still interested in taking part they were given a letter of consent (Appendix C) to sign as acknowledgement of their full understanding of the process and their willingness to participate.

B) Participant Suitability

Once the participant contacted me, three questions were asked to determine suitability for this study. They were asked if they were currently serving in the Canadian Armed Forces, if they were currently seeking treatment for an O.S.I. and what their current supports were. The preliminary questions are to ensure that the veteran is currently seeking treatment and has outside formal, or informal, supports. The individual will need to have been seeking treatment for a period of six months or longer. This is to

ensure that the veteran has started their journey to recovery and also, it is to ensure that the individual is a veteran and not currently in service. Ethically, this question needed to be asked as it was important that the veteran had support in place as well to ensure that the interviews did not become a therapeutic session. Further, this would ensure that the veteran had supports in place if the interviews triggered traumatic memories.

ii) **Data Collections Instruments**

A) Demographic Form:

The participants filled out a demographic form prior to the start of the interviews (Appendix D), which provided general information about the veteran and his service. This was filled out with me and was meant to help start to build the relationship between the participant and myself. In addition it provided basic information about the veteran that would help me to understand his story more fully in the analysis section. Each participant was given the option to complete this sheet verbally.

B) Narrative Interview

The narrative interview began by asking the veterans to share where they thought their story started in regards to their experiences with O.S.I., and to explain their story of how they got involved with an operational support service (Appendix E). I took notes so that I did not need to interrupt the participant when they were speaking and so that I could remember points that we could come back to. Sometimes I used short questions to make sure that I understood what the participant had told me. Also, after the veteran had finished telling their story, if I needed more information on something they had told me I

would probe for details on a specific event. If I needed more information when we were talking, I would ask questions such as, “*So, you are saying that ...?*”, or to get more information “*Please tell me more*“, further to learn what they thought or felt about something “*Why do you think that is...?*”. Each interview ranged from 30 minutes to two hours.

C) Time Line

A time line was created during the interview; this was used to help individuals remember the process of treatment. It was also used as a tool for the researcher to refocus the veteran on the support services and not recounting extremely traumatic events (C.T.R.I., 2012). This tool originally came from a two day workshop on Strategies for Resolving the Impact of P.T.S.D. through Crisis Trauma Resource Institute. However, originally meant for treatment the use was modified to assist with this research. Ethically I needed a tool that would assist me in keeping the focus of my research on O.S.I.S.S.

During the interview I was able to make a timeline to assist with understanding the veteran’s stories. I did not interrupt the veteran as they spoke, and after they had finished their story I was able to bring them back to the beginning of their story and ask for clarification on each part in chronological order. Further, I was able to see where each part of their story transitioned. I put a strike across the line each time the veteran talked about another worker, service provided, or something that was relevant in the veterans’ story revolving around their treatment. The time line was not used in the analysis of the date and was meant more to assist the narrative interview process.

D) Field Notes and Reflective Journal

Narrative inquiry requires the listener to pay attention in an emotionally attentive and engaging way. The listener's identities and preconceptions come into play, particularly when interviewing across geographical, religious, class/race, and age difference (Riesman, 2008). This is why during this inquiry I kept personal reflections on the process. This was used during the analysis process to reflect on some of the questions that came up for me. I was able to also write down my personal biases and beliefs. During the analysis I was able to reflect back on my journals and consider what was missing, and it allowed me to have some consistency, as well as helped me to keep on track. Also after each interview I reflected on some of the most evident outward themes. I was able to listen to recordings and reflect if I was leading these themes by my questions or if each theme came up prior to me asking the question.

Further, this was used as a tool for "triangulation of data" which is the idea that reflects looking at a participant from multiple points of view; this is supposed to improve accuracy (Neuman, 2011). In the analysis I used this to provide depth and complexity into how I looked at a subject. Here I was able to listen to how the stories were told, use the demographic sheets, transcripts, my field notes and reflective journals. This was done through reflection on each of the material and combining themes present in all data sources.

Narrative Analysis

Narrative Analysis refers to an analytical family of methods for interpreting the transcription of a participant's narrative. Attention to sequences of action, language, communicated meaning, and what is significant for the participants are features that distinguish narrative analysis from other methodologies (Riessman, 2008). This attention is needed during the analysis section of the transcript. Narrative analysis is case centered generates "categories" that prompts the reader to think beyond the surface of the text and move towards a broader commentary (Riessman, 2008). These categories in my research are highlighted with subtitles in the literature review and the findings in the result section.

I used two of types of narrative analysis for my thesis: thematic narrative and structural, but it must be kept in mind that the categories are not mutually inclusive. Thematic narrative analysis is a strategy that interrogates what the story is focusing on rather than how the story is being told (Riessman, 2008). This analysis identifies the themes and overarching stories within and between narratives, where-as structural narrative analysis focuses on how a story is told. This examines how the speaker attempts to persuade the interviewer that a sequence of events really happened (Riessman, 2008). This examines the language the individual uses, as well as where the emphasis when the veterans tell their stories. I have selected to combine thematic and structural analysis so I can describe broad patterns in thematic similarities across the sample, but also the variation in meaning for individuals.

My process of analysis included documenting key themes that emerged from the transcript of the narrative. This is referred to thematic analysis in the literature, which is exclusively focusing on the content. Narrative analysis and grounded theory are often confused, grounded theory examines a large amount of qualitative data for themes, until all themes are exhausted and no new themes become present in future data (Neuman, 2011). Notably, a key feature of the narrative analysis that differs is that the researcher keeps the story “intact” by theorizing from the case, rather than from components and themes across cases (Riesman, 2008). This is where narrative thematic coding is important, although determining boundaries to the stories the analysis must strive to preserve sequence and the wealth of detail contained in the stories (Riesman, 2008). I did this by coding where each story stopped and the next one started. The objective was to generate inductively a set of stable concepts that could be used to theorize across each case, while also remaining case focused (Riesman, 2008). After this I looked at each of the stories and coded the themes that were present. After I had coded all the stories, I took each theme and placed them on a separate piece of paper, here I accumulated the themes together through similarities in meaning. Once these themes were placed together within similarities I looked for an overarching theme. Here I examined my field notes and journals to see if any of my reflections were related to these themes.

Next, I took the larger themes and re-examined the stories that were being told with a structural analysis lens. This was done by looking at when each story began and ended, which started to examine how the story was told. This explored the sequence of the story and how the meaning for the veteran changed throughout their story. The

question then shifted from what was being said, to a focus on a narrator's experience to the narrative itself. Like thematic analysis, the structural approach is concerned with content, but the attention is now focused on what can be learned from referential meanings alone (Riesman, 2008). Here I looked for similarities in experience but also different meanings that the veterans were making to these themes. During my write up of the results I was cognisant of the different meanings each veteran attributed to the themes and attempted to share the different meanings that each veteran made.

Ethical consideration

This thesis was approved from the Research and Ethics board at McMaster University after a formal submission of an ethics application. Confidentiality was assured to each veteran through removing all identifying information from the research. Further the transcripts were sent to each veteran who had the option to remove data from the transcript. All information kept in a secure location either in a secure cabinet or password encrypted electronic file and will be destroyed after five years. Only I was aware of the information each veteran shared and kept this information confidential.

Informed Consent

Each participant was provided a copy of the consent letter to review prior to the interview. I also offered to go over the consent form with the individual prior to meeting for the interview, as well as went over the consent form prior to starting the interview. Each veteran was informed verbally and in writing of all aspects of this study.

Reflexivity

An ethical tension that would arise from the approach taken is the “emic” and “etic” positions used in social science research, which is adopted to understand the different perspectives in understanding groups or communities (LaSala, 2003). Emic is the view point of those living in the cultural group, while etic is the outsider’s standpoint in research (LaSala, 2003). This is often related to the insider/outsider view on a research subject. For me this strain is at the forefront of all tensions because of my experience being from a military family.

This position was evident to me during my interviews on my ability to relate to some of the stories the veterans told and how it impacted their families. Further, I was also aware of many of the cultural aspects of the military. I had to be careful that I did not over relate to the veterans and asked for clarifications on terms. I had to make sure that I was not making meaning to what the veteran told me through my social location and living experience.

A way that I worked through this was with my anti-oppressive focus and the understanding that each person’s experience is different. There may be similarities, but because of their lived experience there will also be differences. I believe it is important to pay attention to the differences, as well as the similarities. Also through conversations with my supervisor I was able to evaluate my insider position as she challenged me to deconstruct common terms, as well as to provide a deeper look at the topics the veterans were really talking about. I also discussed my research frequently with others who would

ask for clarification on information I shared. This would require me to examine some of the ways I was looking at a topic.

i) Insider/Outsider

My process of reflexivity resulted in my questioning whether or not I should disclose my relationship to the military or not. As mentioned above, through my theoretical framework self-disclosure is important and not only supported but encouraged in this research. However, I have a hard time with the use of self-disclosure in my professional practice and I question what is appropriate to disclose about my experience and what is not. This continued to be an issue throughout my study due to my comfort level with respect to this aspect of my research. This may have come from the cultural aspect of the “code of silence”, which is often extended to the military family. This code implies that there are certain aspects of military life that should not be talked about outside of the family, especially to social workers, researchers and “outsiders”. This code is in direct conflict with the approach that I will be taking in my research. In the end I decided that it was important that I disclosed this information.

Further, another tension pertaining to confidentiality and the insider position is that of my family. Since my father was employed by the Canadian Armed Forces for twenty-five years, and continues to work on base as a civilian, he is a much respected man within the military, and is also well known. Taun is a unique last name and there are approximately six families in Canada who use the name, none of which are military families. Due to the fact that the military community is very small and with high mobility

of families it is also interconnected, I must be aware that what I disclose and make public knowledge may also impact my family. It must also be acknowledged that individuals that I may come into contact with will possibly know my family.

Prior to starting my research and disclosing information about family I had a conversation with my father to discuss what information he would be okay with me sharing. I also had conversations with my father throughout the interview process about what information I shared. I also used my father and mother for frequent consultation pertaining to the information I was discovering within my research. My father provided me guidance and a deeper understanding to some of the military concepts that I may not have fully understood.

i) Power

Power is evident within each sphere of society. As an MSW student at McMaster University who is doing research, I automatically engaged in a power dynamic when I am completing interviews with participants. Even the language I use in my consent forms, and throughout interviews, could have the potential to carry power. I tried to make sure that I used layman's terms to negate this power dynamic. Further, I also was open to talking about the consent letter prior to meeting as it may be difficult for these individuals to read such a long document. Also the veterans were able to pick a meeting location of their choice to ensure that they were as comfortable as possible.

I am very aware of my power as a researcher. I am using my position as a researcher to give meaning to the stories shared by the veterans. I have the power to select

what material I will use for my research and what I will not. I will also be providing the analysis on the research. Further I tried to reflect on my power as the researcher and the questions I asked. I wanted to ensure that I was asking clarification questions about their story and not leading questions based on my own personal agenda. This required me to personally reflect after each interview and while transcribing each interview. I tried to transcribe each interview prior to completing the next to ensure I was able to have this reflection done. There was one time that I was not able to do this due to having two interviews out of town in one day.

These individuals also trusted me with sharing their stories and I needed to be accountable to these individuals by providing the veterans with the information I would be using for my research. I also sent the quotes that I would be using to the veterans and was open to talking about why I was using the quotes I selected. Lastly I thought it was important for me to not only defend my work to McMaster University, but also to the veterans. So I invited each veteran to my defense for my thesis.

Chapter Three

Results

These findings represent the major themes that emerged through the narrative interviews that I completed with five veterans. While each veteran's story was unique and provided a different outlook on their experiences with an Operational Stress Injury (O.S.I.) all stories had commonalities that contributed to a meta-narrative. The findings have been organized into four overarching stories that were related to the veteran's

identity, the emotional impact of combat, barriers to treatment, and facilitators to accessing services. Each of these men shared their personal stories of struggle, strength and resiliency as they navigated the mental health system as a soldier and/or veteran. It is my hope to share their stories to help provide insight and an understanding of what this journey was like for them.

These stories may represent past struggles and it is not necessarily representing where the veteran is currently in their recovery. It is also important to note that each veteran's story is impacted by the time period post combat, the services they accessed, where they are situated in their recovery journey and their knowledge of the mental health system.

1) Narrative Identity

Narrative identity is claimed to be created through individuals integrating their life experiences into an internal and developing story of self (Ricoeur, 1991); this provides the veteran a sense of unity and purpose in life. This was evident through the soldier's comments regarding their identity of self, masculinity, cultural identity and sharing their need for a sense of purpose.

i) Identity

The soldiers talked about how their training was integrated into their identity to the extent that it became a notion of "self". As one veteran pointed out:

"The military is not what you do; the military is who you are."

My findings are consistent with the literature stating that once a man identifies as a soldier, the soldier identity remains with them even when they leave the military. All the soldiers that were interviewed had some experience in the Army and in combat that had now been internalized to form the soldier's narrative of self. Here, through the story of a veteran talking about his strategy of trying to get a woman to leave his home by using an aspect of his identity, an ambiguity of self is presented:

“And I said yah, I am a trained killer, I was trained to kill. And she walked out that door just as quickly as a winking eye. And never came back, but you know, I guess we will never know, these guys are definitely trained to kill. How do you fix that?”

Here the veteran identifies that he was trained to kill and demonstrates ownership over the title. However, when talking about how to undo or “fix” the training he refers to “these guys.” This suggests that the veteran is ambivalent with this being integrated into an aspect of his identity while at the same time, highlights the influence of training on the veteran's sense of self. Further, this integration is also present in actions the veteran takes even after they have left the Army:

“Never go to bed until you are ready to get up, I live by that... I mean shit I still sleep with my fucken shoes on, just so that I am ready to roll”

This demonstrates how the military culture is so engrained into his identity that even now he still takes actions he would have in done during combat.

Military identity is also reflected by the veteran's choice to maintain a close connection to the military post combat, or retirement. Examples of the way these veterans maintained their connection included their continuing to work with the military population, writing a book on combat, taking part in parades, ceremonies, and Remembrance Day, fundraisers, advocacy issues for veterans, military related committees, and the continuation of military/veteran peer relationships. One participant exemplified this connection by stating:

“It's things like when we go for coffee every Wednesday morning and that is really something, because you go there, and you kind of forget, you are there shaking hands with a guy you have known for 20-30 years and you are still thinking military.”

Here a veteran demonstrates that he has stayed connected with his military peers for decades and that being with these connections assisted him in forgetting the impact of combat that he is living with. This also portrays that in this peer group they still hold a military identity.

ii) Sense of purpose

The veterans talked about their O.S.I. impacting their sense of purpose in life. After deployment their sense of purpose became questioned, which in turn they identified as affecting the emotional impact of combat and severity to which they experienced it. For example, the sense of loneliness was exacerbated due to the fact that they were no longer working. Now the veterans state that they have found other things that give them

purpose. They identified finding purpose in helping other veterans, assisting family members, through writing, fishing and through employment.

Having a sense of purpose was explicitly and implicitly talked about in all interviews. One veteran talked about his struggle pertaining to his new purpose exacerbating his O.S.I.:

“After I got out (of the Army), I had that feeling of being useless. Not having anything to do, no reason to get out of bed in the morning. Umm, then I started writing and that’s really given me purpose, and now I am on my second book. It takes a lot of time and it is very difficult sometimes, but it gives me a purpose. A reason to get out of bed in the morning. But it also causes me nightmares and problems. Yah I can stop all of this if I stop writing but if I stop writing then I have no purpose, so it’s a catch 22.”

Here a veteran talked about re-living the trauma and the perpetuating the impact it had on him. Although no other veteran talked about their purpose exacerbating their O.S.I. each talked about the importance of having a sense purpose. Others talked about how originally their purpose minimized the symptoms of their O.S.I. Each veteran connected having a purpose with their experience of an O.S.I. which was an emotional impact of combat.

2) Emotional Impact of War

Each veteran talked about the impact the war had on them. These veterans shared stories of their experiences prior to, during, and post combat. During combat there were a few significant instances that the veterans talked about having a lasting impact on them. For example one veteran talked about still seeing an incident in combat clearly:

“And I still see that his leg being tied up, when I lock the door up now I talk to [deceased combat peer] every night.”

Post combat each of the veterans shared that combat had impacted their cognitions and behaviours in different ways including experiences of P.T.S.D. and depression, which can include flashbacks, procrastination, isolation, loneliness, stress, dread, terror, nervous breakdowns, and insomnia or lack of ability to sleep. One veteran explained his flashbacks in this way:

“...as if there was an old fashion lantern with different pictures, and they keep coming around as if they are coming around in my mind. And I see these every once and a while, I see my childhood, I see the war time, I see things that happened in between, it’s always moving around.”

While also explaining his sense of loneliness by:

“It’s one of the things you feel with P.T.S.D., that you’re alone, and even with family; you somehow loose the feeling of love”

Even though they experienced a wide range of emotions linked to loneliness, depression and other feelings, the veterans felt that it was integral that emotional feelings were logical, or no emotion at all was shown. As one participant stated:

“Army is twisted, it’s very twisted... it’s like emotions aren’t even involved”

Here a veteran reflected on how a situation was handled in the military. He felt that the cultural identity and employment system does not allow for emotions. The need to hide emotions was also exemplified when a veteran discussed not wanting to talk with his peers in a support group because of the fear that he was going to cry:

“I never said shit, because if I did I was going to cry.”

Lastly, they provided insight about the difficulty of managing their emotions, which was prevalent in many of the interviews. One veteran talked about trying to avoid confrontations by only going out during times when there would be minimal people around. A couple soldiers talked about “road rage” and becoming very quickly angered when driving. Another veteran also identified his feelings of being very bitter. As this one participant stated:

“I lose my shit fast”

This is congruent with the literature as it often identifies the male’s symptom portrayal of depression, or other mental health issues, being shown through anger and/or irritability.

Another commonly experienced impact of war is sleeping difficulties. Many veterans experience sleeping difficulties and nightmares post combat and consequently,

deny themselves sleeping medication because of their fear of not being able to wake up from these nightmares:

“My problem with sleeping medication is that I want to wake up and I don’t want to sleep. I want to wake up and normally I do wake up, it’s not pretty what I do, but I do wake up.... And I am just afraid that if I take some of these medications that they want me to take, I will sleep through it and I won’t be able to wake up.”

This veteran spoke to his fear of re-experiencing his trauma through nightmares being significantly more distressing than the lack of sleep with no medication.

Each of these quotes demonstrates the impact that combat had on the veteran’s emotional aspect of their self.

3) Barriers to Seeking Treatment

As highlighted above, after they leave the army, veterans experience many different impacts of combat. There are 27 Canadian Forces bases across the country in which many of the military specific services are located, however, there are combat veterans in reserved units who do not live near or have access to these services. This hinders the veteran’s ability to access services, or requires the veterans to travel a far distance in order to access these services. Two out of the five veterans had to travel over an hour in order to seek treatment. One other veteran identified that he also had to travel for treatment prior to moving to a city that had a specific clinic that served veterans.

While location is a consistent barrier to accessing treatment, there are many more barriers than the physical barrier mentioned above. When seeking mental health treatment stigma is frequently felt by the participants. This was also true and evident in the veteran's stories of accessing support, the pressure of seeking support stemming from an external sources and stigmas impact on their employment.

A) **Stigma**

The stigma of having an O.S.I. emerged as a significant theme within the veteran's stories. As mentioned above it was difficult for this veteran to acknowledge that he had a mental health issue and this was evident in each participant's stories about the first time they accessed support. As one veteran stated:

“It was scary because nobody wants to accept or admit that they have a mental illness and even today, I refuse to look at it as a mental illness, umm but we all know it is. So that was extremely difficult.”

Here the veteran talked about the stigma of having been diagnosed with a mental health issue and not wanting to admit that it is an “illness.” The way mental illness is generally constructed is that there is something wrong with the veteran, where through their training their identity is of strength and resilience.

The impact of having a mental health diagnosis affects the veteran in all areas of their life from their career, social, as well as impact on how they see themselves. The mental health label changes how their coworkers and superiors see how they can do their

job. One veteran provided an example of not being able to carry a weapon, however, as an infantry troop this was a core component of his position. In addition, it changes how peers and family members see them and as changes how the veterans see themselves.

“They are trying to label us with something all the time, and stop us from doing our job pretty much, but it’s necessary, we just don’t have a good opinion about them (social workers).”

Another Veteran demonstrated how stigma emerged in the kinds of questions, or questionnaires, that mental health professionals asked of them. This is seen as a tool to determine if the individual is going to be labelled with something.

“...they were asking us all these questions, like how many alcohol beverages do you have in a week, this and that, everyone lies, you know... You lie because you don’t want to end up being classified as being broken.”

This idea that one’s response can equate a label of ‘broken’ was similarly felt by another veteran:

“the questionnaire kind of scare you a little bit, because it asks you what you went through, and a person in my position overseas had experienced everything on that list, so it kind of freaks you out in the sense like oh crap they are going to flag you for sure for a mental disorder of everything.”

In both of the above experiences the fear of the unknown and the stigma of being diagnosed with an O.S.I. are present.

As suggested, stigma can have a negative correlation with the soldier's ability to do their job as well as a veteran's ability to be rehired. An older veteran reflects on his view of stigma and employment:

“But like anything else, you are in the military, there is no such thing as a privacy issue, you go get help it will probably end your career, it will certainly stop you from doing anything significant anymore.”

However, another Veteran disagreed with the last quote:

“I don't think it's a hidden secret, people avoid talking about it, because of the career implications, that is now gone ...it's ok to come out and talk about it....during that time period there is some restrictions, let's face it, you're probably not going to get promoted.”

Here the veteran talks about the reduced stigma in the present conditions of the military versus historically, but also identifies current restrictions due to the stigma. These men still fear those restrictions to their employment as it was such an integral aspect of their identity and sense of purpose. The social stigma compounded this fear. Many of these men were in leadership positions which they described as an additional struggle:

“Prior to me getting the help, I knew I had issues, but I wouldn't accept it, like most people, especial as a senior in the military, you are the one that looks after everyone else so you can't be down. So I kept it hidden.”

The leadership position further complicates the process of seeking assistance. In addition, the issue with seeking support in the military is that is so entwined with the soldier's employment that it becomes a barrier.

All but one veteran waited until they were no longer serving before they sought assistance for their symptoms and the impact on their lives. Stigma affects how they access service, how they see the interactions between the helper and veteran, as well as the impact on their careers.

B) Structural Barriers

i. process

The veterans highlighted a range of structural barriers to accessing support. One way in which this was evidenced was through the lack of process that maintained the veteran's confidentiality:

“In the military there is no such thing as a privacy law, there is no medical privacy, if you have an injury, whether it be physical or mental, there is no doctor patient privilege...military people understand there is no privacy in the military. Issues are brought out and are told to your commanding officer.”

When individuals seek help in the military their commanding officers are notified. Many services are only available during business hours and this means the soldier will have to miss work to make their appointment and will be required to tell their commanding officer why they need to miss work. Their peers and coworkers are

cognisant of when individuals are not present. Further, for those who live on base they are also living with the men they work with, which makes it increasingly difficult to have privacy.

One of the most evident barriers that the veterans spoke about was the amount of paper work and requirements of written documentation in order to obtain services. It was identified that this was more difficult for the older veterans who may have more information to share pertaining to their service and less of a “formal” education to assist them with this task.

“.. the way [service provider] gets around things is burying you in paper work and hoping you quit..”

Further veterans felt that when it came to financial assistance individuals were more focused on proof and it was difficult and timely to navigate the system as civilian workers were not aware of how complex the situations were with veterans. These veterans used words such as not “fitting” the “normal” mold of what these service providers saw on a daily basis. With Old Age Pension, individuals had to provide proof of their citizenship and how many years they were in Canada in order to be eligible. However, in the military individuals are posted overseas frequently. Veterans are asked to provide proof of when they left and came home, however, this can be a difficult task for those who are transient due to military needs.

“It’s the point that all these people told me one thing and they don’t even know their own rules... It took me 6 months to get it sorted out.”

This was a quote from one veteran; however, other veterans mentioned that they had experienced similar things. After speaking to numerous individuals who instructed the veteran that proof was necessary, he spoke to a supervisor and found out that this was not true. When a soldier is in service, no matter where he is in the world, he is considered to be on Canadian soil, as he is serving his country and still paying taxes. There seems to be a pattern of inconsistent information that was provided to these veterans creating additional barriers for the soldiers.

Another veteran went on to talk about the feeling that the government was out to prove why individuals were not able to get support. The veterans also felt that the government agents did not understand the complexity of a soldier's situation and that when there were complexities in their stories that it must mean that someone is not telling the truth. Here a veteran explains:

“And their focus is on people who cheat, old age pension, Canadian pension, and I think there is the assumption out there, if the story isn't straight forward and you haven't gotten written documentation, we better look into it. He is probably trying to cheat us and probably trying to cheat the government.”

Here a veteran describes his frustration with the process and systematic barriers:

“..having being diagnosed with P.T.S.D. and dealing with some of these bureaucratic, can be really hard. I can understand why people, you sometimes hear of people going crazy inside these government offices. They are probably well

meaning people but they are just so locked into their own rules they don't even understand their own rules and regulation.”

Here a veteran empathizes with stories on the news of when individuals have taken extreme measures due to frustration with governmental bureaucratise. There seems to be a collective frustration with the amount of “red tape” as one veteran calls it, when seeking support.

ii) *The Need for Culturally Relevant Service Provisions*

The veterans talked about working with civilians versus military service providers, the importance of understanding the military culture and employment, the rapport between themselves and the worker, techniques used, and how assisting their families also assists them. Each of these veterans worked with military personnel's, ex-military and civilians during their recovery process. There were varying opinions on their preference to work with a civilian or military profession; their opinions differed from indifferent, strongly against, and strongly for working with civilians. Here are two quotes that show the difference of opinions:

“She was a civilian social worker, I think that's the problem, what I had with the social worker, was they weren't in the military and they didn't understand.”

Here a veteran talks about being completely against seeing a military professional:

“I finally went to see a doctor, he was civilian. I wouldn't see a military doctor.”

There were two main reasons why individuals differed on their preference for a civilian or military profession; this was due to the barrier of the lack of privacy in the military and the idea that civilians would not understand the basics of the military training and culture.

Veterans also talked about the professional not understanding his military experiences being one of his concerns, however, when he met with the professionals they had all specialized in military treatment. He attended treatment at a centre that's primary focus was the military.

“One of my big concerns was that I was going to talk to someone who has no idea what I am talking about, and that wasn't the case, they really do know what I am talking about. And they know what everyone's talking about because they focus on military and ahh members and their families. So that was a big relief, having someone to talk to that really did understand, made a really big difference.”

However, another Veteran explained that this was not the case for him:

“She was a Korean lady (psychology student) and unfortunately she knew nothing about the military life or the Korean War... So I bought her a book on Korea and let her read it, to educate her on Korea.”

This veteran talked about one of his struggles working with this student that had no education on her background or the military. This veteran felt so compelled to assist her in understanding that he purchased her a book on the Korean War. Further this veteran described his frustration with this worker and how he felt he needed to help her

understand the basics, which took over the primary purpose of why they met. It was also recognized by another veteran that experience working with military personnel was key in success with working with these men:

“Having the knowledge and understanding what it’s like for the veteran makes a huge, huge difference. And I am guessing it’s not something that they went to school to learn. It’s something they learn by working with veterans.”

This highlights the importance of practitioners understanding the military culture. The importance of understanding military culture was also evident in the veteran’s frustration when a worker did not start their appointment on time and provided an analogy related to his training on why this is important to him.

“I show up here on time, you can show up fucken on time. I have walked into his office, it’s like 15 minutes after and I just open his door and he has a patient another troop sitting there, and I am like you have timings to meet and like get a watch.... you have to make it to the chopper, if your 15 minutes late, he is gone.”

Here another veteran talks about how seeing a social worker or other professional could be considered a threat and is highly stressful. He relates it back to his training from the military, to assess the threat, the threat being the stigma or employment. By providing information to the veteran on the background of the individual and agency it allows the veteran to make their own assessment prior to meeting with the worker. This enables the veteran to start to do their assessment of the threat, so that they can feel more prepared going into the situation, which can lower anxiety. Veterans are trained to prepare

themselves for each situation and these techniques allows for self-determination, as well as are culturally appropriate and to the military culture. This veteran describes it best:

“Yea, they don’t give you the background of the person or anything like that, it might make military people feel better for the fact that they know what they are going into, like they are not cause in our training and everything, we always get an assessment of the area, we go in and check it out, so I think it might be better to give an assessment of what you are going into because it makes the person feel more comfortable. I think that’s the key of everything, make the person feel comfortable, that there is not threats, and they don’t feel threatened of anything. High threat, high stress.”

In addition, the ability to have a choice in what worker the soldier had also seemed to be important:

“The ones that they forced me to [go see] were a lot worse than the ones where they said you can do this if you want and they give you multiple options.”

Understanding the veteran of soldier training is very important because many aspects are engrained into how they function. These relatively simple concepts pertaining to choice, providing the veteran with background on the worker, the importance of being on time and tailoring the questionnaire so they are relevant to the specific soldier help to start to build relationships and help in the veteran’s culturally relevant recovery

4) Facilitators to Accessing Service

Accessing support was the last narrative that was present within all five veteran’s stories. Each veteran accessed support to varying degrees to assist with their personal recovery. The formal services that the veterans identified as assisting them with their O.S.I. were as followed: Veterans Affairs, Old Age Security, Canadian Pension, Family

Resource Centre, Operational Stress Injury Support Clinic, Hospitals, Individual Counselling (military and civilian), Doctors, Nurses, and the Family Resource Centre for the Military. Supplementary the veterans identified that they also all used informal supports such as friends and family.

i) Specific Service Provision Strategies

Once veterans were able to work through the many barriers of seeking treatment they reflected on what was helpful when working with any professional. Each of the veteran suggested “getting to the root of the problem” or “pulling things out” and the most beneficial strategy in working with them.

“She (social worker) was trying to get to the bottom of what was going on instead of just doing the regular check in the box kind of thing. She was actually trying to get to the root of the problem.”

Further, the other veterans echoed this sentiment and talked about the professional “pulling things” out of them and putting it in a logical sequence for the veteran to understand:

“I always like talking to her because she, she sense everything that you are saying and then she gives you a lead to what you are really thinking. She kind of pulls everything out of you. She puts it in a sequence and you can answer to it. She makes it simple for you.”

Another veteran talked about a similar method of how the professional proceeded forward even though the veteran did not want to talk about the subject. The veteran reflected back on this and stated it was helpful and made him feel better:

“You want help but most people don’t want to talk about it... But they make you talk about it; make it come out of you. And it’s the only way I am going to feel better about things.”

The veterans talk about the workers exploring what was actually going on. The professionals used their clinical skills in order to help the veteran and worker to understand what was going on. They worked in partnership with the veteran instead of using questionnaires and systematic strategies to help explore what the veteran was experiencing.

A veteran also talked about the fact that service provider initiating contact being a positive experience for them. Further they discussed the importance of face to face contact.

“This I found very, just great. It was a chance to sit down face to face instead of always talking to them on the phone.”

Part of the support they received was education so that they were able to make their choices. These veterans talked about it being helpful for the worker to educate them on what was going on:

“Talking to him is good too, because you can relate something that is happening at home, and you’re curious, he will switch it on and give you some background so you can relate to what’s going on. And he picks out that conversations without you even knowing.”

Veterans talked about not wanting to be told what to do and instead having veterans support them in their journey.

“It’s when people start to preach, to tell you how they think you should do things, that’s when veterans get upset. They are not there, I think they are there for the support, they are not looking for guidance they are looking for support.”

Although there are diversities within the veteran population, veterans have a very good understanding on what works for them. The use of cultural understanding, self-determination, providing resources and education, as well as tailoring the service to the specific veteran is helpful strategies when working with this population.

ii) *Supporting Family Supports Veteran*

Many of the Veterans talked about their families in the interviews. They spoke about the importance of support for their families while they were away and that by supporting their family it was also support them. These veterans talked with a great amount of respect for their families and highlighted how important these supports were for them:

“Now that takes a special kind of person. And she survived it. I am very proud of her (his wife) naturally but it’s not just her, that’s the kind of mentality,”

Most of the family members were not supported formally and relied on informal peer support to assist them. The formal supports that were mentioned were the Family Resource Centre and Family Peer Support Coordinators. Much like for the veterans there was even more of a lack of culturally relevant support for the families and often these families had to travel to get formal support. Although there is report of some material being provided to family members, it does not always do its function:

“Well if they, it’s a system in which if they don’t go to it they don’t know what’s going on, so if they don’t go to the workshops or anything they just get a booklet, and they read the booklet and they get the wrong vision of what’s going to be going on. They don’t go to talk to the groups of parents of those who are back; they get a skewed view of what’s going on”

Here a veteran explains that there were supports available to his family, however, they were not able to go due to the fact of them not being accessible and close by. The booklet provided to his family actually increased the stress as it portrayed a skewed vision of what was happening. This lack of communication caused the family to stress and put additional weight on the veteran. This veteran suggested

“If they went to the house and see how the family works while you’re gone, or how they are feeling while you’re gone, cause when your over there you can’t

really talk to your family, so maybe if they had that, the support to make sure that they are ok and they know what they are doing.”

However, this does not seem to be a pattern for the other veterans where their families were not aware of any formal supports that were offered for them. The majority of men talked about their family seeking informal supports such as friends.

This veteran sums this section up best when he says:

“P.T.S.D. does not just affect the member it affects everybody, and it does not necessarily mean the immediate family, the wife, the kids, it can affect other family members as well.

By providing formal accessible assistance to the family it will have a snowball effect and also continue to support the veteran or soldier. Also if the veteran is supported fully post combat this may have some preventive measures for the individual.

iii) Peer Support

The veterans I talked to spoke about informal and formal peer support both being helpful and useful in different ways. As one veteran mentioned that before they felt that they were able to talk to anyone that is a soldier due to the basic training and understanding between each of the soldiers or veterans. Here a veteran talks about his comfort and ability to talk with anyone in the military.

“I would talk to them about everything I would talk to them (social workers) about but I would talk about more stuff, my experiences and everything like that. Just

because when you talk to your peers, that have been over there, because a lot of my friends have been over there, you talk about what you did and they will talk about what they did and you kind of relate to each other and you get just talking and it helps more than not talking about it or talking to other issues. I find that if I am talking to someone in the military that has been overseas I talk about the issues that affect me most, other than talking to a social worker.”

The fact that he feels that his peers understood the military life, even if it was not exactly the same mission that they also understood what he was going through, would also be able to help shed light on the situation as well.

This tends to suggest that there is reliability through personal experience. Here the veteran talks about the mutual understanding and rapport through sharing of experiences. He highlights that he would go deeper into issues with his peers even though he was seeing a social worker.

“I felt that I was a lot better, but there were still things I wanted to talk about but I did not want to talk to her (social worker). I talk about them with my peers instead.”

Psycho-educational groups were most commonly mentioned to be co-facilitated by a peer and a social worker or another professional. Here a veteran explains a psycho-educational group post combat that was co-facilitated by a civilian social worker and a veteran:

“People opened up a lot more because it was just military people there. It was military person paired with a social worker, so military person would talk and the social worker there would just be listening, so it’s kind of like, we ended up forgetting that the social worker was there because we are all in civilian clothing,”

Here the veteran talks about forgetting the civilian social worker was present referencing that the group became comfortable for the veteran and that common experiences were being shared.

“Generally it is good, it is a chance to speak, say you know, look at people, and you are saying something to them and you can look over and they are going (nodding) and you know that they have had the same general experience and you know you aren’t talking to someone who experiences are foreign to you.”

Here a veteran talks about what he believes the differences are between a peer support service and another type of treatment service. He distinguished that each plays a different role in his recovery

“One organization you talk about how you are doing and the other you talk about what’s bothering you.”

Here the veteran talks about how one organization he works with he received social support and the other organization address more clinical issues with him. He speaks to what he believes is the different between peer and individual support.

Not all veterans' experience with formal peer group was positive. Congruent with the literature of social work groups these veterans also got frustrated with the process, dynamics and problem behaviours that tend to show up within groups. Below a veteran explains a negative experience he has had with formal peer social support groups:

“Sometimes they can be a bit of a platform for people to vent their own issues.”

Other veteran talked about his relief in the fact of finding out that he was not the only one experiencing what he was going through:

“I start working with the [peer support program] and that was huge for me, because then I can evolve in a group of ex-military or serving members that are going through the exact same thing as I was going through, and although I would not wish this on anyone, it was actually a relief that I was not alone, and that there was a lot of people out there that suffered, that we are all the same.”

As mentioned before some veterans experienced loneliness post combat, the peer support group seemed to help this veteran not feel so alone with his O.S.I. Another veteran commented on this fact:

“Well I think it give a little togetherness, especial to those in your neighbourhood, you get to see those guys, sort of relax a little bit, some relaxation there, and a little camaraderie and clowning around, kind of makes you feel loose. And kind of wanted, because there is that feeling that nobody really cares about you and nobody really wants you”

There seems to be a strong push for peer support and culturally appropriate services in the literature. This seems to be congruent with the findings in this study. Although the veterans also identified a need for individual support that alongside the peer support.

Chapter 4

Discussion

These findings must be understood within the context of military culture. Truly, as one veteran stated, “the military is not what they did it is who they are”. Moreover, soldiers go through extensive training on how to protect themselves and “kill their enemy”. Following this training, they may be sent into combat where they will have no choice other than to use the skills they learned to protect themselves and their brothers in combat. Soldiers will experience situations and climates that few can imagine, but when arriving home, many soldiers are expected to integrate back into their daily lives where society has changed and they, themselves, have also changed. Many times this integration is difficult in itself, however, compounded with an O.S.I. can be overwhelming for the combat veteran.

The veterans who participated in my research honoured me by sharing their emotional stories of how combat changed them and the impact it had on their lives. Through narrative interviews with five veterans several themes emerged, including: the veterans’ narrative identity, the emotional impact of combat, as well as the barriers and facilitators in seeking treatment. However, the most striking issue that emerged from my

research, as well as the veterans' stories, is the impact that the stigma associated with having an O.S.I. has and consequently, what this means in the context of access to appropriate counseling and support.

Stigma

When an individual is diagnosed with an O.S.I. this can be seen, or felt, to be a failure on the individual's part. The concept of honour and sacrifice relate back to the vital parts of the military culture and this helps us understand the inherent stigma that is predominantly in the military surrounding mental health. This was a major theme within each of the interviews, as well as a consistent theme in the literature. Stigma is seen within the diagnostic label and is connected to the military employment.

Label

Frequently, society's reaction to the effects of the soldier's experience post combat is pathologized. There has been a construction of what is said to be "normal" and "abnormal" psychological states which society deems to be mental health disorders or issues. These service men have had their worldviews changed due to their circumstances which are assessed, diagnosed and labelled, instead of being viewed as having a normal response to extreme violence (Bragin, 2010).

Furthering this tenuous environment, soldiers may be expected to complete employment duties, and as mentioned above, the soldier is assessed every three months to ensure that he is still capable of being employed. Within a culture that explicitly trains its

members to “suck it up,” it is not difficult to see why disclosing symptoms or seeking treatment for mental health issues might be viewed as a sign of weakness (Bryan & Morrow, 2011). However, notably the Department of National Defence is trying to change the stigma around this subject. Unfortunately soldiers have also been trained explicitly to be able to withstand any physical or mental challenge. This means that when a soldier is experiencing symptoms of mental health issues, there is not only stigma surrounding this issue, but it can be seen as a failure to the soldier’s mission and training. This may also be a reason why the military has higher confidentiality in accessing this information or individuals that hold this information.

Discussions surrounding the name, and classification, of combat or operational stress reactions continue due to the ethical dilemmas surrounding the labelling of an O.S.I. and the profound effects that such labels can have on individual soldiers and the military unit (Nash, 2007). However, many of these veterans required the label in order to proceed with treatment. The diagnoses can reassure the soldiers that they are not alone and that their symptoms make sense, but can also harm the soldier and the military unit in which they serve. These diagnoses hold a heavy burden of stigma for most civilians, but soldiers carry additional stigmas due to the areas discussed above. Their employment requires them to remain calm, focused and in control regardless of adversity, which can be difficult due to the stress symptoms (Nash, 2007). A diagnosis can impact the soldier’s superiors and peers’ confidence and trust within them.

Stigma and Military Employment

Overall, one of the most evident fears seen in the literature is the fact that the soldier may be deemed “unfit for service” (Bryan & Morrow, 2011). The military faces a paradox between the mentality of being fit for service and seeking help for problems related to combat. This was also seen within the interviews with the veterans, as the many of them reported not telling the professionals what they have and are experiencing as they did not want to be determined not fit for service. When linking this comment to the veterans, several explicitly stated that they waited until after their service in the military before seeking assistance. 65% of those who met screening criteria for a mental health diagnosis reported that they would be considered weak (Pryce & Shackelford, 2012). Three out of the five veterans in my study waited until they were out of the service to seek treatment. The other two veterans sought out treatment due to being mandated, as well as the stress impacting them physically.

When the concept of stress as a problem enters the awareness of military leaders, rather than just as an unavoidable component of warfare that should be overcome and/or ignored, it is most commonly seen as a challenge to their leadership skills (Nash, 2007). 63% of veterans indicated that they were concerned that their unit leadership would treat them differently (Pryce & Shackelford, 2012) and this is due to their responsibility for their troop’s morale, safety and will to fight. Furthermore they also bear the full responsibility for deciding when and how to use the “resources” of war (Nash, 2007), which in this case are the soldiers.

Another area of stigma was evident in the lives of veterans who held a leadership position. It was difficult to seek assistance when they were in charge of assisting others,

and three out of the five veterans in my study were in leadership positions at some point. The military's emphasis of the leader's accountability for all subordinates at all times, expects that the service man will inform the leader when he will be absent (Bryan & Morrow, 2011). Furthermore, there is likely even more pressure when the leader needs to be absent and others are relying on him. Since many mental health treatment programs take place during business hours, the soldier is less likely to participate in the programs as his absence would be obvious. Almost half of service men have reported the inability to get time off in order to attend mental health appointments (Bryan & Morrow, 2011). Furthermore the reluctance to leave the group can also be contributed to the soldier's culture, which holds in high regard the development of close in-group bonds. Leaving the group to seek help from an "outsider" can be looked down upon and may even be seen as jeopardizing the groups safety (Bryan & Morrow, 2011 & Richardson, Sareen & Stein, n.d.).

On another side of the issue mental health workers in the military have increased limits to confidentiality. These workers perform their services primarily for the organization rather than the particular soldier they are working with. In the civilian population the client can choose the workers they wish to see and the workers first loyalty is to the client. In the C.A.F. the practitioners aid and/or manage the control of 'deviant' behaviours and ensure that the soldiers are fit for duty (Daniels, 1969) which puts the worker in a surveillance role. The soldiers are very aware of this and may withhold information from the practitioner to ensure they continue to have employment. Soldiers have the option to seek confidential treatment outside the military, however, many

soldiers state that those practitioners do not have any idea of what soldiers have experienced. This was also seen in the interviews when the individuals talked about the lack of privacy in the military.

Similarly seen through the interviews the soldiers can continue to have difficulties with treatment once they have left service due to the remaining connect to service life. It is important to remember when the veteran leaves the military, it could be for a number of reasons however, this is also a difficult transition. The veteran is leaving not only a job but a sense of community and a way of life. Many veterans do not stray very far from this way of life and stay connected to the community. The complexity of this topic is important for researchers and practitioners to keep in mind. Furthermore, the understanding that much of the veterans' recovery should be based from a deep cultural understanding. The veteran should have the ability to choose what services he uses: civilian or military. However, even when using civilian services a deep understanding of the military culture and employment is important to provide proper care.

Supports

Given our understanding of the way in which stigma impact veterans who are living with an OSI, it is important to understand how stigma effect their experiences of and access to support. It has been repeatedly stated that the military is not just employment but also a life style. Through their training and the way they live their lives a different culture presents itself. Employment with the army requires a high level of commitment and employs tactical methods that ensure even in extreme conditions the

units maintain social cohesion, loyalty and collective representation. These facts, combined with frequent moves and postings, at times isolation from the civilian world, as well as a sense of duty, have a lasting impact on these individuals (Sherwood, 2007). The military can be a closed system, with its own language, terminology, acronyms, training and cultural references (Burrell, Adams, Durand & Castro, 2006). This can be very difficult for a helper who is unfamiliar with the culture and because of this the veteran may end up explaining, educating and familiarizing the professional with the lifestyle rather than being able to work through the reason they are there. When the veterans in their interviews explained their process of obtaining assistance this fear was present, there was an overarching concern that the professional would not understand what they were talking about. There is a delicate balance of having to ask the veteran for explanations and having enough knowledge about the military culture, history and employment to function as a positive helper.

It is important to note that individuals working in mental health services typically take on a pathological worldview which forms the basis for an approach to practice. This approach examines what is not working or what is going wrong rather than what is (Grant & Cadell, 2009). Since many of the service members' identities are based on strength and elitism, the use of these terminologies are at odds with their culture and reinforces the disconnect between themselves and the mental health services. The language that the soldiers and social workers use to speak is very different and this can be seen in the comparison between social works terminology and C.A.F. terminology. Studies have shown that the soldiers respond very differently when the social worker use the same

terminology as them which reflect some of the issues that a civilian social worker would have, where as a uniformed social worker would have had basic training which would orient them to the language used in the fields. However, the C.A.F. provides protection on land by air and at sea, and there are a variety of different branches in each force's element. This illustrates the diversity even within the C.A.F. which causes differences in the languages being used.

Support was not just seen as mental health services. Veterans talked about different aspects of recovery and treatment being social support, financial support, family support and support with employment. The men did not talk about treatment in a solely clinical perspective and their narratives encompassed what would be considered a holistic healing process. This suggested that cultural appropriate services need to be offered inter-professionally and even through multi-disciplinary teams.

Peer support

A growing body of literature has increasingly been able to demonstrate positive outcomes for peer support in the context of self help groups, consumer-run organizations and services, as well as peer support workers in mainstream services (O'Hagan, Cyr, McKee & Priest, 2010, Nash, 2007 & Bryan C. & Morrow, C. 2011). Furthermore there is now more emphasis being placed on the uniqueness of peer support workers and their ability to facilitate and support more culturally appropriate services in mainstream organization (O'Hagan, Cry, McKee & Priest, 2010).

Many of the veterans in my study sought out formal peer support with the services ranging from a uniformed social worker, operation stress injury social support program and psycho-educational groups that are co-facilitated or facilitated by other veterans. Although there is civilian social workers in the military the veterans I spoke with did not refer to their formal peer support being a uniformed social worker. A veteran did however talk about the desire to speak to a uniform over a civilian and this may be related to the previous stated idea that the veteran found it easier to speak to anyone in the military over a civilian.

In addition to this the veterans also talked about treatment coming from both formal and informal peer supports. The veterans highly discussed the impact of these supports and when reflecting on some of the frustrations they experienced in relation to it they resembled issues pertaining to problem behaviours in group, limitations to open groups and group dynamics. For example one veteran talked about hostile behaviour and monopolization of the group (Corey & Corey, 2006). However, these issues are not specific to peer support rather the characteristic of group dynamics.

Contrary to the frustrations experienced, there seems to be a comfort in this unspoken understanding between veterans. The veterans interviewed spoke about the fact that other veterans did not judge them, which is directly related to them feeling less stigmatized when talking with peers who have experienced an O.S.I. Also the veterans seemed to benefit from hearing what others were going through in their lives and how they coped. Even though they reported that they did not tell each other what to do with

their problems, the idea of hearing others own solutions to what was going on seemed to give the veterans ideas on what may work for themselves.

Interestingly since the veteran's worked as team members and a cohesive unit while in the military, the peer support group brought this element back into their treatment. It also seems to reduce the stigma in receiving assistance for their O.S.I. as they are not the only ones experiencing this and they do not feel as if they are being judged by others experiencing the similar thing.

IMPLICATIONS

Ideology of injury

Combat stress has been referred to as shell shock, traumatic war neurosis, hysteria, battle fatigue, gross stress reaction and now an O.S.I. Labeling a mental health diagnosis as an injury is a relatively new phenomena that is happening within the military. The ideology of a mental health diagnosis being an injury is ingrained in the stories of these veterans as they refer to "fixing," or "curing" the diagnosis frequently during the interviews. Even the label O.S.I. distinguishes what the veterans are experiencing from others that have a mental health diagnosis.

But still the ideology of an injury is engrained within the comments of the veteran questioning whether it is realistic to believe that there is a cure. The parallel between a physical injury and a mental health injury is evident through the conversation related to fixing or curing the mental health diagnosis. When using the terminology injury does this

provide the assumption that one can heal similar to a physical injury, or does healing on a mental level take another shape? And what does healing actually mean? These are questions that may be beneficial for future research to explore.

Neuroscience has shown that trauma does actually impact the physical structure of the brain and how it functions (McFadden, 2012, Coon, Brown, Malik, & McKenzie, 2005 & C.T.R.I., 2012). So is there truth to the ability to physically heal? There is a lack of knowledge on how the brain actually heals to be able to answer this question which makes this area that needs furthermore research in the field.

Implications to Social Work Practice and Research

It is important for social workers to take an anti-oppressive stance in their practice which requires not only being culturally sensitive but a commitment to recognizing and addressing power imbalances that arise (Mandell, 2008). Veterans' living with mental health concerns is a relatively new domain that needs future attention due the influx of soldiers that are coming home from Afghanistan with an O.S.I., as well as the number of veterans who have lived with an O.S.I. for years due to the lack of services/research. This is also important when addressing the military population because veterans will not only use military services but will also make use of civilian services. Furthermore, it has also been illustrated that service provisions need to view the veterans in a holistic manner demonstrating some aspects of cultural understanding with this population.

Consistent with other research that asserts that most soldiers do not want to be labeled as 'mentally ill.' (Nash, 2007), the men in my study suggest that the use of

appropriate terminology with this population is central. The terminology used can be directly linked to the stigma a soldier may experience, becoming one of the main barriers for the veteran.

When referring to effective workers it is also important to note that with this neo-liberal social service atmosphere, it can be difficult to meet timings due to unmanageable case loads, unexpected crisis' and standards that need to be met. However, this can clash with the military culture where soldiers have been trained that it is unacceptable and even dangerous not to meet timings. Small acts such as starting and finishing an appointment on time could be useful in helping to create a therapeutic alliance with the veteran.

When examining the professionals that are working with soldiers and veterans, it is important to note that a large percentage of these individuals have to be registered through the Ontario College of Social Workers and Social Service Workers due to the fact that hospitals, the Department of National Defense (D.N.D.) and many clinical practices require their clinicians to do so. Each of these workers is held to the code of ethics which determines what ethical practice is. This code specifies that each worker is to respect the inherent dignity of each individual and also dictates that social workers respect their unique worth, diversity, unique beliefs and self-determination (C.A.S.W., 2005). These principles are directly in line with veterans' culture and requires the treatment of these individuals as strong and competent individuals who are able to determine what would work best for them.

Traditional mental health approaches are commonly used within the C.A.F. to provide treatment to the soldier's mental health issues, but these traditional approaches can be in contrast to the soldier's culture. Mental health treatment typically adopts an individualistic one to one approach where emotional vulnerability is encouraged. In contrast to this treatment approach, the C.A.F. culture highly values the collectivist identity and emotional toughness. In many traditional mental health approaches, individuals are encouraged to self-identify for treatment in locations that are filled with medical professionals, such as hospital, which reinforces the idea of illness (Bryan & Morrow, 2011). When the veterans spoke about their treatment, they did not speak highly of the evidence based tested treatment and questionnaires and showed preferences toward relationship based culturally appropriate services.

To help address some of the barriers to service there also needs to be recognition in improving the "marketing" of mental health services in a more culturally competent manner. Bryan and Morrow (2011) have suggested that programs should be designed to fit the military culture. In order to achieve this, mental health professionals should partner with C.A.F. personnel and leaders to develop programs that present "performance enhancement" programs and not mental health programs. At all stages of program development these individuals should be consulted (Bryan & Morrow, 2011).

Moreover, non-traditional approaches to mental health services should be delivered from a soldier-centric perspective that works with the collective nature of the group. It is important to incorporate evidence and strength-based strategies that fit the soldier's mindset. It has been suggested that the practitioner take the time to learn the

soldiers training background and curriculum to be able to identify a pre-existing skill set, and present mental health concepts as job skills by tying them into a pre-existing occupational skills set. Next, it needs to be recognized for the potential personal growth associated with combat exposure and overcome the assumption that effective health promotions must occur within an office setting within a weekly hour template.

This is just one option a social worker can take, but it puts them in the community instead of in health services and uses prevention in research minded practice (Stepney, 2005). This might prove to be effective for circumventing mental health stigmas and improving penetrations of service into the soldier population. The soldiers have overcome many physical and mental barriers in the past; this is very much part of who they are and identity work may be key when working with a veteran. Each veteran talked about the importance of purpose in their life as it became very much part of their identity. Furthermore, by strengthening and using the soldier's identity, versus the use of the pathology identity that the society has put on them, may provide a useful strategy when working with this population.

The use of multidisciplinary teams can also assist in the treatment of veterans in a holistic manner. These teams can include psychiatry, nursing, social work, medical doctors and peer support workers. The use of these teams are the main mechanism to help ensure holistic care and a seamless service for soldiers throughout their recovery process crossing the boundaries of primary, secondary and tertiary care (Mental Health Commission, 2006). In addition, it provides a shared knowledge base and indeed divides

up exclusive claims to specialist knowledge and authority and allows for cultural competence among a team (Mental Health Commission, 2006).

Peer Support

Finally, the use of peer support can also be seen as a possible solution to the stigma, shame and isolation that an O.S.I. can bring to veterans, as well to increasing access to services. Echoing Figley and Nash (2007) my study showed that peer support assists in engaging veterans into treatment, to share personal experience, firsthand knowledge of systems, and can serve as a role model (Figley & Nash, 2007). The use of peers can also assist with the power differentials between the professional and client and increase access to support.

Since veterans stay connected to the military culture, the peer support can also be seen as a strong social support for the veterans. Research has also shown how the erosion of social support can contribute to the development of mental illness for those who have experienced trauma (Nash, 2007). A formal group may be beneficial for those living on base but also those who live away from base, possible web based groups may be beneficial. Having a peer support group would allow the veterans to stay connected to the military culture and also provide a social support for these veterans.

Peer support can be used as culturally appropriate treatment as these individuals are experts on the military culture and can be paired up with civilians in order to provide more culturally based services, as well as be advocates on veterans' issues. Furthermore,

as some veterans in this study shared, they were able to help other veterans through similar issues as shared knowledge and experience are very important factors.

The combination of peer support and clinical treatment can assist veterans during their treatment process. Veterans may initially find it too difficult as well as triggering to be in a peer support groups and having the option of meeting with a clinician, or a peer support worker, one on one may be a usefully tool in such a situation.

Chapter 5

Strength and limitations

Limitations

Combat trauma by its very nature can disrupt meaningful connections within the soldier's story and memory. Interpretive work with the narratives of individuals, who have experienced trauma, entails investigators to forge links and connections in their stories.

A limitation to this study was the amount of time given for completion, not allowing for me to work closer with the individuals and ensure these connections were their truths. I would have liked to work closer with the individuals in my study to ensure the connections I was making were true for them. Furthermore, I was not able to present all the sub narrative's and themes due to the limited time and space and would not have been able to honour these stories appropriately, if I had incorporated them into my thesis.

Due to the limitation of time and the restrictions to recruitment within the military population, I was not able to recruit from a diversity of sectors within the population. In order for recruitment in many sectors that veterans frequent I would have required an additional ethics application which would have been a timely process. If I wanted to explore some of the other narratives that were less pronounced across each transcript, further interviews could have been useful.

Also one veteran stated that there was a significant difference between some of the issues he was experiencing in comparison to the older veterans who would have different struggles. My study provides an overview of five veteran's experiences with an O.S.I. and the services they used and may be applicable to some veterans, but each sector has different needs. It is very difficult to generalize this study to the military population.

Strengths

I believe that in research the researcher is always present and that there are times when the researcher does not use themselves and the reader has to guess what position the writer is coming from. I believe that a strength to my study is that I present my position throughout the paper. This allows the reader to understand how I impacted the research, which strengthens the information because I show transparency and allow the reader to interpret that.

Another strength behind this study is my understanding of the military culture. As I grew up in the military, I had a deeper understanding of what these veterans were talking about. The validity of this thesis should be assessed from within the situated

perspective and traditions that frame it. This could have also been a limitation if it was not for my thesis supervisor who ensured that I clarified subjects that may not have been as apparently evident to an outsider. Furthermore, I was able to consult with civilian and military peers to ensure that I was providing culturally relevant information.

Finally, my use of narrative interviewing, and the way in which this created a space for the veterans voices come through in the research, proved to be a strength of my study. By choosing narrative inquiry the veterans were able to lead me down their story path while I was able to focus on each participant and ensure their voices did not get lost within the data. As a result the findings were made up of the veteran's words, voice and stories. I did little talking in the interviews, allowing for a natural flow of what the veteran wanted to share. In the analysis, I was then able to address themes that arouse, while shedding light on the difference of opinions within these topics. It was my hope that this process was anti-oppressive and a positive experience for each veteran.

Conclusion

These stories illustrate the narrative identities that five veterans shared and the importance of purpose within these men's lives. Furthermore, each of these men honoured me with the ability to share the emotional impact that combat had on them. There has been a lot of talk and literature written on P.T.S.D., however, this has been primarily framed as a mental health issue versus a normal reaction to extreme violence.

This violence is something that a majority of individuals could not imagine. However, these men live day in and day out with the memories of war and the impact that

it has on their daily lives. Each of these veterans spoke about the impact their employment and culture had on seeking services. In many aspects of the veterans' stories were comprised of stigma and the impact it had on seeking treatment. Condensed with stigma, the structural barriers exacerbate the soldier's ability to seek culturally appropriate services in a timely fashion. Furthermore, these structural barriers do not solely impact the veterans in one area of their lives but have a ripple effect on all areas.

Lastly, these veterans provided explicit service provisions that they believe would assist them and other veterans in the future. Not only do these men believe that individual support is important to them, but supporting their families also seems to be an important aspect of treatment. Even with individual treatment each veteran talked about the importance of peer support, whether it was too informal or formal, and the role of peer support seems vital in a holistic culturally appropriate treatment.

This exploratory study has examined provide veterans experiences of O.S.I.S.S. Further it has also opening many aspects of the veterans experiences that can be further explored in the future while also providing concrete strategies when working with veteran. In this study I have reviewed the literature available on the subject, illustrated my methodology, provided the themes present in the narrative interviews, further discussed the results and their implications while highlighting the strengths and limitations to this study.



APPENDIX A

**PARTICIPANTS NEEDED FOR
RESEARCH IN SUPPORT SERVICES FOR MALE VETERANS**

We are looking for male volunteers to take part in a study of Support services for Veterans

You would be asked to: attend one confidential interview and fill out a background information questionnaire.

Your participation would involve 1 session;
each session will be about 60-90 minutes long.

In appreciation for your time, you will receive a \$5 Tim Horton’s gift card for your time. I will also reimburse transportation cost if arranged prior to interview.

For more information about this study, or to volunteer for this study,
please contact:
Jennifer Taun
Masters in Social Work Student
519-221-4305 or
Email: taunj@mcmaster.ca

**This study has been reviewed by, and received ethics clearance
by the McMaster Research Ethics Board.**

<p>— Call Jenn: 519-221-4305 or email: taunj@mcmaster.ca</p>			
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APPENDIX B

Email Recruitment Script

Sent on Behalf of the Researcher

by the Holder of the Participants' Contact Information

Jennifer Taun,

Masters Candidate in Social Work

Study Title:

A Study of Operational Stress Injury Support Services from a Veterans Perspective

Sample E-mail Subject line: A Study of Operational Stress Injury Support Services from a Veterans Perspective

Dear Veterans,

Jennifer Taun, a McMaster student, has contacted the Operational Stress Injury Support Service Clinic (O.S.I.S.S.) asking us to tell our male veterans about a study she is doing on male veteran's perspectives of support services. This research is part of her Master of Social Work program at McMaster University.

The following is a brief description of her study. If you are interested in getting more information about taking part in Jennifer's study please read the brief description below and or **CONTACT HER DIRECTLY** by using her telephone number or email address.

Tel: 519-221-4305 or taunj@mcmaster.ca

Jennifer Taun is inviting you to take part in a 60-90 confidential interview which will take place in a convenient time and place. She will work out those details with you. She hopes to learn more about what is beneficial for supporting veterans. Jennifer Taun has explained that you can stop being in the study at any time. She has asked us to attach a copy of her information letter that gives you full details about her study.

In addition, this study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Office of Research Services

E-mail: ethicsoffice@mcmaster.ca

Sincerely,

A solid black rectangular redaction box covering the signature area.

DATE: _____

Appendix C

Consumers

LETTER OF INFORMATION / CONSENT

Understanding Support Services from a Veterans Perspective

Investigators:

Student Investigator:

Jennifer Taun

Department of Social Work

McMaster University

Hamilton, Ontario, Canada

(519) 221-4305

E-mail: taunj@mcmaster.ca

Faculty Supervisor:

Dr. Saara Greene

Department of Social Work

McMaster University

Hamilton, Ontario, Canada

(905) 525-9140 ext. 23782

Email: greenes@mcmaster.ca

Dear Veterans,

Purpose of the Study

My name is Jennifer Taun, I am a McMaster student, that has contacted the O.S.I.S.S. clinic asking them to tell their contacts about the study I am doing on your experiences in seeking treatment for an operational stress injury. The following is a brief description on my study. If you are interested in getting more information about taking part in my study, PLEASE CONTACT ME DIRECTLY by using my McMaster email address: taunj@mcmaster.com or her telephone number 519-221-4305.

Procedures involved in the Research

I am seeking 4-7 male veterans with lived experience with an Operational Stress injury systems who are/or have been involved in operational stress injury support program as part of their recovery process.

If you agree to be in this study, you will be asked to take part in a 60 to 90 minute one on one interview during which you will be asked to talk about your experiences seeking support services. A time line will be created about the treatment process. It will take place in with a location of your choice. With your permission, the interviews will be audio-recorded and these recordings will be transcribed by myself. These transcriptions will be forwarded to you prior to analysis. You will have the option to remove information that you do not want used for research. If any direct quotes are used I will inform you of this and you will have the option to request that the quote not be used. After the information is analyzed, a summary report will be written. You are welcome to see this document and your feedback on it would be appreciated.

I would like to retain the transcripts to use for my Master's thesis.

Potential Harms, Risks or Discomforts:

The risks involved in participating in this study are minimal. However, the interview may raise issues that you find difficult to think and talk about. Also it can be difficult to separate experiences of support services from the trauma experienced during the service. This may cause undue psychological risks. Please know that you do not need to answer questions that make you uncomfortable or that you do not want to answer. You are also able to stop the interview or take a break from the interview at anytime. If you are still feeling distress due to the interview several resources that are able to support you immediately will be provided to you. If you choose to have your interview at the O.S.I. clinic, all interviews will be held during the clinics business hours, so that support is immediately available. I also have taken several trainings and worked in the mental health field for the past four years. This will provide me with some understanding of the issues you may be experiencing and appropriate referrals.

While every effort will be given to protect the identity and confidentiality of participants, some may still worry their identity and confidentiality will be compromised. Please see the section below on confidentiality.

Legally Required Disclosure

Although I will protect your privacy as outlined above, the law requires it that if I suspect a threat of suicide or self harm I will need to report it to the proper authorities. If I suspect this I will inform you that I am making the report prior to doing so.

Potential Benefits

The research may not benefit you directly beyond the opportunity to share your story. I hope to learn more about the benefits and barriers for individual seeking treatment post combat. I hope that what is learned as a result of this study will help us better understand the role or peer support. In addition, your participation may help enhance social worker knowledge on how to support veterans and the impact of peer supports.

Reimbursement

You will receive a \$5 Tim Horton's gift card for participating in the study. If transportation is an issue for you I will reimburse you for any travelling costs. All travel cost reimbursements need to be arranged prior to the interview.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me and my supervisor Saara Greene will know whether you participated unless you choose to tell them. Since your group at the O.S.I.S.S. clinic is small, others may be able to identify you on the basis of references you made. Please keep this in mind in deciding what to tell me. You will have an option to remove stories after the interview if you decide that you no longer wish to share that information.

Your audio-recorded interview file will be transferred and stored in a password protected computer file or encrypted computer storage device which will, in turn, be locked in a file cabinet (along with the completed short questionnaire). Only I will have access to the locked cabinet. I will not use your name on any documents (it will be replaced with a code name) or any information that would allow you to be identified on the data (such as transcripts and field notes on computer files). Anything that could identify you will not be published or told to anyone else without your permission.

I respect your privacy. No information about you will be given to anyone without your permission, unless the law requires so, as for example if there is immediate harm to you or someone else.

Audio files of interview will be deleted once they are transcribed. Following completion of the research study the transcripts of interview will be kept for 5 years and then be destroyed.

Participation and Withdrawal

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, you will be asked if the information you shared up to the point of withdrawal can remain part of the study. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will not affect your continuing access to services. You will also be able to keep you \$5 gift certificate and any transportation compensation agreed upon in prior to the interview.

You will be given a copy of this consent form for your record. Withdrawal from this study will no longer be an option after June 20th 2012.

Information about the Study Results

If you would like to receive the summary personally, please let me know how you would like me to send it to you. This information will be available by October 2012.

Questions about the Study

If you have questions or need more information about the study itself, you may contact:

Jennifer Taun (Investigator): 519-221-4305 or e-mail: taunj@mcmaster.ca

Dr. Saara Greene (Supervisor): 905-525-9140 x 23782 or e-mail: greenes@mcmaster.ca

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administrative Development and Support

E-mail: ethicsoffice@mcmaster.ca

CONSENT

By signing this form:

1. I agree that you have explained the study, the possible harms and benefits of participation, and my right to withdraw from the study at any time even after I have signed the consent without reason being asked. You have answered all my questions.
2. I agree that the interview be audio-recorded. Yes No
3. I agree that I have been told that my records will remain private. You will not give my information to anyone, unless the law requires you to.
4. I agree that I have read and understood pages 1 to 3 of this consent form. I agree, or consent, to take part in this study.

Research participant's Name

Research participant's Signature

Date

Name of Person Obtaining Consent

Signature

Date

I would like to receive a summary of the study's results.

Please send them to this email address

or to this mailing address:

... No, I do not want to receive a summary of the study's results.

Appendix D

UNDERSTANDING OPERATIONAL STRESS INJURY SUPPORT SERVICES

INTERVIEW BACKGROUND INFORMATION SHEET

**DO NOT
Put your name
on this sheet.**

INSTRUCTIONS: Please fill in this that will provide us with some basic background information about you. There will be an option for the individual to do this demographic page verbally if they do not wish to write the information down.

1. I served as (Check one):
 Army
 Navy
 Air Forces
Specifically _____
2. I serviced in the Canadian Armed Forces for _____
 prefer not to answer
3. My age is _____
 prefer not to answer
4. I'm (Check one):
 single
 married
 separated
 divorced
 a common-law spouse
 prefer not to answer
5. I have been out of service for _____ months or years
6. I have been using operational stress injury support services for _____
7. Where did you serve?
8. What was your rank?
9. Have you had a physical injury due to your employment?

Appendix E

Interview Questions

UNDERSTANDING OPERATIONAL STRESS INJURY SUPPORT SERVICES

Jennifer Taun, (Master of Social Work student)

(Department of Social Work – McMaster University)

Information about these interview questions: This gives you an idea what I would like to learn about support services for Veterans who have been diagnosed with an operational stress injury. Interviews will be one-to-one and will be open-ended. Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that ...?*”), to get more information (“*Please tell me more?*”), or to learn what you think or feel about something (“*Why do you think that is...?*”). I will be taking notes so I do not need to interrupt you when you are speaking and I can remember points that I would like to come back to.

- 1) As you know I am here because I want to know about your experiences accessing and being involved in operational stress injury support services.**

- 2) Please tell me about the support services you have used since?**
Please tell me more about why you think that?

- 3) What are your thoughts on the support services?**

- 4) Is there something important we forgot? Is there anything else you think I need to know about?**

END

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