Navigating Barriers:

A grounded theory of the experiences of Canadian Armed Forces veterans with post-traumatic stress disorder.

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ABSTRACT

This research project serves as an initial foray into the experiences Canadian Armed Forces veterans with PTSD. Several problems are identified with the current sociological and social scientific literature on military veterans, the foremost of which was a lack of Canadian data. This study was conducted using a grounded-theory approach; several interviews were conducted with Canadian Armed Forces veterans with PTSD living in Southern Ontario, in order to uncover themes and patterns of experience. Analysis of these interviews indicated that the experience of Canadian Armed Forces veterans with PTSD is patterned by encounters with barriers. Veterans perceive, negotiate, and navigate these barriers as they progress through the processes involved in having PTSD. Participants in this study also identified several navigational aids with regards to these barriers, the most prominent being that of social support, especially on the part of fellow veterans. This study provides several possible avenues of further research that are indicated by the analysis.

Keywords: Canada, veterans, PTSD, barriers, grounded theory

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CHAPTER ONE: INTRODUCING THE RESEARCH PROBLEM

There is a human cost in the operations of a military: injury and death are considered very real possibilities in this line of work. Although individuals sign on knowing these risks, it is never clear how a person will react to the reality of these situations when they are encountered. A bomb goes off, or a trigger slips. An enemy has you cornered in a war-zone, or a tank runs over a soldier during a training exercise. Catastrophic injuries cannot be unseen, and somebody has to clean up the mess. Over the last few decades, there has been increased recognition of the mental health consequences of military service; in Canada, these are known as operational stress injuries (OSIs), and encompass a range of psychological injuries including post-traumatic stress disorder (PTSD), anxiety disorders, and depression. While the recruiting methods of the Canadian Armed Forces make for an enlisted population "at lower risk" for psychiatric disorders, the traumas faced by enlisted members result in a population with rates of psychiatric disorders similar to those in the broader Canadian society (Paré 2011:6). The study of PTSD and related health issues has increased in tandem with its recognition. PTSD has become increasingly fleshed out in definition, vastly evolving from its early days in medicine and academia as shell shock and battle fatigue.

When I first started this project, it seemed as though realistic manifestations of PTSD were out of the public eye. The primary place of PTSD in the media was in fictional television dramas where the dangerous war veteran trope seems to play out again and again. Shortly after I committed myself to this topic, *The Globe and Mail* ran an article titled, "Rash of suicides among Canadian soldiers puts post-traumatic stress in spotlight" (Globe Staff and Canadian Press 2013). *Global News* followed up more than a month later recounting the many soldier and veteran suicides that had happened in the winter months of 2013 and 2014 (Tucker 2014). I remember reading articles about Canadian Armed Forces veterans who began speaking to the news-media about having PTSD, and I remember reading the public forums that are the comment sections of news websites. Some people were supportive of veterans coming forward with their problems; others were offended with what they saw as lies put forward to draw attention. There were people who thought that veterans who spoke to the news media were brave, and there were people who thought that anyone that truly had PTSD would never, ever talk about it on such a public platform. Over that winter and the months to come, what had been previously thought of as a private health issue became the subject of public scrutiny.

In 2014, Veterans Affairs Canadian was closing offices across Canada and cutting staff (Berthiaume 2015). While the department was downsizing, it was simultaneously running ads aimed at helping veterans and encouraging them to use transition and rehabilitative services that the department offered. In the wake of the winter suicides and veterans coming forward with PTSD, the cuts were taken negatively by the veteran community, as were the ads (Beeby 2015). There are several explanations on the part of Veterans Affairs Canada to explain these cuts, including the anticipation of lower utilization of veterans' services owing to the decline in veterans of the Korean War, which made up a large part of the veteran population (Brewster 2015b). Service utilization has gone up, however (Berthiaume 2015), and case workers are overloaded, prompting the promise of new funds for Canadian Armed Forces veterans (Brewster 2015a) although these promises were made over the course of a long-running election cycle.[1] Proponents of psychiatry and the medical sciences continue to study and refine their knowledge

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[1] The increase in service utilization is partly explained by the introduction of the New Veterans Charter in 2006, which was aimed at redefining the social contract that existed between the Canadian Armed Forces and its members (and veterans) by "taking into account the different needs of a new generation of veterans who have been involved in complex, ill-defined and more dangerous operations" (Kerr 2014:9). This redefinition drastically changed the rules with regards to who qualified for services and benefits. Prior to this change, veterans who had been deployed to areas of conflict were given preeminent status over others, and were more likely to qualify for services and benefits (Canadian Forces Advisory Council 2004).

of PTSD and its health-related consequences, and the public interest in the situations of veterans with PTSD continues to grow. Despite this growing spotlight, the sociological landscape on the subject of PTSD in Canadian Armed Forces veterans has remained woefully barren.

While existing literature currently does a great job covering American and other non-Canadian contexts, there are several notable gaps in the current literature on military veterans with PTSD. Although American and other international sociological literature can be informative, it is not appropriate for academics to blindly extend these findings to the Canadian context. Despite Canada's falling presence as peacekeepers[2], and evolving stance on the international stage (Murray 2010), the Canadian Armed Forces have long been framed as a "peacekeeping" body. Jefferess (2009) describes a national tendency to romanticize Canada's peacekeeping history, aggrandizing the successes, minimizing the failures, and using the 'mythology' as a point by which to reference Canada's international mores. Canada's international actions may no longer strictly align with this mythology - the story that Canadian civilians, soldiers and veterans tell themselves - but the story is no less important for it. W.I. Thomas famously wrote that "if men define situations as real, they are real in their consequences" (1928:572); if the peacekeeping myth persists regardless of actions that would speak otherwise, the Canadian military and veteran population may harbour experiences that are contextually different from other military populations. El-Gabalawy et al. (2015) point out that, "in addition to variable military experiences, Canadians differ significantly from Americans in other important ways such as access to health care" (38).

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[2] According to a report for July 31st, 2015, Canada currently ranks 68th of 124 nations which are currently contributing peacekeepers to United Nations initiatives (United Nations 2015).

Cultural disparities aside, there is also the tendency for recent, scholarly social sciences literature to focus on war and combat veterans, which can lead to a misconception of who can acquire or develop PTSD. According to Veterans Affairs Canada, a veteran is “any former member of the Canadian Forces who successfully underwent basic training and is honourably discharged” (VAC 2015a). Furthermore, Veterans Affairs Canada specifies that OSIs, including PTSD, result from the performance of operational duties (VAC 2015b). PTSD can result from a wide range of operational duties outside of combat and/or theatres of war, but the focus in the literature on combat/war veterans helps to obscure this reality. In addition, much of this same literature focuses on quality of life indicators and intimate partner relationships, but there is no literature that appears to indicate that these are important issues identified by military veterans in specifically.

When it comes to Canadian Armed Forces veterans and their *experiences* with OSIs like PTSD, there is a visible gap in the sociological literature; this study will be among the first to address this problem. The primary aim of this exploratory study was to answer the question: what are the experiences of Canadian Armed Forces veterans with PTSD? More specifically, I wanted to explore veterans’ experiences of being diagnosed and coping with PTSD on an everyday basis. This inquiry was informed by a symbolic interactionist framework, a decision that was premised by the ephemeral nature of experiences, which are lived, relived and constructed between individuals. Given the limited research focusing on this population and the potential issue of faulty extrapolation from international studies, I chose to conduct a grounded theory inquiry. Charmaz states that “grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves. Thus researchers construct a theory ‘grounded’ in their data” (2014:1). Since the premise of this study was a general lack of data with respect to the population in question, the use of grounded theory was prudent to the creation of relatable information.

In this analysis, I have found that the experience of having PTSD is marked by encounters with and navigations of barriers – barriers in understanding, barriers in disclosing, and barriers in help-seeking. While PTSD has its own medical and psychological definitions and implications, there is a world of social consequences that Canadian Armed Forces veterans with PTSD encounter and navigate, which have yet to be explored.

SITUATING THE PROJECT

This project was born out of a need for academic research on the experiences of Canadian Armed Forces veterans with PTSD. *Chapter Two: Contextualizing the Problem* situates PTSD in terms of the development of the diagnosis, as well as its unique place in the Canadian context as an operational stress injury (OSI). I then provide an overview of the state of the literature on PTSD, first in the Canadian, and then in the non-Canadian, contexts. This section points to the problems in the literature, namely: the lack of Canadian research into the social situation of veterans with PTSD; the unclear logic behind treating certain aspects of the experience of veterans with PTSD with primacy over others; and finally, the tendency to focus on war and combat veterans, to the detriment of knowledge on the condition of veterans in general.

Chapter Three: Theory and Method is divided into two parts. It begins with an explanation of the theoretical and methodological framing of this study. I explain how symbolic interactionism informs the ontological and epistemological assumptions in the study. Experiences are assumed to be intangible – able to be referenced, but not concretely visible. These experiences are created, recreated and analyzed between people and as part of an internal dialogue, which informs understandings of past, present, and future actions and experiences.

What follows is an explanation of the decision to use, and development of, grounded theory – specifically constructivist grounded theory as explicated by Kathy Charmaz (2014). The second part of the chapter is dedicated to the actual methods employed in this study. I outline the data collection – interviews that were, for the most part, audio-recorded – as well as potential issues with data collection. These issues include the expectations and assumptions of my participants and the way I situated myself, the researcher, in the process of data collection and knowledge production. I explain grounded theory methods of initial and focussed coding, and then give a brief outline of the course that this research took which culminated in a completed analysis. I conclude this section with an explanation of the study limitations and benefits.

In *Chapter Four: Analysis*, I separate the experiential process of PTSD into four parts. This separation is done for the ease of analysis – all four sections are integrated, but are unique in their own ways. I explain these sections separately and then pull them back together in the final discussion.

I. PTSD as a Barrier is presented first in order to better understand the veteran perspective as they move through the other parts of the process of PTSD. In accordance with symbolic interactionism, internal dialogues are used to examine situations and experiences. As an injury of the mind, PTSD affects this internal dialogue in an intimate way. Symptoms such as elevated anxiety and extreme mood swings contribute to the context by which Canadian Armed Forces veterans analyse their own experiences. In this section, I outline various symptoms that participants identified as particularly problematic, as well as the situational problems that arose in the wake of these symptoms.

II. Barriers to Acknowledgement outlines barriers that participants identified between the time of acquiring and the time of acknowledging (or personally realising) the condition of PTSD.

These barriers included doubting oneself, normalizing problems, minimizing problems, burying problems, and flatly denying problems, and were often linked with fears of stigma and losing one's job. This section concludes by outlining navigational aids and experiences which helped veterans overcome these barriers.

III. Barriers to Telling Others begins with an explanation of the tendency for immediate family to be placed outside of the 'others' category, by simple expedience that they tend to be cohabiting with the veteran for the duration of the problem and therefore have been exposed to some outward manifestations of PTSD. For this reason, telling immediate family is not considered the same as telling other people about the problem. I follow this up with an explanations of the barriers to telling other people about having PTSD, which include the fear of stigma and reinforcement of personal reticence in the wake of negative reactions to previous cases of disclosing. These barriers are a part of an iterative process of telling others and incorporating the reactions of others into decisions about how to proceed in other social situations. This section also concludes by outlining navigational aids and experiences which helped the veteran overcome these barriers.

IV. Barriers to Formal Support describes barriers that are somewhat different from the previous two sections, in that they rely heavily on input (or failures of input) from other individuals in the process of both building and navigating barriers. There are barriers within the Canadian Armed Forces when it comes to detection of PTSD and attitudes towards disclosing, despite the fact that the military itself has a number of dedicated professionals whose job it is to provide outreach and aid to members with mental health injuries. There are potential barriers when it comes to working with medical professionals, both within and outside of the Canadian Armed Forces. When participants personally evaluated the credentials and experience of those medical professionals as useful or not, their evaluation affected their willingness to cooperate (for better or for worse). There were also a number of barriers that participants pointed out when interacting with Veterans Affairs Canada, which included a lack of knowledge of services, mountains of paperwork, and long, frustrating periods of waiting for feedback from the organization. Concerning Veterans Affairs Canada specifically, participants identified social support, specifically in the form of mentoring, to useful for navigating these barriers.

In the final section, *Chapter Seven: Discussion and Conclusion*, I reiterate the complexity of the experiences of Canadian Armed Forces veterans with PTSD. I outline the varying nature of the paths that participants in this research took throughout the process of experiencing PTSD. I then address the problems in the literature (explained in *Chapter Two*) in light of the analysis. Finally, I address the emergence of potential research avenues that require further investigation.

CHAPTER TWO: CONTEXTUALIZING THE PROBLEM

There are several points of context to address while engaging in a thoughtful exploration of the experiences of Canadian Armed Forces veterans with PTSD. PTSD became an official diagnosis with the publication of the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) in 1980 (DSM-III), but the symptoms that it describes had been noted long before the DSM-III's publication. In this chapter I give a brief overview of the history of PTSD as it is now known, and specifically address the Canadian context in which PTSD is viewed as an operational stress injury (OSI). I then address the state of the literature on PTSD; this includes academic research on the social experiences of Canadian Armed Forces veterans with PTSD, the gray literature provided by the Department of National Defence and Canadian Forces Ombudsman's office, as well as the areas of focus in non-Canadian literature. Several problems are suggested by the review of academic research: the lack of Canadian focus on the experiences of veterans with PTSD from a social sciences perspective, a gap in the international literature that legitimates the choice of several highly specific research areas (such as spousal tension), and a tendency to ignore non-war/combat veterans. These problems come together as a motivation for the use of grounded theory methodology, which I will explain in greater detail in the following chapter.

AN OVERVIEW OF POST-TRAUMATIC STRESS DISORDER

The explosion of current research on PTSD generally coincides with the entry of Post-traumatic Stress Disorder in the DSM-III, but the history of the illness precedes the term. Trimble (1985) succinctly presents the timeline of the condition, noting that greater interest in the condition was incited by the American Civil War and World War I (7). Prior to these wars, Trimble asserts, the condition sporadically speckles the pages of history through personal documentation and stories.

However, these wars gave rise to large groups of people being jointly or individually traumatized by similar events; the sudden, visible increase in mental health casualties of war was impossible to deny. The condition resulted in varying terminology – in 1919, the term "shell shock" was used to describe an assumed physical reaction to the concussive power of artillery exposure; in the 1940s, this assumption was refuted, with researchers identifying exposure to "horror and fright" to be the primary cause of the condition (8). There were some works appearing at this time speaking of nervous shock due to workplace injuries, and subsequent skepticism of the validity of these conditions in the pursuit of money (8-11). During and shortly after WWII came the rise of "combat exhaustion" and "traumatic war neurosis" (Brende & Parson 1985:67-68). Earlier diagnoses and studies became overshadowed by the Vietnam War, and the publication of the DSM-III. The timely proximity of these events, as well as the war-riddled history of studying the condition, arguably tied PTSD to war and combat in the popular perception.

The DSM-III describes PTSD as the "development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience" (1980:236). Since the publication of the DSM-III, there has been a dramatic increase in the number of studies that focus on PTSD. The DSM-IV, published in 1994, changed the criteria, "most notably to specify that PTSD can apply to civilian populations" (Paré 2011:4). The description of a traumatic event became more specific:

> …the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (DSM-IV 1994:424).

The most recent DSM includes a further cause: “Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)” (DSM-5 2013:271). The definitions provided by the DSMs are (and have been) the authoritative points of reference for anyone examining and/or researching PTSD.

THE CANADIAN CONTEXT

Occasionally during this study I have used the acronym for operational stress injury – OSI. This terminology is Canadian in origin, conceived by retired Lieutenant Colonel Stéphane Grenier, who was working to increase the legitimacy of, and reduce the stigma attached to, “mental health injuries” (Subcommittee on Veterans Affairs 2015:2). Veterans Affairs Canada defines an OSI as:

> …any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police. It is used to describe a broad range of problems which include diagnosed psychiatric conditions such as anxiety disorders, depression, and post-traumatic stress disorder (PTSD) as well as other conditions that may be less severe, but still interfere with daily functioning. (VAC 2015a)

Unlike PTSD, OSI is not a diagnostic term; “according to the CAF [Canadian Armed Forces] and DND [Department of National Defence], it only refers to a ‘grouping of diagnoses that are related to injuries that occur as part of operations” (Subcommittee on Veterans Affairs 2015:2). Although PTSD is the focus of almost all of the academic research that I have retrieved, it is pertinent to mention that, in the context of the Canadian Armed Forces and its affiliates, PTSD falls under the categorization of an OSI. Much of the aforementioned research describes PTSD in concurrence with these other types of OSI; for this reason, I had framed my initial research and interview questions with the terminology of OSI. As I spoke with participants in the study, it became apparent that they primarily spoke in terms of PTSD, although OSI was sometimes used interchangeably to describe the condition.

Aside from the inclusion of Canadian context, it is important to note that the old and new DSM criteria for PTSD is not limited to trauma that occurs specifically in warzones or in direct combat. Veterans Affairs Canada identifies OSIs as *resulting from operational duties*, and as such is not limited to Special Duty Areas and Special Duty Operations, which include theatres of war and combat areas.[3] This differentiation is extremely important, as it indicates a broad range of people who can get an OSI like PTSD in the Canadian Armed Forces: anyone performing operational duties, which can be in or outside of Canada and in or outside of combat. There is sometimes a blindness, an ignorance in academic and public perceptions that creates the belief that military personnel must have gone away or been in combat to acquire an OSI like PTSD. In reality, there are many ways in which these injuries can be acquired, and not all individuals acquire these injuries when exposed to similar traumas. Furthermore, those who acquire PTSD may not experience these injuries in any uniform way.

THE STATE OF RESEARCH ON PTSD IN CANADA

In "Veteran's Health in Canada: A Scoping Review of the Literature," Aiken et al. mention overwhelmingly American results in the search for studies particular to veteran health. Although their study focussed on health in general, they indicate that "fully one-third of the literature [that

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[3] According to definitions from Veterans Affairs Canada (2014a): "Special Duty Area (SDA): Specific geographic areas outside Canada where members are exposed to conditions of elevated risk. / Special Duty Operation (SDO): Missions/operations which involve elevated risk. These may take place in or outside Canada."

they retrieved] pertained to PTSD" (2013:157). This study is useful because it gives a fairly indicative rundown on the state of current academic literature regarding military veterans with PTSD. The drawback is that this scoping study focussed on three databases – Embase, Medline, and Psycinfo (154) – which are primarily medical and therefore tend to focus on the medicalized aspects of PTSD. Aiken et al. indicated a small turnout of studies on "social health concerns," but these studies focussed on veteran health in general, rather than on PTSD.

Given this study, I conducted a similar database search in ProQuest Sociology and Sociological Abstracts, as well as JSTOR Sociology and Social Sciences, using the keywords *Veteran**, *Canad**, *PTSD, post traumatic, posttraumatic, shell shock, battle fatigue, combat stress,* and *gross stress* (asterisks are used as an indication for varying word endings, such as Canada or Canadian). I manually searched the titles (to rule out obviously irrelevant studies) and the abstract and location data, in order to rule out studies that were on non-Canadian subjects/participants, which invariably resulted regardless of search parameters. The result was one article titled "The Construction of Post-Traumatic Stress Disorder and Its uses by the Canadian Armed Forces" (Godoy-Paiz 2004). Godoy-Paiz acknowledges the suffering that service in the Canadian Armed Forces can cause (2004:15), but her focus on discourse lacks tact. Godoy-Paiz uses PTSD in her analysis to discuss discourse-building and the use of victimhood to bolster the Canadian peacekeeping identity while proverbially sweeping any atrocities committed by Canadian Armed Forces under the rug. PTSD is used in this analysis as vehicle for a conversation that is, in essence, not about servicepersons and veterans, but about public perception and national discourse.

Despite the poor showing on the database search, there *has* been some research conducted on the family relationships of Canadian Armed Forces servicepersons and veterans with PTSD. Ray and Vanstone (2009) conducted a study based on in-depth interviews with veterans with PTSD on their family relationships, finding trends in emotional numbing and anger, and emotional withdrawal from their families. Ray and Vanstone indicate that these veterans were "contemporary peacekeepers" with previous deployments in areas with "intrastate conflicts (civil wars)" (840), but not whether these war veterans were currently employed or retired from the Canadian Armed Forces at the time of interview. Other studies on family relations were investigated from the perspective of family members. Baker and Norris (2011) investigated the experiences of women-partners of Canadian veterans diagnosed with PTSD; they found that women experienced ambiguous loss of their partner or former relationship, made attempts to accommodate and adapt to their new family situations, and tended to experience deleterious mental health consequences. Studies on the adolescent children of Canadian servicepersons with PTSD found experiences of emotional loss of a parent (Kwan-Lafond, Harrison, Albanese 2011; Harrison, Albanese, Berman 2014). These studies with family members are helpful in contributing to the knowledge of military and veteran family relationships, but an increase in research on veterans' own experiences with PTSD is needed to flesh out the pool of knowledge, not only on family relationships, but in all areas of veterans' lives.

Even though the body of research on the social experiences of veterans with PTSD is small, efforts are being made to expand it. The Canadian Institute for Military and Veteran Health Research (CIMVHR) was founded in 2010 in order to "address the unique health care needs of our soldiers, our Veterans and their families" and became a research hub for the health and wellbeing of the military and veteran population (Hanlon 2015). CIMVHR had released three books between 2011 and 2013 to showcase research (largely medical) on physical and mental health of servicepersons and veterans. In 2015, CIMVHR launched the *Journal of Military, Veteran and Family Health* (JMVFH), whose purview includes the social health and wellbeing of these populations (JMFVH 2016). These initiatives (CIMVHR and JMVFH) are important moves for the expansion of Canadian research on the experiences of Canadian Armed Forces veterans with Operational Stress Injuries like PTSD.

THE OMBUDSMAN REPORTS

Academics working in the relatively new area of social health and Canadian military veterans often use gray literature produced by Canadian government and military institutions to supplement their resources. This includes several significant reports were issued from the Department of National Defence and Canadian Forces Ombudsman between 2001 and 2012 which resulted from investigations into the treatment of PTSD and other OSIs in the Canadian Armed Forces. While these investigations were geared specifically towards institutional review and policy creation/change, these reports offer valuable insight into the experiences of Canadian Armed Forces members and veterans of recent service. Since it is difficult to access members for research purposes, these reports serve as a source of information that is both distanced from and in cooperation with the Canadian Armed Forces.[4]

The initial investigation, which culminated in the publication of *Special report: Systemic treatment of CF members with PTSD* (Marin 2001), was launched in response to a complaint regarding the overall treatment of Canadian Armed Forces members with PTSD. This report outlines a major qualitative study comprised of interviews with over 200 people, of whom over 100 were current or retired Canadian Armed Forces personnel (*v*). Marin investigated claims of

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[4] I would like to thank Deborah Harrison for pointing me in the direction of these reports.

a dominating mental health stigma fostered by the existing military culture of the Canadian Armed Forces. This stigma manifested in several ways, such as: the perception of weakness in those with mental health injuries; the perception of soldiers using mental health injuries as a way to defraud the system; problems with chain of command; and poor reception of PTSD diagnoses by peers. Marin noted members' reluctance to admit to, or personally accept, a mental health problem (80-84); he also noted the positive impact that peer support (174) and back-to-work initiatives (147) could have on members diagnosed with PTSD. Marin lauded the Canadian Armed Forces on the steps that had been taken to help members with PTSD, such as the marked improvement in "the quality and quantity of deployment-related training at the unit level since ... 1996" (*vii-viii*). However, the Ombudsman also warned that the Canadian Armed Forces should not be satisfied with these minor accomplishments – at this point in 2001 there were still many changes that needed to occur. These changes involved the improvement and standardization of education, increased coordination of care, increased provision of resources, and a refurbishment of the administrative/bureaucratic system to better serve its members (206).

In 2002, Marin released a follow-up report, *Review of DND/CF actions on operational stress injuries*. This report, resulting from further interviews with over 300 people (3), acknowledges the great initiatives that the Canadian Armed Forces had taken since the initial investigation, and the receptiveness of the senior levels to dealing with the problem of PTSD/OSIs. Marin reported on the progress made, and the difficulty of trying to change the culture and attitudes of such a large organization. It was noted that negative attitudes persisted towards mental health injuries (*iii*), especially in the form of resentment towards the individuals believed to be defrauding the system (97) and/or increasing the workload of non-injured members (99). Marin indicated that the nature of the military bureaucracy was limiting the dissemination of pro-care initiatives and enthusiasm towards the issue of OSIs (*vii*). There was also a noted distrust between the Chain of Command and medical officers/caregivers despite the fact that both groups were generally dedicated towards the issue of OSIs. This distrust was attributed to a lack of communication between these groups (96). The report ended on a similar note to the first: the Canadian Armed Forces were doing well at addressing the OSI issue. New education programs were approved of, but not yet initiated, and "the in-theatre mental health care resources and reintegration programs put in place for the Battle Group that went to Afghanistan were successful" (99). However, Marin found a lack of "urgency" to deal with mental health issues at the unit level, as well as limited efforts to provide discreet care for military members who might otherwise be reluctant to come forward (99). Marin concluded that there was still much work to be done.

Six years later, in 2008, McFadyen released another follow-up report from the Ombudsman's office, *A long road to recovery: Battling operational stress injuries. Second review of the Department of National Defence and Canadian Forces' action on operational stress injuries*. This investigation included more than 360 individual interviews (8), and again was carried out for the purpose of assessing the organization's general progress in the area of PTSD and other OSIs, and the specific progress on the recommendations in Marin's reports in 2001 and 2002. McFadyen noted that of the 31 recommendations made in the initial report, 18 had failed to be addressed (3). For example, a national level position was to be appointed whose sole duty was to coordinate PTSD/OSI related initiatives and efforts, and to standardized quality of care across the country. In reality, it had been appointed as a secondary duty of lesser importance to members already burdened with other full time duties as their primary role (24). Bureaucratic barriers to occupational transfers persisted (17), and data collection and database construction had fallen behind (12-13). Recommendations in this second follow-up report were expanded, but the primary call seemed to be for the Department of Defence and Canadian Armed Forces to actually work on implementing the original recommendations (29).

The most recent follow-up report was released in 2012, eleven years after the initial investigation. This report, *Fortitude under fatigue: Assessing the delivery of care for operational stress injuries that Canadian Forces members need and deserve* (Daigle 2012), compiled the findings from over 200 formal interviews, and contact with almost 500 people connected to the Canadian Armed Forces and/or the treatment of individuals with OSIs (7). Daigle framed the state of Canadian Armed Forces dealings with OSIs as generally positive, indicating vast improvements in commitment by leadership (56), in the education of members from enlistment and throughout their military careers (54), in the increase in caregivers employed, and in the enthusiasm of caregivers despite being plagued with staff shortages (57). Also found was a general weakening of the stigma surrounding mental health injuries, although it is apparent that this stigma persists (58-59). Daigle points out that the initial recommendation to implement a database designed to track the prevalence of OSIs in the Canadian Armed Forces was still unaddressed (4).

These investigations were holistic in the sense that they covered issues from micro to macro settings in the Canadian Armed Forces. Persisting mental health stigmas, fear of committing ‘career suicide,’ issues of with Chain of Command, coordination concerns, caregiver understaffing and caregiver burnout were only a few of the problems that the initial report and follow-up reviews shed light on. Some of these issues became apparent during my interviews with Canadian Armed Forces veterans with PTSD. These Ombudsman reports were valuable because they make explicit the common experiences of Canadian Armed Forces members with

PTSD and other OSIs, especially from the years 2001-2012. Veterans whose services predate the 2001-present frame, however, are not experiencing this culture change and benefit. While there will almost certainly be a generational change for veterans in this transformed system, veterans of the earlier system will continue to require service for decades to come. These reports only explain part of the background(s) of Canadian Armed Forces veterans; the other part lay in the experiences of veterans after they are released into civilian Canadian society.

THE NON-CANADIAN ACADEMIC LITERATURE

There is an abundance of non-Canadian literature on military veterans with PTSD, which will prove useful for comparison once the Canadian research base has been further established. A trend in the literature I have retrieved is a tendency for studies to focus on war veterans (Byrne & Riggs 1996; MacDonald et al. 1999; Hautamaki & Coleman 2001; Renshaw Rodrigues & Jones 2008; Solomon & Dekel 2008; Solomon, Dekel & Zerach 2008; Solomon et al. 2011; Kar & O'Leary 2013), and more specifically, combat veterans (Taft et al. 2007; Taft et al. 2009; Jelusic et al. 2010; Cohen, Zerach & Solomon 2011; Renshaw & Campbell 2011; Snyder 2014). While these populations are important, they are by no means the only types of military veterans who acquire PTSD and other OSIs. The prevalence of academic literature that is focussed on these two (sometimes overlapping) groups only furthers misconceptions of PTSD and other OSIs being exclusive to individuals who have been stationed in warzones.

Much of the social-scientific research on military veterans with PTSD appears to focus on quantitative methods in the form of scales, questionnaires, checklists and inventories that the individual participant is meant to fill in. These measures are sometimes used to report on 'quality of life indicators'. Butterfield et al. found that "women [veterans] with PTSD had poorer health functioning as compared to women without PTSD across all measured physical and emotional domains" (2000:739). Other studies of male veterans with PTSD also noted trends of poorer health than control populations (Benyamini & Solomon 2005; Anticevic, Kardum & Britvic 2011). Southwick, Yehuda and Giller (1991) used a questionnaire designed for veterans to "measure subjective feelings about himself and about relationships with others" (180). The results indicated that veterans with PTSD had higher rates of self-criticism and guilt than patients who were clinically depressed with no PTSD (181). This still appears to be the case in more recent research, as Dekel et al. (2005) used surveys and scales to measure self-worth and beliefs in the "benevolence of the world," (409) finding that individuals with PTSD generally had lower levels of both self-worth and belief than control groups.

The use of quantitative methods to report quality of life indicators is useful; researchers can report on generally larger populations than if they were assessing quality of life qualitatively. The drawback is that by using extreme quantification to turn all indicators into statistics, these studies lose sight of the actual experiences of real, flesh and blood individuals living with PTSD. These measures indicate that this population is worse off regarding physical, emotional and social health, but offer little meaningful understanding of the issue beyond the numbers.

Much research (mostly quantitative, with occasional qualitative and mixed methods studies) has focussed on the ways in which having PTSD affects intimate partner relationships. Some studies focus on general tension in relationships (MacDonald et al. 1999; Renshaw, Rodrigues & Jones 2008; Solomon & Dekel 2008; Solomon, Dekel & Zerach 2008; Renshaw & Campbell 2011; Solomon et al. 2011), while others focus very specifically on situations of interpersonal violence and abuse (Byrne & Riggs 1996; Taft et al. 2007; Taft et al. 2009; Finley et al. 2010; Taft et al. 2012; Kar & O'Leary 2013). Occasional studies looked at the concerns and considerations of parenting for veterans with PTSD (Caselli & Motta 1996; Beckham et al.

1997; Ruscio et al. 2002; Cohen, Zerach & Solomon 2011); these studies are generally quantitative in nature. There is further research on the families of veterans with PTSD, but this research has been conducted with focus on the experiences of spouses and children, rather than on veterans' own perspectives and experiences (Rosenheck 1986; Frederikson, Chamberlain & Long 1996; Dekel, Solomon & Bleich 2005; O'Toole et al. 2010). While this research provides valuable insight on the consequences of living and caring about someone with PTSD, it is not focused on the actual lived experiences of veterans in their own right.

Some of the studies regarding spousal relationships are conducted qualitatively, through the observation of interactions between couples and through interviews which were sometimes done with couples, and sometimes conducted individually. Typically, these qualitative methods studies yield smaller population samples, which is considered the primary drawback. However, these methods allow researchers to have greater insight regarding the lived experiences of an individual than one would get through pre-categorized quantitative indicators. While quantitative research is important to understand the scope of the issue with regards to population size and the severity of suffering from PTSD and other OSIs, corresponding qualitative research must be used in order to produce a more comprehensive understanding of the problem.

THE PROBLEMS

There are a few things that are problematic with the current research on military veterans with PTSD. First, there is a lack of Canadian focus from a social sciences perspective – what Canadian focus there is revolves around the medicalized parts of being a Canadian Armed Forces veteran with PTSD (see Aiken et. al. 2013). Second, there is a distinct gap in the literature explaining why certain aspects of the PTSD experience – particularly relationships with intimate partners – have been chosen as primary research topics by so many scholars. If intimate partner relationships are a primary focus of military veterans, then it should be uncovered and given its place in the literature as a legitimation of the topic of study. Third, the focus on war and combat veterans serves to obfuscate the reality of who can acquire PTSD and other OSIs, and renders invisible a swathe of non-war and non-combat military veterans who have suffered psychological injury in the service of their country. It is my intention for this study to be a *preliminary* contribution towards solving these problems.

CHAPTER THREE: THEORY AND METHOD

The existing sociological and social scientific literature on military veterans with PTSD amounts to a wealth of research. The United States and Israel have made considerable contributions to this large body of knowledge – research from a Canadian veteran's standpoint, however, was conspicuously absent. A further examination of existing international literature revealed a focus on war and combat veterans. When the social experiences of veterans *were* examined, it was typically a specific social experience – that of spousal relationships and the way they are affected by the presence of PTSD in a partner. Although this literature might be of some use[5], I am wary of applying it to the Canadian context because the Canadian Armed Forces has been styled as a peacekeeping body for so long. Comparatively, the United States Armed Forces is more directly engaged in armed conflicts. The Israel Defense Forces, which has also featured as a large part of the international literature, recruits via conscription, which creates yet another distinct social/cultural context which individuals reference in their experiences with PTSD.

From these diverse military characterizations, which are dissimilar from the Canadian Armed Forces context, came questions: what are the experiences of Canadian Armed Forces veterans with PTSD? Are these veterans – inclusive of all veterans, not just those who have experienced combat and war – particularly concerned about spousal relationships? Do they frame their experience as medicalized, as some of these studies might suggest? And finally, can we legitimately assume that these findings from the international literature necessarily apply in the same ways to a population whose military dynamic is arguably different from many other militaries that have been studied? There is too little research on the Canadian context to safely

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[5] The literature involving spouses, for example, might eventually prove relevant to the Canadian context, as spousal tension did appear as an important, albeit small, aspect of my findings.

make such blanket assumptions. While the existing literature on PTSD is undoubtedly useful, and there is much value in comparative assessments to other military regimes, I am also attentive to the fact that the Canadian experience is likely to be unique in many ways. That is, much of Canadian veterans' experiences with PTSD may be as yet undiscovered in the existing literature. In order to make useful comparisons, a knowledge base must be developed around the experiences of Canadian Armed Forces veterans with PTSD. The question, then, becomes how these experiences should be investigated.

The first section of this chapter, *Theoretical and Methodological Framework*, is devoted to answering this question. Using symbolic interactionist assumptions and a grounded theory methodology, my goal is to keep an open mind as to the experiences of Canadian Armed Forces veterans with PTSD. Employing a methodology wherein the findings are grounded in the data appeared as the most logical course of action in order to uncover facets of the experience of PTSD that may be unique to the Canadian context. In the second section of this chapter, *Method*, I outline the actual steps taken in devising and executing this research project.

THEORETICAL AND METHODOLOGICAL FRAMEWORK

Framing with Symbolic Interactionism

The experiences of Canadian Armed Forces veterans with PTSD are various: this military involves many different branches of service which are involved in diverse training and operational processes at any given time. Acknowledging these many contexts and the existence of multitudinous viewpoints about PTSD, I have framed this research within the theoretical context of symbolic interactionism. Although this framework was at first loosely alluded to, its strength became more apparent over time as I discovered the barrier-laden process that underlies the experiences of Canadian Armed Forces veterans with PTSD. Symbolic interactionism is concerned with social experiences, meanings and meaning-making – concerns which were central to the research problem. What follows here is a brief explanation of the development and major assumptions of the symbolic interactionist perspective.

George Herbert Mead is without a doubt the progenitor of symbolic interactionism. Of all his contributions, his seminal (posthumously published) work, *Mind, Self, and Society* (1934) has had, as Prus writes, "the greatest impact on the sociological community" (1996:52). Herbert George Blumer, Mead's most noted descendant in the sociological field, credits his premises for symbolic interactionism on the work of Mead. As Blumer explains:

> [Mead's] central concern was with cardinal problems of philosophy … showing that human group life was the essential condition for the emergence of consciousness, the mind, a world of objects, human beings as organisms possessing selves, and human conduct in the form of constructed acts. He reversed the traditional assumptions underlying philosophical, psychological, and sociological thought to the effect that human beings possess minds and consciousness as original "givens," that they live in worlds of pre-existing and self-constituted objects, that their behavior consists of responses to such objects, and that group life consists of the association of such reacting human organisms. (1969:61)

Mead spoke of a self and mind that arose through social interaction. He posits that it was the existence of the socially created self that was the basis for internal monologue; as Mead writes, "the individual comes to carry on a conversation of gestures with himself. He says something, and that calls out a certain reply in himself which makes him change what he was going to say" (1934:141). Freudians might call it the interaction of the ego and the superego. Cooley touched upon this as a manifestation of *the looking-glass self*, of which he wrote: "a self-idea of this sort seems to have three principle elements: the imagination of our appearance to the other person, the imagination of his judgment [sic] of that appearance, and some sort of self-feeling, such as pride or mortification" (1902:184). The lay-person might call this an internal filter. The difference, as explicated by Blumer, is that "Mead saw the self as a process and not as a structure" (1969:62), continuing that "[other] schemes which seek to lodge the self in a structure make no sense since they miss the reflexive process which alone can yield and constitute a self" (63). Mead credits his view for being able of "give a detailed account and actually to explain the genesis and development of the mind" (1934:224), in opposition to the above-mentioned popular denotation of the mind and self as presupposing social interactions. Mead's theory of self and mind allows for the individual to both influence and be influenced by social interactions and experiences.

Blumer, as a student of Mead, adopted and interpreted Mead's concepts in his 1969 publication, *Symbolic Interactionism: Perspective and Method*. Blumer argued that although Mead did not theorize explicitly about society, "such a scheme is implicit in his work" (1969:61). Mead's position on self and mind is evident in Blumer's characterization of symbolic interactionism:

> The term "symbolic interaction" refers, of course, to the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. (1969:78-79)

Meaning is a primary concept in Blumer's tenets of symbolic interactionism. Just as Mead criticized popular conceptions of the self as a given, and without origin, Blumer criticized popular conceptions of *meaning* as a given. Blumer positions symbolic interactionism against notions that meaning is either inherent to the object that an individual is considering, or inherent to the individual based on their psychology and/or physiology (1969:3-4). Instead, Blumer views meaning as a result of social interaction, saying that "symbolic interactionism sees meaning as social products, as creations that are formed in and through the defining activities of people as they interact" (4-5). Blumer's individuals are also in opposition to popular conceptions in the way that they handle meaning – instead of being passive receptors of outwardly-originating meaning, individuals are considered as agentic, actively interpreting meaning as they encounter/acquire it (5-6). These notions of meaning and agency come together in Blumer's outline of the fundamental premises of symbolic interactionism:

> The first premise is that human beings act toward things on the basis of the meaning that the things have for them …The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has had with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (1969:2).

The driving force behind symbolic interactionism, then, is the context, negotiation, and interpretation that is brought to a social encounter. People draw upon their previous knowledge and experience, gained through other social encounters, in order to navigate the current encounter, and ultimately, use this same encounter to inform future encounters and interactions.

Blumer's work on symbolic interactionism is foundational to the sociological field, and subsequently draws a lot of criticism, from both opponents and supporters of symbolic interactionism. Puddephatt (2009) outlines critiques of symbolic interactionism generally, and Blumer specifically, noting that "all contemporary critiques and dismissals of the interactionist paradigm seem to stem from Blumer's solipsistic reduction of the meaning making process purely to the sphere of social interaction" (103). A contradiction is identified between Blumer's insistence on the social origins of meaning and his acceptance of an obdurate reality – that is to say, a material world with the ability to resist meaning and essentially "talk back" to human observations (95). Puddephatt is also critical of Blumer's entirely socialized version of individuals, saying that "people are not Blumerian 'blank slates' to be filled only with abstracted information from linguistically enabled socialization, but also share various universal social instincts and 'biologic' characteristics" (102). Although Blumer's individuals are agentic – able to interpret meanings, define and assess situations, and react accordingly – Blumer has essentially written off origins for this agentic individual that come from biological predispositions or external interactions with the non-human, non-social elements of the world.

Given these critiques, Puddephatt has compared and contrasted Blumerian ontological and epistemological assumptions to that of Mead, on whose work Blumer developed his theoretical paradigm. Mead posited that human behaviour was the result of a complex, inseparable interplay between the "socially self-conscious individual" and the "biologic individual," (1934:347) the latter of which is made up of "primitive human impulses" (349) and is rooted in the physical body (351). Mead's work on the self was developed in rejection of the assumption of the purely psychological individual (Pampel 2007), but that rejection did not make Mead's work exclusionary. In his attempts to emphasize the social in *Symbolic Interactionism: Perspective and Method* (1969), Blumer, instead of raising the social in primacy to other factors, defined social interaction as *the* generator of the self.

Noting a contemporary turn away from mind/body dualism which downplays or ignores the embodied self (92-95), Puddephatt advocates a return to Meadian epistemology (103). This involves acknowledging that the self, and subsequently, human interpretation arises from the convergence of biological, social and asocial sources. This convergence is exceptionally important with regard to research on disabled or injured bodies, and specifically to the research problem outlined in this project. Canadian Armed Forces veterans with PTSD have a condition rooted in their body – a condition which not only affects their body, but their modes of thought. The object under investigation is the experience of Canadian Armed Forces veterans with PTSD. The symbolic interactionist framework characterizes these experiences as interpretive, negotiable and fluid. How, then, is the analysis of veterans' experiences best conducted?

From Symbolic Interactionism to Grounded Theory

Due to the lack of research on the experiences of Canadian Armed Forces veterans with PTSD from a sociological perspective (or even a social sciences perspective more generally), I reasoned that it was necessary to begin this research with as few assumptions about my sample population, or the process of experiencing and seeking care for PTSD, as possible. Given the symbolic interactionist framing of the problem, this meant going to the source and asking individual Canadian Armed Forces veterans with PTSD about their experiences and the meanings that are associated with having and coping with PTSD. The study therefore required inductive methods to try and uncover emergent themes and issues that are most relevant according to the meanings and experiences of my research participants. A variety of methodologies were considered for this study. Ultimately, I chose grounded theory methods, reflecting on Creswell's assessment of how the researcher should determine whether to use grounded theory:

> Grounded theory is a good design to use when a theory is not available to explain or understand a process. The literature may have models available, but they were developed and tested on samples and populations other than those of interest to the qualitative researcher. Also, the theories may be present, but they are incomplete because they do not address potentially valuable variables or categories of interest to the researcher. On the practical side, a theory may be needed to explain how people are experiencing a phenomenon, and the grounded theory developed by the researcher will provide such a general framework (2013:88).

There were many points this research touched upon that aligned with Creswell's assessment: the lack of literature on Canadian Armed Forces veterans with PTSD; the tendency for international literature to focus on extremely specific categories (spousal relationships, combat/war veterans); and a general lack of research and theory about how veterans actually experience PTSD in their social context. What follows here is a brief outline of the development of grounded theory, and the specific choice of Kathy Charmaz's 'constructivist' grounded theory (2014) as the guiding methodology for this project.

Glaser and Strauss published *The Discovery of Grounded Theory* (shorthand, *The Discovery*) in 1967 in response to several problems that they witnessed in the field of sociology. One of these problems was the tendency for sociologists at this time to merely test theories, rather than generate them (6-9). Another problem was the overwhelming enthusiasm for quantitative methods which distinctly lessened the perceived legitimacy of qualitative methods. Charmaz (2014), while reviewing the emergence of grounded theory in the field of sociology, explains both the location and timing of *The Discovery*: at this point in the United States, "quantitative methodologists reigned over departments, journal editorial boards, and funding agencies … [and] that some sociologists quantified measures to persuade outside audiences, not because they believed quantification to be necessary" (Charmaz 2014:6). Glaser and Strauss described the perception of qualitative research as merely a method "to provide quantitative research with a few substantive categories and hypotheses. Then, of course, quantitative research would take over, explore further, discover facts, and test current theory" (1967:15-16). Although Glaser and Strauss accept the importance of quantitative methods and theory testing, they also advocate the use of qualitative research, specifically inductive methods, as a legitimate means of inquiry and theory generation. Their goal was put forth as a standardization of qualitative research methods, to "further the systematization of the collection, coding and analysis of qualitative data for the generation of theory" (Glaser & Strauss 1967:18). This focus on systematization appears as an effort to specifically appeal to proponents of quantitative research by satisfying positivistic ontological needs. By providing systematic means of data analysis, qualitative methodologists could more closely mimic the rigor of the scientific method, while developing theories from induction, rather than deduction.

After the publication of *The Discovery,* Glaser and Strauss experienced a divergence: they subsequently published several works on grounded theory separate from each other. Heath and Cowley (2004) demonstrate this divide succinctly, noting various methodological departures including the varying importance of induction, upon which Glaser placed more emphasis, than Strauss (143-146). Glaser's data is constantly compared and re-compared with new and previous data with the intention of watching for emergent patterns and questions to follow. For Strauss (in collaboration with Corbin) 'inductive' analysis becomes reliant on a linear process of finding data, and making deductions, to be followed up by verification. Heath and Cowley note that, "rather than emphasising deduction followed by verification, they talk of deduction followed by validation and elaboration from further data comparisons, which *ensure* emergence" (145). Charmaz (2014) describes the open criticism that Glaser expressed towards Strauss and Corbin's version of grounded theory methodology:

> Glaser (1992) contends that Strauss and Corbin's procedures force data and analysis into preconceived categories, ignore emergence, and result in 'full conceptual description,' not grounded theory. In short, Glaser argues that Strauss and Corbin's approach contradicts fundamental tenets of grounded theory. (Charmaz 2014:11)

Despite these methodological divides, the intent of *The Discovery* remained to provide a system and legitimation for the use of qualitative methods to generate and verify theory. Clarke (2005) notes that "their challenge – which they ably met – was to articulate a new qualitative methodology in the belly of the haute positivist quantitative sociological beast of the 1960s (3), pointing out that the focus at this time was legitimizing qualitative methods, which came at the potential cost of "other users shearing off key aspects of the epistemological apparatus of the method" (4). Clarke, however, posits that epistemological concerns are "foundational" for grounded theory, specifically that of *materialist social constructionism*:

> Many people (mis)interpret social constructionism as concerned only with the ephemeral or ideological or symbolic. But the material world is itself constructed – given meaning(s) – by us, by those whom we study, and is what we study (our own constructions of our research problems, including nonhuman material aspects). It is present and to be accounted for in our interpretations and analyses. (2005:7).

Clarke's epistemological emphasis moves away from the initial appeals to positivism, a flat denial of the assumption that "what is to count as knowledge must be based on what an observer can perceive by his or her senses. This perception must be 'pure experience' with an empty consciousness" (Blakie 2007:110). In Clarke's epistemological stance, observers of phenomena cannot separate themselves from what they study – true to the symbolic interactionist stance of this project and Clarke's insistence of symbolic interactionism and grounded theory as a theory/method package (2005:2-5). This does not run counter to the existence of an obdurate reality; although objects are able to 'talk back' to the observer in ways that can resist meanings and expectations of the observer, these objects are still observed and defined through an interpretive framework. An observation of a phenomenon is an encounter to which we bring our individual contexts and interpretations. Symbolic interactionism not only characterizes the nature of social experience, but also informs epistemological claims: researchers and research acts are included in the symbolic interactionist framework.

Glaser and Strauss (1967) acknowledge that the researcher "does not approach reality as a *tabula rasa*... he must have a perspective that will help him see relevant and abstract significant categories from his scrutiny of the data" (3). However, as per the title of their book, Glaser and Strauss emphasize that theory is 'discovered' from the data, rather than constructed by researchers who are conducting the research act. This emphasis aligns with the original goal of

Glaser and Strauss to offer a qualitative route to theory generation which mimics the positivist values of the scientific community. By emphasizing the 'discovery' of theory from the data, the position of 'objective researcher,' can be inferred. The inference of an objective researcher is problematic under a symbolic interactionist paradigm that includes the research act.

Kathy Charmaz addresses this problem in her work, *Constructing Grounded Theory: 2nd Edition* (2014)[6], which I have used as the methodological guideline for this project. Charmaz, like Clarke, identifies a theory/method package, saying that "symbolic interactionism offers grounded theorists an open-ended theoretical perspective that can inform grounded theory studies" (277). Charmaz explains that she "chose the term 'constructivist' to acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data and to signal the differences between [her] approach and conventional social constructionism of the 1980s and early 1990s" which tended to align themselves with ideas of socially constructed phenomena as analysed by 'objective' researchers (14). Further to this differentiation, Charmaz writes that "research acts are not given; they are constructed. Viewing the research as constructed rather than discovered fosters researchers' reflexivity about their actions and decisions" (13).

This implication of the researcher is important when it comes to a very basic step in the research process: literature review. Charmaz identifies literature review as a contested part of grounded theory method, and with good reason: Glaser and Strauss, the originators of the method, "advocate delaying the literature review until after completing the analysis [because] they do not want you to see your data through the lens of earlier ideas," and encourage the researcher to let the data speak for itself (Charmaz 2014:306). Many researchers have identified

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[6] Which builds upon the 1st edition, published in 2006.

this delay as problematic. Charmaz summarizes this view: “grounded theorists increasingly recognize that a lack of familiarity with relevant literatures is unlikely and untenable” (306). This protest directly reflects Charmaz’s earlier assertion of the researcher’s undeniable presence and participation in the construction of knowledge and research. *Constructing Grounded Theory* is replete with instruction aimed at cultivating self-awareness and reflexivity throughout the research process. Charmaz encourages the researcher to remain aware of, and to interact with, the contexts which they bring to the research, inclusive of prior knowledge and experiences.

METHOD

Interviews

I chose to conduct a series of exploratory interviews in order to better understand the lived experiences of Canadian Armed Forces veterans with PTSD. These semi-structured interviews focussed on answering the following research questions: for the Canadian Armed Forces veteran with PTSD,

- How did PTSD develop in their minds, and from their perspective?
- What meanings do they place on PTSD?
- How has their understanding of PTSD been shaped by others?
- How do they endeavour to deal with their PTSD?
- What has their experience of having PTSD been like, over their lifetime?

Based on these questions, I formulated a list of open-ended questions that would facilitate interviews with participants, which can be found in Appendix A. While I was devising these questions, I subjected them to reflective questioning (Charmaz 2014:64-65) in order to improve clarity, open-endedness, and to help safeguard against potential research assumptions that I may not have initially been aware of. Although much of the existing non-Canada research focuses on spousal relationships, I arranged the interview schedule so that intimate partner and spousal relationships were only one of many potential prompts. I did this in order to minimize leading the interview towards these areas, which would have ensured that these relationships arose as a theme, defeating the grounded theory aims of the study.

Situating the Researcher

In accordance with constructivist grounded theory, it is important to situate the researcher in the context of the project, since they are involved in the creation of knowledge, which follows the same process of negotiation and recreation through social interaction as does the phenomenon being studied. In order to carry out this study, and in the interest of transparency, I have acknowledge my own position as an outsider to this population, being neither a veteran nor having PTSD. While I am well informed on the subject, it will never be the same as the actual lived experience, and therefore I acknowledge veterans as experts in their own experiences, beliefs and values.

My social location, as the child of two Canadian Armed Forces veterans, one with PTSD, has provided me with exposure to this community. This exposure also created assumptions about veteran perspectives that I had to consciously acknowledge in order to approach the perspective of the population I was studying with an open mind, as well as a clear understanding of my own biases. To facilitate this personal acknowledgement, I consulted with other academics regarding the neutrality of the questions I had designed for my interviews, changing questions where it was deemed appropriate.

As I progressed through interviews, it became clear that the question-guide would become of questionable use: although I had subjected my own guide to reflective questioning, it became clear that I had been assuming a sort of linear pattern of discovery of PTSD, followed by a later disclosure of the condition to other people. These expectations often led to awkward, but humorous, moments during the interview. I viewed these moments as a boon: all participants whose stories differed from my initial assumptions were eager to explain their often unique experiences in depth.

Throughout the process, I created memos which not only facilitated analysis, but explored my own assumptions and any hand I might have had in leading interviews. By constantly reviewing and questioning my methods, I helped safeguard the data from my own forced assumptions. To this end, and to give credence to this claim, I am willing to admit (with some academic embarrassment) that I was forced to set aside a section of one of my early interviews that had been unduly swayed. To be specific, June had told me that after a traumatic experience, when her military superior had asked if she was okay, she had said 'yes,' even though she was not. I believe now that she was trying to tell me that she was still too shocked by the experience to really process it, but owing to the analysis of previous interviews, I began asserting that the silence may have been brought on by a military-trained reflex to 'suck it up and move on' that Teddy and William had alluded to. By forcing my own assumptions onto June's story, I effectively contaminated the data. Owing to the fact that data transcription and analysis happened during the accumulation of interviews for this study, I was able to spot my error, and worked harder to foster self-awareness during future interviews.

Protection of Participants

This research was conducted following approval from Lakehead University's Ethics Review Board. Due to the sensitive nature of the topic and the potential vulnerability, this study underwent a rigorous vetting process by the Board. All participants read the study's formal

Cover Letter (Appendix B) and Consent Form (Appendix C), the latter of which included the ability to opt out of the study at any point before or during the interview, and to opt out of audio-recording – an option which was taken up once. To help preserve anonymity, participants names have been changed and some direct quotes have had specific names and locations redacted.

At the beginning of each interview, I reiterated the clauses in the Consent Form which outlined the ability to decline answering any questions, to stop the interview at any time, or to opt out of the interview at any time. I also reminded the participants that I do not have training in counselling, and urged them to contact services outlined in the Cover Letter should they feel distressed following the interview. At any point during the interview where a participant began to broach the topic of traumas they had experienced, I reminded them that they did not have to talk about the traumas in particular, since this study was about experiences following those traumas, and not the traumas themselves. Despite this, many (but not all) of the participants decided to disclose the details of at least some of their traumatic experiences in order to contextualize their stories. The Cover Letter encouraged participants to ask about the research should they have any further questions, and I closed each interview by asking the participants if they had any questions about the research, in order to facilitate transparency in the study.

Participants' Expectations and Assumptions

During the interviews, it became clear that some participants brought with them certain assumptions of what I was doing, and the sort of information that I would be looking for. Even though I gave information sheets and an explanation of the purpose of the project – to talk about the development and day-to-day experience of their OSI through a social and interactive lens – some of the participants felt it was important to outline the exact traumatic incidents that contribute to their OSIs. Other participants would only answer the questions I asked, without volunteering those situation(s) that may have contributed to the formation of their OSI. I often re-iterated during interviews, when I sensed we were getting close to that subject, that participants should not feel obligated to explain traumatic incidents.

Finding Participants

Finding research participants is tricky for this particular population, since the condition of having PTSD is considered medical information, which is generally kept private. Originally I had hoped to contact participants through an organization specific to Canadian Armed Forces veterans with PTSD, associated with Veterans Affairs Canada; however, leaders of the organization declined to participate in *any* studies at the time of research. Therefore, I turned to a backup plan of snowball sampling through a personal contact – a person I know who is a veteran with PTSD who I did not interview. He forwarded the study information (the Cover Letter and Consent Form) as well as my Contact Information (Appendix D) to individuals he knew who fit the simple criteria of being a Canadian Armed Forces veteran with PTSD. I do not know how many people were contacted, as that information was kept private from me. Based on the information that was forwarded, those individuals decided whether or not they wanted to contact me to learn more about the research and/or to indicate that they would be willing to participate in an interview.

I intentionally cast the net wide with regards to criteria for participation in this study; this was partly due to the difficulties in contacting this population. Between those veterans who are at the stage in the process where they might not recognize the existence of a problem, and those veterans who are aware of a problem but unwilling to admit it (or unwilling to disclose to other people), it seems likely that there is a large section of this population that will be cut off from potential examination and exploration. Due to the hidden nature of this population, I did not want to add criteria constraints that would potentially close off access to any part of the veteran population who was willing to speak to me. I also left my criteria intentionally inclusive to account for the fact that veterans come in all forms, recent and past, young and old, from different branches of the Canadian Armed Forces and with different contributing factors to their current condition. If there are patterns to be found among Canadian Armed Forces veterans with PTSD, they should – and did – transcend these variations.

Seven people contacted me about the study, and six chose to participate. Participants ranged from 42 to 55 years of age, having joined the Canadian Armed Forces at between 17 to 35 years of age. The duration of time served in the military ranged from 6 to 26 years. Three of the participants served with the Military Police branch of the military, and three served with the Army branch, one of whom later served with the Air Force branch. Five of the six participants were male, and all six participants had been diagnosed with PTSD (some with comorbidities such as anxiety and depression).

Data Collection

I conducted semi-structured interviews with six Canadian Armed Forces veterans with PTSD. Five of those interviews were audio-recorded, while I took brief notes. One of the interviews was not audio-recorded and I took extensive notes, which I used to help write a fuller account of the interview shortly after conducting it. Recording the interviews allowed my subjects to be more free-flowing in their narratives, with occasional questions and prompts from me, the interviewer. Audio-recording also allowed me to capture vocal nuances, such as sympathetic sounds and moments of heated speech, that might have otherwise been overlooked or forgotten. I organized my thoughts more quickly when I was not as focused on recording specifics and writing what the participant said. I am a little skeptical about the non-recorded interview. While it was informative, every time I started writing quickly, the participant tended to elaborate more on the topic at hand. If it looked as though I was particularly interested in something, more would be said about it. I am concerned that this participant was responding more to recording-prompts than conversational prompts, and in future interviews along this line, I will be more inclined to use my own post-interview accounts to recall interview details.

Analysis

Analysis began as soon as the first interview ended. Immediately after the participant and I had parted company, I took a moment to write down my thoughts, feelings and observations on the interview. These recordings, which took place after each interview, involved my assessment of how the interview went, my thoughts on how the participant felt about the interview, reflections on parts of the interview that were particularly resonant and on parts of the interview that felt awkward or uncomfortable. By recording my immediate thoughts, I aimed to preserve those parts of the interview that could not be captured by audio-recordings, including visual cues such as body language, and accounts of the physical settings in which interviews took place. I used these written accounts to supplement memory during transcription: as I transcribed interviews I attempted to capture non-language sounds such as murmurs of assent or sympathy in order to better represent the tones of conversation. In some transcriptions, I included (in side-notes), memories of gestures or particularly memorable facial expressions[7]. Including these sorts of non-linguistic or non-vocalized gestures and cues allowed a better recollection of the specifics of the conversation, and the contexts in which participants were speaking.

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[7] For example, while explaining the ignorance of a third party, a participant opens and closes their mouth and waves their hand without saying anything, in order to indicate apparent exasperation.

Interview transcriptions and audio were imported into a qualitative data analysis program, Nvivo9, for coding. Coding began immediately after the first interview, as part of a process of constant comparison between earlier and later interviews. I coded in accordance with the guidelines provided in *Constructing Grounded Theory*, wherein Charmaz writes:

> The logic of grounded theory coding differs from quantitative logic, which applies *preconceived* categories or codes to the data…in contrast… grounded theorists *create* codes by defining what we see in the data. Codes emerge as you scrutinize your data and define meanings within it. Through this active coding, you can interact with your data again and again and ask many different questions of them. As a result, coding may take you into unforeseen areas and new research questions (2014:114).

Given the exploratory nature of the study, as well as the fact that little to no social research has been done on the experiences of Canadian Armed Forces veterans with PTSD, these codes that were constructed from the data were particularly valuable. This coding was done largely with gerunds (when possible), to preserve participants' actions and engagement with their experiences. Charmaz, referencing Glaser, writes that "we gain a strong sense of action and sequence with gerunds. [Nouns] turn these actions into topics" (2014:120). Charmaz argues that using gerunds and coding close to the data help the researcher to analyze the perspectives of participants more closely: "That is the point," she writes, "If you ignore, gloss over, or leap beyond participants' meanings and actions, your grounded theory will likely reflect an outsider's, rather than an insider's view" (2014:121).

My initial coding generated hundreds of codes. I organized and reorganized these codes frequently, shuffling information and scanning for repetition, patterns, and promising categories; during this process, I generated memos. The most promising of these memos concerned the emergence of barriers as an important category – participants talked about perceiving stigma and leaving barriers behind. Organizing my codes along general barriers across the process appeared lucrative. At this point, I filed away all of my previous codes and tackled my interview transcripts afresh, doing a more focused coding around experiences of encountering barriers. Codes such as “reinforcing personal barriers” and “navigating help-seeking barriers” began to surface. Memo creation during this part of the process involved “prewriting exercises” outlined by Charmaz, specifically that of ‘clustering’:

> As Gabriele Rico (1983) explains, clustering gives you a non-linear, visual, and flexible technique to understand and organize your material … because it offers a diagram of relationships, clustering shares some similarities with conceptual or situational mapping in grounded theory (see Clarke, 2003, 2005; Clarke & Friese, 2007; Soulliere, Britt & Maines, 2001). (Charmaz 2014:184)

These ‘clustering’ exercises generated visual diagrams early in my analysis. With some processing, these diagrams proved to have strong explanatory power, given the complex nature of the process being examined – it is for this reason that several diagrams of the process of navigating barriers feature in my analysis and discussion.

‘Encountering barriers’ was recognizable as an emergent category midway through the interviewing for this project. An important aspect of grounded theory is *theoretical sampling* – in this case, sampling until the saturation of the emergent category, ‘encountering barriers.’ As Charmaz states, “theoretical sampling involves starting with data, constructing tentative ideas about the data, and then examining these ideas through further empirical inquiry” (2014:199). It was after the fourth interview that the memo on barriers was penned, and the subsequent re-analysis began. I continued interviewing, testing if this concept of barriers had any merit with other veterans, and found that it continued to be relevant with these new participants. The result is the overall analysis that I have laid out in Chapter Four.

STUDY LIMITATIONS AND BENEFITS

There are a few limitations to this study that are important to note. As pointed out by Paré (2011), “there are no procedures in place to monitor service personnel released from the CF

[Canadian Forces], except for VAC clients" (8). Given that PTSD is a health issue, information about individuals with PTSD is more likely to be kept confidential.

This study is limited in its sample size, which under the purview of other methodologies, detracts from its generalizability. A larger study might capture categories that were missed in this project, such as veterans under the age of 40 and over the age of 60 and those who served with the naval branch of the Canadian Armed Forces. Additionally, further research involving more veterans who are women would provide insight into the similarities and differences in gendered experiences of PTSD. However, given the goal of grounded theory methodology, the sample size suits the purpose, which "[aims] data-gathering toward explicit development of *theoretical* categories derived from analyses of [the researcher's] studied worlds" (Charmaz 2014:199). While the sample represented in this study is minute compared to the population size, exploring, explaining, and perhaps most importantly, theorizing about the experiences of Canadian Armed Forces veterans with PTSD and other OSIs is an important step forward for sociological research. As such, this research aids in defining areas that could be pursued and sets a precedent as a pilot study for similar research on a larger, more inclusive scale. Potential avenues of research arising from this study are explored in *Chapter Five: Discussion and Conclusion.*

CHAPTER FOUR: ANALYSIS

Canadian Armed Forces veterans experience PTSD as complex set of processes. From the time the individual undergoes exposure to traumatic experiences, they become involved in a chain of actions and potential actions (which I have outlined in *Figure 1*). The early stages in the process involve detection and acknowledgement of a problem; participants in this research demonstrate that these stages do not usually occur simultaneously, with several participants having their PTSD (or the potential for it) go undetected while they are still in the military. After acknowledging a problem, veterans make the decision about whether or not to tell people about their problems. These people include members of the veteran's individual social network ('Others'), who can act as informal supports to the veteran, but whose reactions can also serve to reinforce the barriers to disclosure as perceived by the veteran. Medical professionals (who are included as agents of formal support) have been separated from the 'Others' of the veteran's social network for the purpose of this study, since veterans accord different considerations to medical professionals when they make decisions about disclosure (which is explained in more depth in Part IV of this Chapter). During the other parts of the process, there are various stages which can connect the veteran to agents of formal support. Aspects of formal support include the Canadian Armed Forces, the aforementioned medical

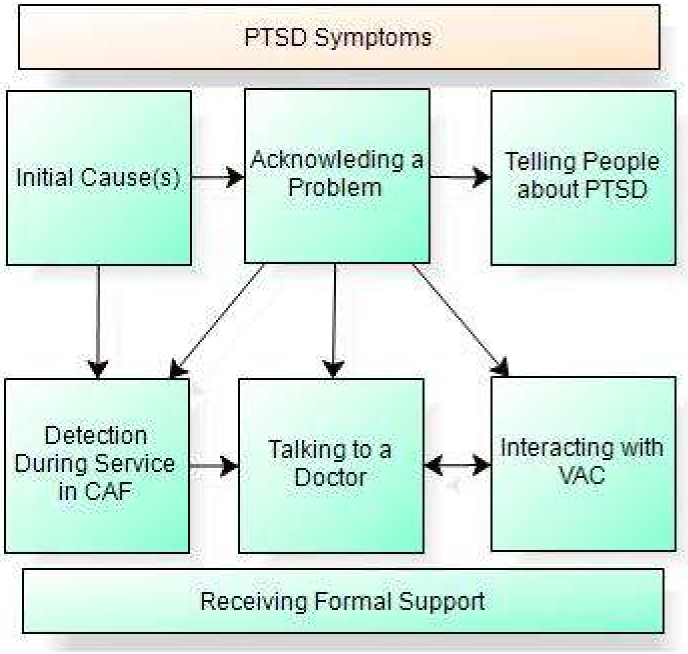

Figure 1: The Social Process of PTSD

professionals, and Veterans Affairs Canada. The process is suffused with PTSD symptoms, which interact with and affect all parts of the process.

Throughout the process there is evidence of the influence and reinforcement of social barriers – forces that the participants react to, which cause many of them to slow or stop movement between stages of the process. There is also evidence of navigational aids and techniques that help veterans to traverse the barriers that manifest throughout the process.

In order to more thoroughly examine these processes, I have divided the analysis into four sections: (1) PTSD as a barrier; (2) barriers to personal acknowledgement; (3) barriers to telling others; and (4) barriers to receiving formal support. Despite this academic division, it is important to remember that these processes are complex and integrated; I reintegrate these processes in the Discussion section of Chapter Five.

I. PTSD AS A BARRIER

The nature of PTSD is insidious: it suffuses all steps in the experiential process because it is inseparable from the thought processes (or internal dialogue) of the veteran as they navigate their experiences. Each veteran brings their unique context to the process; part of this context is an array of symptoms which affect their mental and physical person. These symptoms can serve as barriers to communication between the veteran and others, and can affect internal dialogue of the veteran themselves. June, for example, frequently felt that she was disorganized and scattered during our interview. During one of these moments, she said, “I know I’m getting off track, but…this is how I live.” Veterans that I interviewed did not compartmentalise their injuries – there was no separating of themselves from the injury (no mind-body dualism) because their injuries are primarily in the mind. Symptoms can act as obstacles throughout the overall process of having PTSD, from personally acknowledging the condition, to decisions (or outbursts) involving disclosure of the condition to others, to being able to access various avenues of formal support.

Participants in this research identified a number of symptoms of PTSD and symptoms linked to PTSD which caused problems in their day-to-day living. These symptoms included: mental health comorbidities such as anxiety and depression; extreme mood swings, usually involving anger; disrupted sleep; and an overall decline in physical health. Although their symptoms of PTSD seemed clear in retrospect, several participants had initially failed to recognize that there were problems. There are several reasons for this, which will be expanded upon in Part II of this chapter. Whether participants acknowledged their problems or not, issues manifested in day-to-day living which, for all participants in this research, involved cohabiting with immediate family members. Symptoms of PTSD ultimately led to various issues for these veterans, including disrupted relationships (intimate partner and family), issues with work, and encounters with police. Since these symptoms and problems suffuse the process, it seemed prudent to address these experiences in more depth. This will grant us a better understanding of the context that veterans find themselves in when encountering, reacting to, and navigating barriers.

Symptoms

Mental health comorbidities. Most participants identified mental health comorbidities such as anxiety and depression, which affected their motivation in day-to-day functioning. This is consistent with the DSM-5, which notes that "individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depressive, bipolar, anxiety or substance use disorders" (DSM-5 2013:280). For June and Paul, heightened anxiety resulted in the avoidance of anxiety-inducing situations. June describes an avoidance of spontaneous behaviour, which causes her to feel panicked and out-of-sorts. She also avoids wearing skirts and walking outside at night, which she relates to the threat of sexual violation, which is in turn associated with some of her initial traumas. Paul's avoidance-behaviour is similarly motivated by his past exposure to traumatic experiences in child-abuse investigations, which he conducted as a regular part of his duties in the Canadian Armed Forces. Paul found himself avoiding any situation that might put him into direct interaction with children, due to his automatic associations of children and abuse, and the memories of the investigations that these situations would invoke. Anxiety-inducing situations become barriers in the lives of these veterans, which can cause disruptions in both the processes involved in having PTSD and day-to-day living.

Teddy, June and Mark all identified issues of motivation. Teddy describes a kind of lethargy, saying "I guess some days you just don't feel like doing anything, so I guess if you want to call that depression or whatever." Mark says that the OSI "saps his motivation," identifying it as his primary problem. June mentions an internal struggle just to force herself to leave her house during the day. A depleted sense of motivation can become a barrier when veterans cannot bring themselves to act on situations, and can become particularly troublesome when these veterans try to seek formal support. This will be discussed further in Part IV of this chapter.

Extreme mood swings. Male participants spoke about extreme mood swings, often (but not always) relating to sudden outbursts of anger. When comparing to his life before acquiring PTSD, William says that he had "never been angry. And [now] I'm so angry." William describes being set off in seconds by "the littlest things." Teddy told me about being caught off guard by his boss and "letting loose" at him in an angry burst. Mark explains how his explosive anger at work caused him to lash out and physically kick things around. These outbursts are consistent with PTSD symptoms of “irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects” (DSM-5 2013:272). Anger is difficult for these participants to control, which can create barriers between veterans, their work, and their families.

Disrupted sleep. All of the participants in this study mentioned consistent sleep disruptions. Participants experience regular nightmares that they link to their traumatic experiences, consistent with the symptom description of “recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)” (DSM-5 2013:272). Paul talks about these nightmares being accompanied by talking in his sleep, “shouting, and sometimes punching, and stuff going on,” of which he was told about by both his ex-wife and current partner. Mark talks about only getting ‘soldier sleep,’ meaning 2-3 hours a night. June and Teddy describe situations of panic when their spouses tried to wake them up from sleep; Teddy recalls grabbing and almost breaking his wife’s arm in the moments before he was fully awake. Mark alludes to a similar reaction when he told me that his family would not dare to do something like waking him up – that it would be a very bad thing. Aside from the negative impacts that this sleep disruption has on sleeping partners, the regular disruption in sleep can result in insufficient rest for the veteran, which could affect their daily functioning.

Decline in physical health. While there has been some research indicating a relationship between PTSD and physical health issues, the actual nature of this same relationship remains obscure at the time of this study. (Qureshi et al. 2009; Nillni et al. 2014; U.S. Department of Veterans Affairs 2014). El-Gabalawy et al. (2015) provide research on a Canadian population of veterans, finding that their “results are consistent with preliminary research demonstrating that

US Veterans with anxiety disorders, particularly PTSD, have elevated rates of cardiovascular disease, gastrointestinal conditions, autoimmune diseases, poor lung functioning, and pain" (42). The link is clear, although the nature of the relationship continues to be hazy. Participants in this study characterize these declines in health as symptoms of their PTSD. I have included *Decline in Physical Health* as a (generalized) symptom because not only is there still room to prove, disprove, or further explain a potential connection in a research setting, but also because, for these veterans, physical health issues were tied up with what it meant to have PTSD. As Teddy told me:

> TEDDY: I don't want to go off track here, but the other thing that people have to realize with PTSD, okay fine, we have it, but there but there's other impacts on your health. So my case, there's the diabetes, which is an impact of PTSD, and then there's the sleep apnea, but with the diabetes also comes cataracts… joint pain, you know all kinds of stuff and I'm, as far as meds, I take 12 different pills every day. I never used to, before I retired, I never used to take anything!

William and Mark both mention 'snowballing' health issues. William is jointly dealing with PTSD and back problems; Mark also has chronic back pain, as well as neuropathy in some limbs. Physical problems and pain – regardless of causation – can create motivational barriers, causing the veteran to delay action and decisions until the problems and/or pains recede.

Issues Attributed to PTSD

Disrupted relationships. Several participants indicated that their spousal or intimate partner relationships had suffered in the wake of their PTSD. Teddy and Paul both attribute experiences with trauma as the cause of their divorces. William talks about fighting between him and his wife, saying, "What I'm learning right now is that because of my post-traumatic stress, I've caused problems within my marriage, is now caused possible trauma to, second-hand trauma to my wife, and she's got her guard up." Participants all talk about tensions, major or minor, in their current spousal or intimate partner relationships, which they relate back to the condition of having PTSD. Effects on spousal and intimate partner relationships were identified in *Chapter Two* as an area of focus in non-Canadian research; this research highlights inter-partner tensions, as well as situations of partner abuse. While participants spoke of tensions, only one spoke of abuse, which had actually been perpetrated *against* the participant by a former spouse who had also been diagnosed with PTSD. The relationship between PTSD and partner abuse, however, was not thematic in this study.

Participants' reports of relationship tension are consistent with the reports of tension in PTSD afflicted relationships that are found in current literature. I noted that two veterans (William and Mark) specifically indicated that their partners made efforts to increase their family and home related responsibilities (children, finances), in an effort to relieve stress on the veteran. William and Mark both indicated that these increases in responsibility, coupled with a decrease in disclosure about the status of these responsibilities (for example, not sharing instances of children misbehaving and being punished) actually caused them further relationship tension, despite the good intentions of the significant other. Despite these tensions, all participants described their current spouse or intimate partner as either integral, or making vast efforts, towards supporting participants in their struggles.

Participants also talked about disruptions in parent-child relationships, especially regarding those participants with young children. There was some estrangement among teenaged children, but especially apparent was the damage that male participants believed had been done to their relationships with their young children (under 10 years of age). William and Fred told me that their children were afraid of them, and how angry they could become. When I asked Mark about how he spoke to his children about his injury, he told me that he talked to them and gave them literature to go over, but also that "he is aware that he is very scary looking when he gets angry and yelling, and that even while he would never strike a woman or child in violence, he knows that he has scared his children in his rages." I noted that it upset these veterans particularly to know that the manifestations of their PTSD had served to alienate their children.

Issues with work. All but one of the veterans that I spoke to had either retired or were on disability benefits of some kind. From the information I gathered, it seemed that most of them would rather still be working, but that their PTSD had become too obtrusive to continue to do so. William and Teddy had both reached a 'tipping point' at work that made their PTSD unmanageable (I discuss this further in *II: Barriers to Acknowledgement*). June mentions that it bothers her that she is unable to work, and extends the idea of work into her home-life, where she sometimes finds chores too stressful to tackle. Fred recounted his troubles while he was still in the military:

> FRED: … Eight months later the army thought I had a drinking problem, so they sent me on an AA courses that, we call it a spin-dry in the army. I had a lot of trouble with the military, right? Going to jail, a lot of charges, so from [19-- to 20--] I had 34 charges in the military. Everything from fighting, to AWOL,[8] to drunkenness while on duty, all that kind of stuff, right?

Paul talks about being unable to continue to work in a field that utilises his skills in investigation because they invoke too many painful memories and emotions. In this sense, PTSD symptoms can become powerful barriers that close the veteran off from the world of employment.

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[8] "Absent Without Leave" or "Absent Without Official Leave."

Summary

PTSD, as an injury of the mind, is sometimes an obstacle in itself. Symptoms that affect modes of thinking can become problematic, as the 'personal acknowledgement' stage of the process takes place within the mind of the participant. Furthermore, the physical and mental health symptoms of PTSD can affect motivation – a decrease in motivation can inhibit the veteran from moving forward with various steps in the process which require commitment, such as seeking and maintaining formal supports. Symptoms such as increased anxiety and decreased motivation, as well as the personal issues and frustrations that participants have identified, can add to the context that veterans bring to each situation and/or barrier they encounter and navigate. I ask the reader to keep this context in mind as I move into the next section of analysis.

II. BARRIERS TO PERSONAL ACKNOWLEDGEMENT

There is a point where PTSD develops through exposure to trauma(s), and a point where the veteran personally acknowledges the existence of a problem[9]. Personal acknowledgement is identified in this study as a process separate from that of social disclosure; when and if the veteran personally acknowledges a problem happens in a separate context from social disclosures. Disclosure of the problem involves interacting with other people. Personal acknowledgement, on the other hand, involves a process of internal interactions with oneself (see *Figure 2*, on the following page). This interaction occurs when the individual reflects upon the self, in the words of Mead, as an object (1934) and decides that there is something amiss. In the absence or refusal of this reflection, there can be no acknowledgement.

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[9] The "point" of exposure to trauma may be nebulous, since repeated traumas and exposures can contribute to the development of PTSD. The reasoning stands that PTSD is acquired prior to the individual being able to acknowledge that they have the condition.

Participants in this study identified several barriers to this kind of reflection and subsequent acknowledgement, which included a lack of understanding, the dismissal of the problem(s) by others, fear of losing a job, and fear of stigma. There were several different reactions that were identified in relation to these barriers, all of which effectively delayed acknowledgement of these problems. If the veteran engaged in any of these delaying reactions, they were much more likely to reach a tipping point where problems could no longer be delayed or managed in isolation. These tipping points (such as angry outbursts which disrupted their work) forced veterans to acknowledge the existence of a problem. Reaching a 'tipping point,' seeing PTSD affect others, and being reached out to by other veterans with PTSD all served as navigational aids for traversing barriers to acknowledgement.

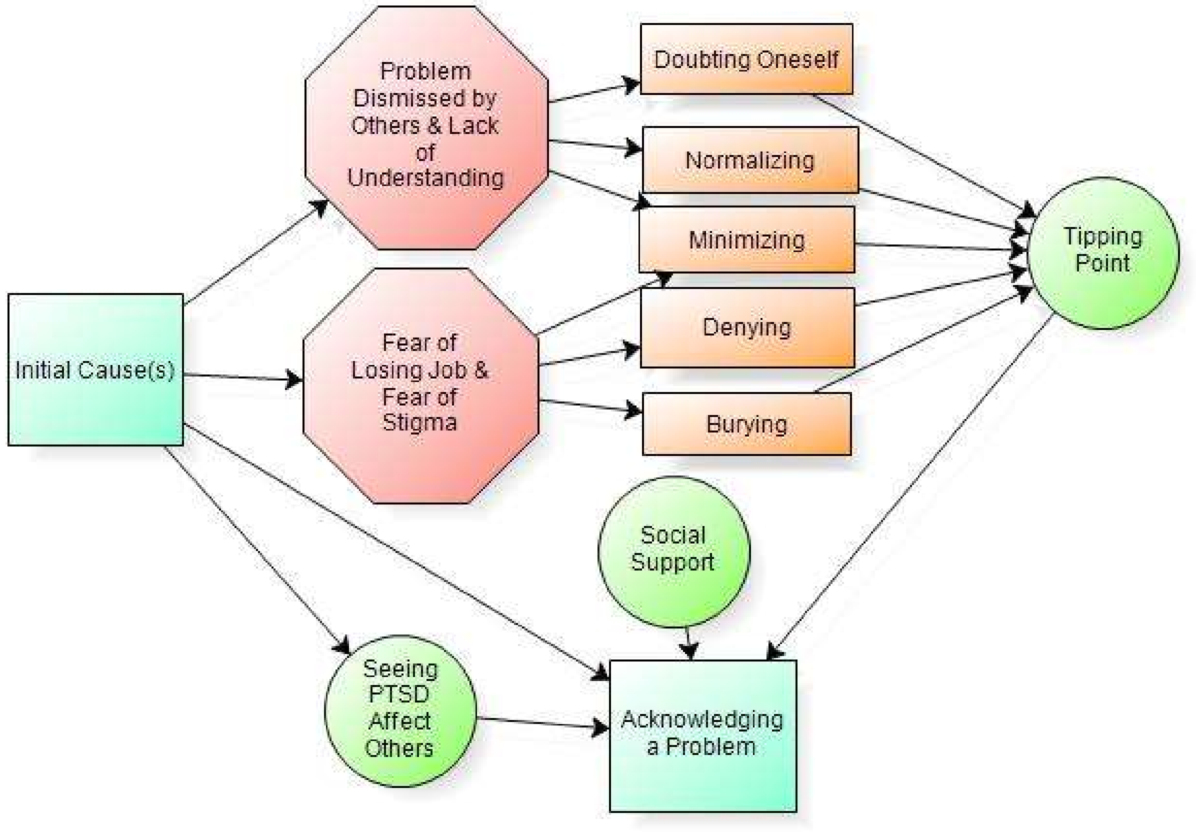

Figure 2: The Process of Personal Acknowledgement

Lack of Understanding on the Part of the Veteran

As participants became aware of problems in their lives, many did not connect their problems immediately as symptoms of PTSD. Lack of understanding led to veterans who suspected an issue of doubting themselves. A few participants questioned the veracity of their feelings. Teddy wondered if he was even really having problems, saying, “I thought oh, maybe you’re just making this up or it’s not really happening or whatever … like maybe you’re not looking at this the right way or whatever.” Paul’s doubt stemmed from a different source, since he did not think PTSD related to him:

> PAUL: When it first came out, and when I first learned about it, I think [sic] it was more to do with people coming back from warzones, right? Combat areas and stuff. Which I’ve never been to. So, you know my PTSD is more related to law enforcement than it is related with uh, wartime, right?

Although stemming from different sources, Teddy and Paul both bring up sources of doubt, one stemming from uncertainty of self, and the other, from uncertainty in knowledge. Self-doubt becomes part of an inner dialogue, where the participant notices their problems and questions them, and then compares their problems to preconceptions of what it means to have a mental health issue, or what kinds of people are able (or allowed) have those mental health issues. At the time Teddy and Paul were struggling with self-doubt, they delayed talking about their problems or personally acknowledging them, waiting to see how these same problems would pan out. Their lack of knowledge and uncertainty of knowledge acted as a barrier to acknowledging that they might be suffering from PTSD.

Dismissal of the Problem by Others

Some participants recognized that there might be an issue, and reached out to other people in different ways. Having their problems dismissed by others contributed to the veterans withdrawing from communicating further, normalizing their issues:

> WILLIAM: I did kind of reach out a couple times, but I didn't get the response I was kind of looking for, and kind of, when everyone got back, and their minds and everything else were elsewhere, right?
>
> JUNE: I knew one person but he was like, busy with his own stuff and he was like…it's like he really, doesn't want to hear about my problems.
>
> PAUL: I think I may have mentioned it when I left the military, 'cause you have to do a medical when you leave. And they were talking about mental health issues and stuff like that. And I think I may have mentioned it, but I can't remember for sure.

Although Paul is uncertain about whether he mentioned it in his medical evaluation, he indicated that he would not be surprised if he had said something that did not make it into his file. This doubt about the thoroughness of evaluation was shared by William, who spoke about attempting suicide shortly before his release.

> WILLIAM: I tried to kill myself again, about uh, 20 days before I was being released. And they still released me. They didn't keep me to make sure I was okay or nothing. Oh, there's the door."

These experiences of dismissal, both by acquaintances and doctors, can reinforce the barrier to personal acknowledgement of a problem. If other people appear to dismiss your problem as unimportant, especially those in a position of medical authority, there is a potential for the individual to also dismiss their problems as unimportant. At the very least, a sense of illegitimacy is brought to the individual's internal dialogue concerning their potential problem.

Fear of Losing a Job

A powerful barrier to acknowledgement was the awareness that admitting these problems might cost the veteran their employment, inside or outside of the Canadian Armed Forces. Several participants mentioned the fear of losing employment, which was consistent with the findings in the Ombudsman reports (outlined in Chapter Two). William was in denial at the time when he convinced his doctor to 'downplay' the diagnosis – which he did not agree with – because he worried that he might lose his job. His diagnosis was changed, at that point. Fred talked about watching his friends come forward to ask for help, and finding themselves medically released six months later. It was not just the fear of losing *this particular* job that bothered Fred, but also opportunities for employment elsewhere. Fred explained that "before I joined the military at 20 … [I had] no education. I finished Grade 12, that's all I had. So nothing to fall back on. Military was my life, was my career." Paul was also worried about his employment, in a civilian job:

> PAUL: So even though in a case like this, I felt like I needed help, I also didn't want the stigma attached to it, that, you know, now I can't even carry on and do my job properly because I've got mental health issues or whatever, right? …And then, because there's the financial insecurity that comes along with that, right? If I get labelled as such, I'm never gonna get a job in the industry again, and how am I gonna pay my bills, and now your whole future, it's in limbo, right?

The fear of losing not only your current job, but potentially jeopardizing your chances of future employment, is yet another facet of the internal dialogue that veterans may experience. If a person is aware that admitting a weakness can potentially lead to socially and economically compromising themselves, it will influence their decisions about whether to admit to that weakness. With regard to personal acknowledgement, these problems may be consciously or unconsciously suppressed as the veteran internalises the message that PTSD and other OSIs will not be tolerated in servicepersons in the Canadian Armed Forces.

Fear of Stigma

Usually, the fear of losing a job was accompanied by the fear of the stigma associated with PTSD. The fear of stigma had implications in addition to potential job loss. When William and Fred brought up their previous denial of their problems, I asked if they remembered what they thought of other people who were coming forward with PTSD and other OSIs. Fred told me that he had thought, "They're weak. You know, they're faking it. They're… you know what I mean? I was just as guilty or… as naive and stupid as the rest of them, right?" In this case, stigma is a powerful barrier to personally acknowledging a problem. William told me that he did not want to deal with the stigma. Fred told me he was a military machine. Teddy said, "I guess it's like the old saying in the military, well, just suck it up and get on with things." Paul pointed out that, "PTSD, ten, twenty years ago, oh ten, fifteen years ago, wasn't really an open topic of discussion, right?"

By the time I interviewed Mark it was becoming clear that stigma and the military attitudes were tied together. I asked Mark to elaborate on what the stigma was all about. 'He said that when he was in the military, there were no women. He was in a Regiment with seven hundred men. You didn't talk about it because you didn't want to be labelled an MIR commando. You had to suck it up.'[10] Mark describes a masculine environment where weakness is not tolerated. Stigma can be a powerful barrier to self-acknowledgement. If you are trained up as a military machine, then admitting weakness can undermine that identity.

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[10] I spoke to a contact to clarify: MIR (Medical Inspection Room) commandos were people who were constantly in and out of the MIR. My contact describes how being called an MIR commando was an embarrassing thing; the term was used to imply that you were faking illness, or that you were weak.

Reactions to Barriers

As participants reflected on times in which they did not acknowledge their PTSD, they explained their actions and ways of reasoning about their symptoms several different ways. Participants buried, denied and minimized their problems, rather than acknowledge them personally. Often these reactions led to tipping points where the participant suddenly, dramatically realised that they had been suppressing problems, which they were no longer able to deal with on their own.

Burying. The most common reaction to these barriers to acknowledgement that I noted among my participants is what June described aptly as "happiness in the wrong things," and can be more succinctly denoted as 'burying.' Ignoring and escaping the problem became a recurring story, even if it manifested in different ways. William described his decompression period – a time between being in a Special Duty Area and coming back to Canada – as essentially pointless:

> WILLIAM: We went to Cyprus, and Cyprus[11] is, uh, they give you a bunch of courses, but to be honest with you, they're, they're nothing.
>
> ROBIN: You don't know how helpful they are?
>
> WILLIAM: Because we're already decompressing by way, we really drown ourselves in booze.

William was not the only participant who had turned to alcohol as an escape. The idea that participants could lose themselves in other things, rather than confront their problems, was something that June touched on several times:

> JUNE: I didn't know what it was, and I didn't… I was so busy taking care of [my husband] too through his OSI and depression and alcohol, right? So I just buried everything.
> …
> JUNE: …you can lose yourself too, by doing too much for other people.
> …

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[11] Cyprus is a common location for "Third Location Decompression," which takes place between deployment into a Special Duty Area and returning to Canada (Abercrombie 2014).

> JUNE: We're all lost. We all need something, right? So whether you look for what you need in drugs or alcohol or sex, or…oh God...

June mentions burying herself in order to deal with her husband's issues, highlighting the idea that it is not just vice that veterans may use to avoid dealing with their problems. Mark later reinforced this idea during his interview, saying that during his military career, he was the sort of person who did not drink, and had two jobs at any given time. He compared himself to World War II Veterans, who he said 'dealt with their issues by working too hard'. By burying their problems in response to encountering barriers, veterans delayed acknowledgement of the issue.

Denying. Denying refers to rejecting the possibility of having a problem. There is no room for negotiation when the veteran is denying. In the face of doctors who were trying to tell him that he had PTSD, William repeatedly rebuffed diagnoses: "I told [him], listen, I'm seeing someone already, there's nothing wrong with me, right?" Fred, while not being diagnosed immediately with an issue, staunchly resisted the idea that he had a problem.

> FRED: 'Cause I'll be honest with you, Robin, I was a soldier. I didn't think there was anything wrong with me. I thought it was everybody else that was fucked up. Honestly. Cause I was a soldier, I was an infanteer. You know. In my mind, it's drink and fight. Cause that's what I was trained for, for 20 years, you're kind of like a machine, right? You know, that's what I am. Because that's what I thought I was.

The flat denial of a problem means that the veteran has preconceived definitions of those problems – this could refer to who can get PTSD (which is sometimes simply, "not me"), what PTSD is specifically, and why it occurs. Whatever these preconceived definitions, the veteran places themselves squarely outside of them. Denying also served to delay the acknowledgement of the issue.

Minimizing. Minimizing is actually a reaction that involves the veteran acknowledging, however slightly, that they have a problem, but invalidating it in comparison to others. Teddy's sister reminded him that other people "were in worse shape than him." Paul actively minimized, pointing to his training in Critical Incident Stress Debriefing as a reason: “So, I thought with some of that training, I was under the impression that I was coping with it pretty good.” Digging deeper into this process of minimizing, Paul explains:

> PAUL: Um, I think in my own definition I call it Willful Blindness. Right? I think deep down inside I knew that I should have been reaching out long ago, but I was taught, you know, cause of discussions too on limited resources, and uhm, and people are coming back from Afghanistan and places like that, that I was, said there's, you know, there's a lot more people who need it more than I do. Right? And again, that’s not the right way to look at it, obviously. Especially when you're, to the point where you're getting suicidal and stuff, right? Uhm, so yeah, that's like I said, I call it Willful Blindness. I knew I needed help but I found excuses within my own system to... [be] in denial, right?
>
> ROBIN: Well that's, I think a lot of people tell themselves that, they're like, well if they have it worse than I do, then I'm okay, and, you know.
>
> PAUL: Yeah, or I don't want to burden their resources having their therapist waste their time on me and that type of stuff when there's someone that might need it more than I do.

Paul’s minimizing reinforces a sturdy barrier to personal acknowledgement: in an organization as large as a military, it seems very likely that an individual will be able to find someone who they deem as worse-off than themselves. Devaluing suffering by comparing it to a variety of suffering experienced by others does nothing to address actual problems that are lived with on a day-to-day basis by the veteran.

Navigating Barriers to Acknowledgement

There are a few different ways that participants navigated barriers to acknowledgment of a problem. Some participants only acknowledged that they had a problem when they reached a tipping point, or a defining moment when they realized that their lives were being disrupted in ways that they could no longer manage. William, who had been staunchly denying his problem despite the fact that doctors were trying to convince him otherwise, realized that he had a problem when his work performance started failing. He recognized that his work was being disrupted on a regular basis, in ways that were too blatant to deny. Teddy's tipping point also occurred at work, when, under conditions of extreme personal stress, he yelled at his boss. Mark's tipping point came when, during a severe case of road rage in which he left his car and pulled another driver out of his own vehicle, Mark realized that he was doing all of this in front of his young daughter. It was at this point that he realized that whatever problems he may have been actively denying were no longer affecting only him, but also his family. Reaching a tipping point is a jarring experience, and is less of a navigation than it is careening through the barriers that had kept the veteran from acknowledging their problem.

A gentler way that participants navigated these barriers was through social support; specifically, through others identifying problems for them. Although Fred experienced regular work disruption, he was burying his problem in alcohol and refused to acknowledge the disruptions. It was only when a friend approached him that he acknowledged to himself that anything was going on:

> FRED: He's the one, basically, that saved me. He goes, because we had soldiered together for you know, 10-15 years… he was out by then and working for [redacted], and he said, he said, "Fred, you need to go and get help." … So he says, "I know the signs and symptoms," right?

Fred told me that his wife had mentioned something, but he would not listen to her because he "really didn't give a shit about her."[12] He did, however, take the time to listen when his long-time friend asked him to. The difference, it seemed, between who he would listen to and who he would not listen to, was based on differing levels of trust and relatability. When I mentioned that his friend spoke to him about the problem, Fred corrected me, saying, "We spoke to each other, right? Cause we had the same symptoms, same problems, right?"

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[12] Fred spoke of this marriage in terms that made it clear that it was in the process of dissolving, and stood no chance of being repaired.

Fred was not “told” he had a problem by an outside observer – he and his friend, someone he trusted, compared and related their problems. Paul’s story was similar. A long-time friend, who was in the process of admitting publicly that he had PTSD, called Paul to let him know ‘before he heard it from somebody else.’

> PAUL: I reached out to him and, I said, if there’s anything I can do, if you wanna talk. We had sort of lost touch over the years a little bit too. So we ended up meeting. And… we talked for hours and hours. He stayed at my place for the weekend. And he told me what he was going through and some of the help that was available and stuff like that. And, so, I opened up. I think he was the first person I openly talked to. And told him, you know, some of the, some of the things I was going through. And I think he said something like, “I don’t know if you got PTSD, but” he says, “I think you got something!” And he offered to put me in touch with Veterans Affairs. And I think talking to him was already like, sort of a big relief…

By comparing and relating their cases, Fred and Paul were able to acknowledge their problems in a context where they were not alone in dealing with them. By talking to someone who had already acknowledged their issue, they were talking to someone they felt they could trust, someone who was reaching out through empathy and not accusation. This can make the difference between acknowledging that you have problems and feeling like you *are* a problem. Fred and Paul’s situations indicate that social support is a valuable and effective tool for navigating barriers to the personal acknowledgement of a problem.

Summary

There are several potential barriers that veterans must navigate in the process of personally acknowledging the existence of a problem. A general lack of understanding regarding who can get PTSD and how it manifests, and having problems dismissed by other people can lead to veterans doubting themselves, or normalizing their problems. Fears of job loss and stigma can lead to denial, attempts to bury problems, or a minimizing of problems. Navigational aids in the form of social support, as well as simply observing other individuals dealing with PTSD, can help the veteran to avoid or navigate barriers to acknowledgement. In the event that they have reacted negatively to these barriers, there is a chance that they will reach a tipping point that forces them to acknowledge the existence of an issue.

III. BARRIERS TO TELLING OTHERS

Once an individual acknowledges that a problem exists, the process continues simultaneously along two branches: telling (or not telling) other people about the problem, and seeking formal help. In this section, I will be analysing the process of telling other people about having PTSD. Owing to the fact that doctors are tied up in the systems of formal support, this section purposefully excludes interactions with doctors, who will be discussed in greater depth in Part IV of this chapter. Telling other people involves a process of decision making that is very different from personal acknowledgement. In Part II, I presented the process of coming to accept that there is a problem as slightly complex, but with only one direction: once the problem is acknowledged, veterans move on to the next stages. The process of telling others (*Figure 3* on the following page) is more complex, since there is more than one person (more than the veteran) to convince of the problem. Consequently, as veterans encounter and navigate situations where they want to (or feel they have to) disclose, they constantly evaluate and re-evaluate motivations and decisions about who to tell.

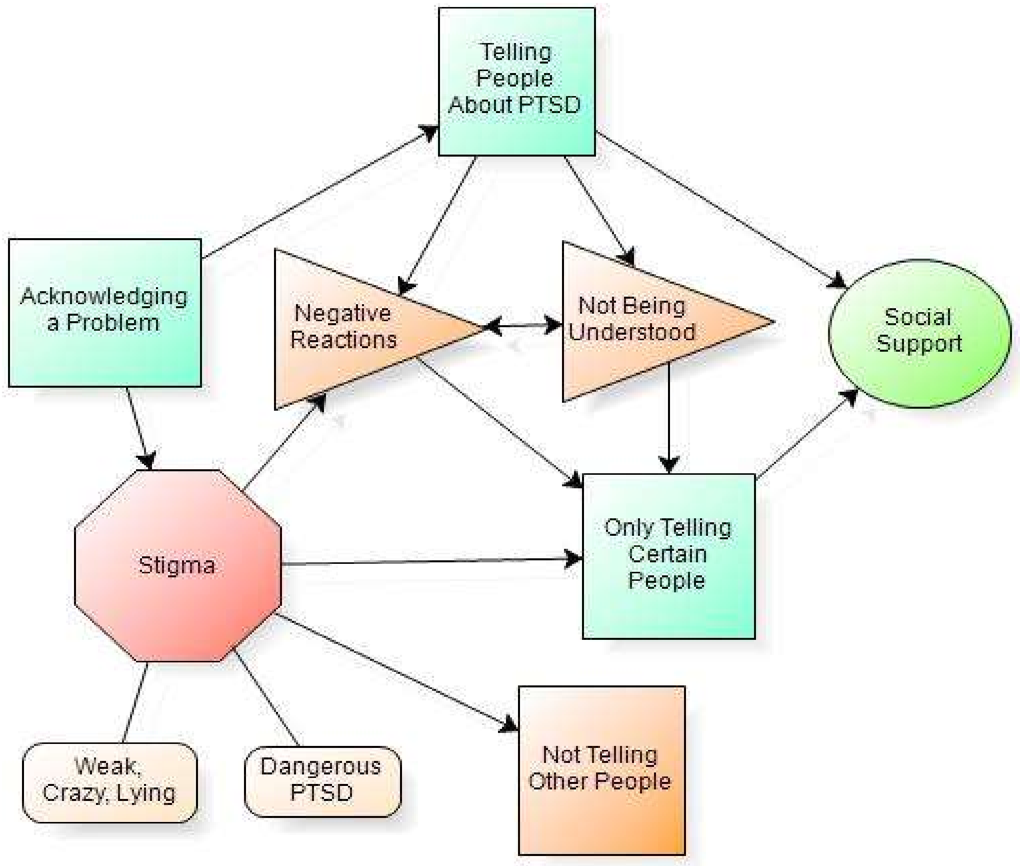

Figure 3: The Process of Telling Others

For participants in this study, the primary barrier to telling other people about having PTSD was the fear of stigma; however, this barrier had the potential to be reinforced by both negative reactions and not being understood, reactions which were sometimes interrelated. Navigational aids when confronting the stigma and reinforcement barrier included a combination of social support and a desire to use the condition of having PTSD as a bridging tool to reach out to other veterans who they suspect have similar problems. The exception to this process is the immediate (usually cohabiting) family, which I mentioned briefly in Part I. I will expand upon this exception to provide more depth, and then move into an explanation of the barriers to telling others and their affiliated navigational aids.

The Immediate Family Exception

Participants in this research were living with immediate family – spouses, intimate partners, and/or children – as their symptoms of PTSD developed. As the participants moved through this process, their immediate families were living alongside problematic manifestations of PTSD. Three participants had marriages that dissolved before the participants' PTSD was recognized. Teddy identifies his traumatic experience as the reason his first marriage 'melted down,' but did not go into further detail. Paul identifies his reluctance to have children due to his traumatic exposure as the reason his wife left him. June was unique among participants, having been married to and divorced from, a serviceperson with PTSD, prior to receiving her own diagnosis of PTSD. June identified physical and emotional abuse as the reason for her marriage's dissolution, but did not explicitly link the abuse to her ex-husband's PTSD.

All of the male participants became aware of their own PTSD while living with a spouse or intimate partner (June, the sole female participant, became aware while living as a single parent). One participant – Fred – became aware of his PTSD as his marriage was dissolving. Fred's now ex-wife had threatened to take his children (at that time, three children under the age of 10) and leave if Fred did not get help, but Fred only began to acknowledge his PTSD later, after speaking with a trusted friend. Fred's marriage is the fourth among the participants that appears to have broken down due (in part) to undiagnosed and unrecognized PTSD.

Four of the participants recognized or were told they had PTSD while they were still in a relationship (which was not in the process of dissolving). These participants spoke of the support from their spouses or intimate partners who learned of the diagnosis with them. This group consisted of Teddy and his second wife, William and his only wife, Paul and his current girlfriend, and Mark and his only wife. Among these participants, family was an exception to negations of barriers to disclosure: participants spoke of disclosure to their spouses or intimate partners as though it were a matter of course.

Participants also disclosed their PTSD to their children, although in varying degrees in accordance with their age (with the exception of Paul, who had no children). Teddy talked about his adult children who lived apart from him: “my kids know, I told them. I made a point of, you know, taking the aside and telling them, just so that they’re in the loop.” Mark told me that he gave his now-adult children literature on PTSD to increase their understanding, although he was unclear about their ages at this point. At younger ages, participants told their children less, because the issue of PTSD is seen as complex and burdensome. Fred described his son (under 10 years old) as very interested in his injury, but does not go into detail with him. June’s children (between 10-18 years old) know about her injury, although she makes a point of mentioning that she cannot tell them everything about it. It was unclear if William had explained any part of his injury to his children (under 10 years old). What is clear among the participants is that children, in addition to spouses and intimate partners, are or will be told about their parent’s PTSD diagnosis. The level of detail varies in accordance with what participants think is appropriate given the age of their children.[13]

Barriers to Telling People about Having PTSD

Fear of stigma. As mentioned in Part II, the fear of stigma can be powerful. Participants spoke in two different ways about stigma, in terms of: military-based views of being weak or being a liar; or civilian-based views of PTSD-afflicted veterans as dangerous. In Part II, I discussed stigma in reference to the negative view that some of the participants held when they

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[13] While it is beyond the scope of this study, it is important to note that research indicates notable differences between the experiences of young children and the experiences of adolescents (see Rosenheck 1986; Kwan-Lafond, Harrison and Albanese 2011; Harrison, Albanese & Berman 2014).

were still employed with the Canadian Armed Forces. Ideas of weakness or 'faking it' were prevalent. Paul's assertion of PTSD 'not being up for discussion', and Teddy's old military saying, 'suck it up and get on with things,' meshed well with these ideas of weakness. If you talked about it, you were weak, couldn't deal with it, or were trying to weasel out of work. This model continued to be espoused when William went to the local news with his story:

> WILLIAM: I went public. Went forward with it. And then I had a lot of backlash on that… they'd say you don't have it, why are you doing this? You're making a mockery of the army, you're making a mockery of what we did, and stuff like that.

Other veterans and servicepersons questioned not only his condition, but his decision to speak on a public platform.

Participants experienced the stigmatic attitudes of civilians differently than attitudes they received from veterans. Teddy describes a time when, in a private meeting, Teddy yelled at his boss. Teddy's boss asked where this rage was coming from, at which point Teddy requested that this meeting be held in confidence. After receiving his boss's assurance, Teddy explained about his PTSD – a week later, he was called in to Human Resources at his work, and was escorted from the premises. When Teddy talked about being let go from his job, he addressed a specific, popular model of PTSD:

> TEDDY: You know they hear all these stories about guys going postal and shooting people and everything else, and they walked me out of the building. … People, you know, they hear a lot of stuff on TV, they see stuff in movies, and … they don't really have an in-depth understanding as to what it is.

Mark commented that "when civilians hear about it, they think Hollywood. They think you're going to go out and start shooting, because that's what the stories and the movies say, but that, he says, is only 2% of the guys out there."

The perception of violent manifestations of PTSD played out in a violent altercation between one participant and police officers. William was headed to the hospital with his wife, seeking emergency psychiatric aid for his anger, when they made the decision to pull over.

> WILLIAM: So she called 911. And the police got there first. She told 911 that, I was a veteran, I had PTSD and needed to get to the hospital, I'm having a difficult time with him.
>
> ROBIN: And they arrested you?
>
> WILLIAM: Well...the police got there first before the ambulance. And then uh, she uh, they told her to drive off, police officer came up to me and I was on my pho - on my phone with my safety plan? Tryin' to calm me down, and they asked me to get off the phone twice, I said no, right? Twice? And then the second time I said "let me record this." Pepper spray came out, and I got beat up. ...and I spent four days in [incarceration – location redacted].

William and his wife were calling emergency services for psychiatric help. What resulted was, in William's view, a criminalization of his condition. William mentions that he is not the only veteran who has experienced this sort of treatment; he recalls a friend who was drunk and resisting police who was 'tased': "he didn't even get charged or nothing like that, but they gave him a good tasin'." Veterans can experience direct incidents of stigmatization and indirect incidents via tales recounted by acquaintances and the media in general; these incidents contribute to the context in which veterans make decisions about who to disclose to.

Reinforcement from negative reactions. Veterans who experience negative reactions from people they disclose to carry those experiences forward in their decisions about whether to tell other people. Teddy's decisions to be guarded about his PTSD was a prime example of this reinforcement: "after I told my boss there once at [work], that's the last I ever told anybody that I had it unless they were a medical person, so like, family doctor or if I go to see a specialist or whatever." When I asked, in reference to the stigma that he faced, if anyone had ever told him that he was faking his illness, Teddy told me that silence was the same as being told you are faking it – it is essentially a denial of your injury by other people. When William tried to reach out to his family for help, he experienced an overt denial of his injury:

> WILLIAM: I tried and talk to my dad or my grandmother and stuff like that. My grandfather served, right? So... he lived in the big city and then moved out to the country, my dad thinks there was nothing wrong with him so…[laughs] four years and, you know, World War II, right?
> ROBIN: So, is he under the impression –
>
> WILLIAM: There's nothing wrong with me. He's still in that denial.

While silence may be caused by lack of understanding, or not knowing what to say, cutting off lines of communication through silence or denial can mean cutting off chances to engender understanding by talking to the afflicted veteran. Feeling cut off from other people and not understood[14] was a common occurrence. Teddy said that, "even when you talk to people who you think should get it like my mother and sister, they don't." June told me that her family is not there for her, and that they do not know or understand what happened to her when she was serving. Mark said that it is important to be able to vent to people who 'get it.' "Military guys get it. Civilians just don't." Mark alludes to the missing factor in civilians that veterans and servicepersons possess: the ability to empathise with the veteran's situation, and to draw on that similar pool of experiential context. Although there were indications throughout the interviews that communication engenders understanding, Mark points out a potential barrier – real or imagined – in the very ability of civilians to understand PTSD from the military context.

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[14] I say 'not understood' rather than 'misunderstood' because the latter has the implication of a mistake that can be corrected, and participants sometimes felt that correction was not possible.

Navigating Barriers to Telling Others

In Part II, I described how barriers to acknowledgement were navigated with the aid of social support. Barriers to telling other people about having PTSD were similarly navigated: the experiences of the veterans I interviewed are replete with examples of PTSD being used as a bridging tool to reach out to other people who are having problems. Sometimes participants were on the receiving end of this outreach; sometimes they were the ones doing reaching out.

When Fred and Paul began to personally acknowledge their PTSD (as described in Part II) it was their friends (who were also veterans with PTSD) who were using their conditions as a point of commonality in order to encourage Fred and Paul to seek help. Fred now works for an organization dedicated to helping other veterans. When Paul retired from his civilian job, he made an announcement about how PTSD was part of the reason he was leaving:

> PAUL: Uh, so from like, one of the big things was finally being able to talk about it, right? Uh, not being afraid of the stigma anymore, right? And since I quit my job at [redacted], since I've started therapy and stuff like that, uh, something like [friend's name redacted], I guess, I've had other people open up to me, and say, do you think I need help? Well, if you're asking, you probably do, right? So, I've had a firefighter and two police officers that have approached me, I, I classify as close friends of mine, and hopefully I can help them, before something drastic happens, right? And that, hopefully they can start living again too.

Half of the participants (three) in this research had made their PTSD very public, in an effort to reach out to other veterans who might still be having troubles acknowledging or disclosing to other people about their PTSD. When William talked about the backlash he received about going public, he said, “I feel alright about it, yeah, it doesn’t matter because I’m getting the help and I’m trying to help others. To realize.” Fred has been invited to speak to children at public schools about the problems of PTSD and other OSIs. He told me that he will talk to anyone about his OSI, and if they go into the conversation with a lack of understanding, he makes sure that they come out of the conversation well-informed.

> FRED: You know, it affects everybody, right across, it doesn't matter if you're rich or if you're the poor sitting on the corner of the street right here, it affects everybody. It doesn't matter how much money you got or whatever, right? So it's not just soldiers, or the rich, or whatever. It affects everybody. Mental health is mental health.

Social support was very important to the research participants. The use of PTSD as a bridging tool for communication was apparent in many different stories. Communication in this sense was used both to increase understanding on the part of veterans about their own conditions, and to increase awareness in civilians who are unclear or misinformed about the specifics of PTSD as it manifests in Canadian Armed Forces veterans.

Summary

The process of veterans telling other people about their PTSD is complex and iterative. To decide whether or not to tell other people, and who in particular to tell, veterans weigh stigma against trust and apply previous reactions to their disclosures as consideration for current dilemmas. The worst reactions that are received, disbelief and fear, can reinforce the weight of stigma in further decisions about disclosure. Social support, on the other hand, serves to bolster participants' willingness to disclose further and, as I will discuss further in Part IV, begin the process of acquiring mentors to help guide veterans through formal support processes.

IV. BARRIERS TO FORMAL SUPPORT

There are several facets to formal support which can be engaged during the processual experience of PTSD. Formal support, here, refers to those systems that have been put in place to assist veterans and servicepersons with their conditions. This assistance can come in many forms, including diagnosis, treatment, and financial aids. Systems of formal support identified in this research included the Canadian Armed Forces and Veterans Affairs Canada. Agents of formal support included medical professionals from a variety of medical practices, and case workers with Veterans Affairs Canada.

When participants spoke of receiving (or not receiving) formal support, several barriers were discussed which can slow or stop the individual from carrying forward with that support. Barriers surfaced throughout different parts of the formal support process. Early barriers were encountered while participants were still in the Canadian Armed Forces. These barriers included insufficient detection mechanisms for PTSD or individuals who might be vulnerable to PTSD, as well as potential backlash from the serviceperson's chain of command. These barriers were only somewhat ameliorated by the presence of professionals dedicated to the care of servicepersons with OSIs like PTSD. When participants described their interactions with medical professionals, they identified and questioned credentials and qualifications, forming opinions about the suitability or unsuitability of the medical professionals when it came to meeting veterans' needs. Finally, in the process of interacting with Veterans Affairs Canada, there were several barriers identified which included lack of knowledge, excessive paperwork, and long wait times. An important navigational aid for dealing with Veterans Affairs Canada was social support in the form of mentoring; a potential navigational aid, "engagement with the process" was also identified (see *Figure 4* on the following page).

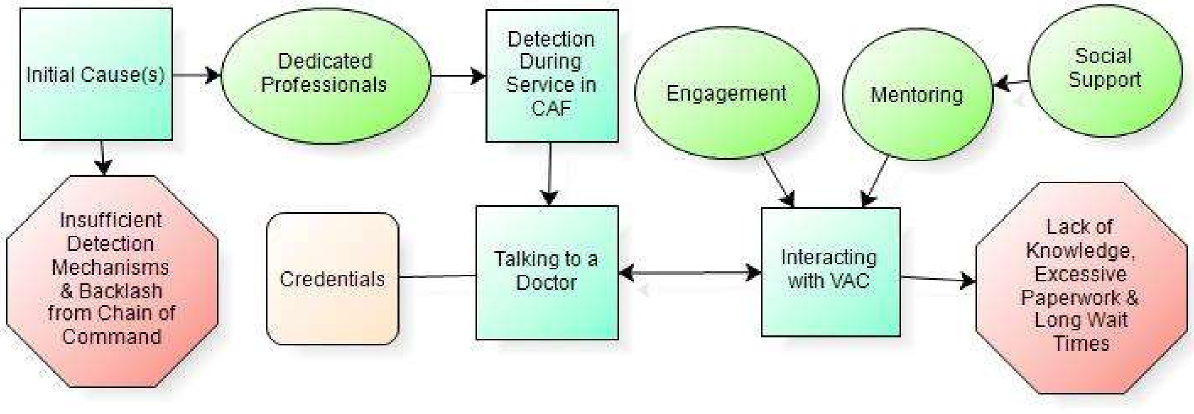

Figure 4: The Process(es) of Formal Support

Barriers within the Canadian Armed Forces

Participants identified barriers to potential help-seeking while they were still serving in the Canadian Armed Forces. Inconsistent and poor early-detection systems for potential mental health issues persisted across time, as reported by participants who left service from 2-20 years ago (as of the time of this research). Paul and Fred both described a 1990s attitude for keeping quiet about problems of this nature. Fred and William, whose traumas and acceptance of PTSD happened in more recent years, talk about the chance of losing their jobs as reasons to not talk about their problems, and indicated that this fear has persisted across the last two decades. Although Teddy's service preceded the 1990s, he received an evaluation for the potential mental health consequences of a traumatic event. Teddy questioned the efficacy of the process:

> TEDDY: The way they, assessed if we had any mental health problems back then is there was a Transport Canada official, I don't know if she was medically trained, she flew in from Ottawa, we were all lined up out in the hallways, and you sort of went in assembly line procedure, she'd ask the standard questions, and think the last one was "do you feel like committing suicide?" and then that was it, no follow up.

Mark, whose service in the Canadian Armed Forces was more recent, told me that there was simply no mentally preparing for the type of trauma he endured, and how despite this, there was no debriefing. When asked, Mark indicated that debriefing "wasn't really part of standard operations at the time."

William, one of the most recently retired veterans that I interviewed, spoke of the problems faced by individuals still serving in the Canadian Armed Forces:

> WILLIAM: For the guys who are still serving, we're just a number. Right? Ottawa has to do their part by branching us off all over Canada or stuff like that. If we can't fulfil a position…right? We're pieces of shit. Because if we're sick, we're hurt, whatever, we get backlash from our chain of command, because they're getting, you know, shit on. Pardon my expressions. But, you know, so, it's a huge ripple effect, right?

William indicates the tendency for individual problems to cause an upset in the chain of command, simply owing to the fact that people of superior rank had 'their own problems to deal with' which took precedence over the welfare of the individuals serving beneath them. Furthermore, William only mentions getting 'proper help' when he left the military – recall that William was released shortly after a suicide attempt, which indicated that he was in an unstable condition.

Despite the barriers that participants perceived while they were still serving, Fred still took a moment to mention that the Canadian Armed Forces *does* make an effort to handle issues of work-related PTSD and other OSIs: "At least here, we're fortunate, very fortunate. Soldiers, you know what I mean? In Canadian Armed Forces. That we have qualified, you know, psychiatrists, psychologists, and nurses that deal specifically with OSIs with the military." Fred's acknowledgement was the silver lining on a dark cloud. Although there were problems with the military system for detection, evaluation and aid for servicepersons with OSIs like PTSD, some participants believed that military members have more access to formal support than their civilian counterparts – police, firefighters and paramedics.

Disclosing and Doctors

> TEDDY: That's the last I ever told anybody that I had it unless they were a medical person, so like, family doctor, or if I go to see a specialist, or whatever. That's it.

In Part III, I addressed the importance of trust when a person discloses their PTSD to other people. Psychiatrists, doctors and people in emergency services are granted a sort of occupational trust, initially, by participants. Although all participants were ready and able to speak with medical professionals after personally acknowledging the existence of a problem, the varying weights that participants gave to medical professionals' credentials became evident throughout the course of interviewing.

If the professional was perceived as having strong credentials, the relationship between that person and the veteran was described more amicably – the professional was viewed as trustworthy, and the veteran spoke positively to the professional's opinions and diagnoses. When Teddy sought help for what he identified as a delayed onset of PTSD, he mentioned his psychiatrist's vast experience with PTSD:

> TEDDY: I guess it was confirmation of what [I] already thought. The guy that I, the psychiatrist that I went to go see I mean, this guy had solid credentials, he had, he's seen seven thousand patients with PTSD, they used to call him Mr. PTSD, and um, so I mean, even after I saw him, I was sure I had it.

Teddy mentions that his current psychologist 'deals with lots of vets.' Mark also spoke highly of his psychologist, who he described as "one of the best PTSD doctors in Canada," having worked with so many veterans.[15]

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[15] Mark's interview was not audio-recorded. It was during this point of the interview that I noticed Mark responding to my note-taking, rather than the question, as a cue. Credentials had been a rising category while coding other interviews, and so I wanted to make sure I wrote down what he was saying. Mark saw that I was writing, and went on further to describe his doctor as well-respected, and a leader in the field. Although I believe this bolstering of

Some participants spoke negatively about qualifications, in cases where it was clear that they were dealing with medical professionals whose specialties did not involve PTSD or Canadian Armed Forces veterans. Teddy described going to a Service Canada office in an area where there was no Veterans Affairs Canada offices, receiving forms and an advisement that there was no one there trained in his area of need. William was incredulous when he was sent through a chain of referrals to a person whose specialty was eating disorders. Although medical professionals are automatically entrusted with the disclosure of PTSD, barriers to trust can be erected between the medical professional and veteran, compromising helpfulness of the medical relationship.

Barriers to Dealing with Veterans Affairs Canada

Participants in this study identified several potential barriers in dealing with Veterans Affairs Canada as an avenue of formal support. June explained to me that she had no idea of the kinds of services that are available for Canadian Armed Forces veterans with PTSD: getting formal support can be difficult if you do not know you have the option to reach out. Once the veteran is in contact with Veterans Affairs Canada, participants identified frustrating bureaucratic obstacles in the form of (what is felt to be) excessive paperwork required of the veteran. After initial paperwork has been filed, participants identified equally excessive waiting periods, wherein the bureaucracy presumably communicates internally and evaluates claims. Combined with the veteran's potential for increased anxiety and motivational complications, these barriers can feel insurmountable.

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credentials to be important, it was not a spontaneous offering, and so I declined to use follow-up comments as evidence to the main body of this analysis.

Fred was particularly passionate about the bureaucratic obstacles of processing paperwork and waiting for answers:

> FRED: Why do you think we're hurting so much in mental health? Why do you think we're hurting so much with Veterans Affairs services? You know what I mean? Why do you think a lot of the veterans with OSIs are so frustrated? Why do you think so many of them are suiciding this year alone? Because they're tired, Robin, of all the bureau - bureaucratic bullshit and red tape and paperwork. How do you think it feels when somebody's got an OSI, who hasn't, who's on the waiting list for a year, when he puts in for a pension, or you've been denied because we don't have enough paperwork yet.

Teddy also felt frustrated about the long waiting periods. When he first acknowledge his problem, it was because of a tipping point where his PTSD was becoming difficult to handle. He began calling Veterans Affairs Canada periodically, since he was feeling some uncertainty regarding his problems:

> TEDDY: I asked them how soon can I get in to see a psychiatrist, and their response was, uh, well, we haven't officially accepted your claim yet, so there's not really much we can do, and I said, well, what about medication? Well, then you're going to be on your own til we approve your claim, and of course back then, I mean they still drag their heels on claims now, but back then you could wait up to a year!

Teddy continued, talking about how Veterans Affairs Canada does not track people whose claims have not been approved of, or which are in the process of being reviewed, to monitor how many of those in-process or rejected claimants commit suicide. Saying, “I guess that’s convenient for them,” Teddy implies that veterans seeking help through Veterans Affairs Canada that are made to wait might resort to drastic measures if that wait becomes unbearable.

The experience of having to wait was framed by some participants as a kind of rebuff – a denial of services, or a designation of unimportance. William, in the face of this experience, advocated a need to be persistent in the face of adversity from doctors, from police, and from Veterans Affairs Canada. This perceived ‘uphill battle’ was referenced often in earlier interviews. By the time I spoke to Paul, I was surprised by his perspective towards the same situation.

> PAUL: There's a lot of bad publicity right now on the way the military is training their veterans right now or stuff like that, but my personal experiences haven't been that bad at all. They've been actually pretty good. Right? Everybody's been very supportive. Like I said, I was frustrated with the timeline that it seemed to take, but when I chill and think about the reasons why, then I understand. It's not that, like they left me hanging, which is...regular follow-ups, I got a bunch of contact people, phone numbers that I can call if I have any questions, or... From the moment I reached out, they've been good at...
>
> …
>
> PAUL: I think it's more being...not being afraid to ask the questions, right? If you just get frustrated and say 'fuck it' and walk away from it, that's not gonna fix anything. You're gonna be back at the same spot you were at, right?

Paul, like William, advocated staying persistent, but this persistence was motivated by a need for Paul to stay engaged in the Veterans Affairs Canada process; Paul explains that he is similarly engaged in his psychological counselling. For Paul, it is not about standing back and waiting to receive aid, but actively making himself a part of the process. Paul believes that this engagement has helped him to navigate what, to other participants, feels sometimes like an impenetrable bureaucracy.

Participants identified excessive paperwork as a problem, but I do not have the depth of information here to say with certainty what is considered 'excessive.' Veterans Affairs Canada has an "Application for Disability Benefits" package available on their website for download, which involves the gathering of some basic information about the potential disability for initial processing (Veterans Affairs Canada 2014b). This package includes a consent form for the release of medical information, wherein the applicant provides their medical practitioner's details, and Veterans Affairs Canada performs the legwork of gathering pertinent medical information. It is notable that Veterans Affairs Canada disability paperwork is separate from any disability exemptions that veterans may get on taxes, which are processed through Revenue

Canada and require different information and criteria of the veteran. There is a possibility that both systems may be contributing to the onerous pile of paperwork that participants identified.

There are mentions on the Veterans Affairs Canada website that if you are having trouble filling in the paperwork, bureau employees will be available to assist veterans with their paperwork free of charge. This creates a bit of a divide between how most of my participants felt, and how Veterans Affairs Canada presents itself. Paul might be the answer here - Paul is the reason that "engagement with the process" is a potential method of barrier navigation. Paul identifies engagement, active learning and the use of supports recommended by Veterans Affairs Canada (which include, for example, various telephone support numbers) as factors that keep him grounded and generally pleased with the formal support he has received.

Several participants identified the need for a kind of mentor to help veterans navigate potential barriers.

> JUNE: Like, not just have a caseworker, but also people, a person that you can just talk to, like a mentor. But also a person to help you with your paperwork. Like [redacted] has been doing that, helping me, like a few years ago… [someone] that's been there and that, you know, suffering from the same thing, but that has a grip on their life.
>
> ROBIN: Helping you with the process.
>
> JUNE: Yeah, with the process. Like, a go-to person. You know, and then getting out of the military, like a go-to person. Like someone, you know, even that could've...so you get out of the military voluntarily or whatever you choose where you want to go, someone to pick you up at the airport, like, from the very get-go. You know so you don't get lost in the system.

Mark told me about how he was actually engaged in this mentor process, although in no official capacity. Mark knows someone who has been having difficulties sorting out records and paperwork for Veterans Affairs Canada, and Mark has been using his experience to give guidance. As with the process of telling other people about your injury (Part III), veterans can also use their PTSD as a bridging tool between Veterans Affairs Canada and people who are unfamiliar with its methods. Paul was a notable contrast to other participants: although Paul continues to rely on social support in other areas, he does not emphasize the need for mentorship. This contrast might suggest that engagement in the process reduces the need for support in the form of mentorship – however, more theoretical sampling needs to be done in this area to confirm or deny this potential navigational aid.

Summary

There are several different points at which veterans can enter into the process of formal support, and each stage offers the veteran different challenges. Early barriers during service in the Canadian Armed Forces included: a persistent military cultural attitude that servicepersons should not talk about mental health issues or injuries; designation of mental health issues as 'less important' by superiors in the chain of command; and systemic problems around irregular or absent educational and debriefing exercises. These early barriers can be associated with the reactions of denial, burying, minimizing, normalizing and doubting that were outlined in Part II of this Chapter.

Participants were generally open to speaking to medical professionals, which suggested the existence of an occupational trust. This trust can be bolstered if the medical professional is perceived as especially qualified or experienced in the area of PTSD. This trust can be broken if the participant perceives that the medical professional's credentials are inadequate or unrelated to the veteran's PTSD diagnosis. No clear navigational aids were suggested by participants to negotiate barriers of broken trust, once they have been erected.

Participants described a number of barriers when dealing with Veterans Affairs Canada which people with anxiety and motivational limitations may find problematic to deal with. Being unaware that resources are available to the veteran is the first of these barriers, with becoming or being made aware as the obvious navigational tool. Another barrier was the perception (or potential existence) of excessive and convoluted paperwork and bureaucratic processes. Participants identified mentorship by another veteran as an important navigational tool. The barrier of excessive wait times (months or years) for the provision of services was also identified. Engagement may prove to be a navigational aid, but until further theoretical sampling is done in this area, no navigational aids for wait times (beyond simply waiting) have been firmly identified.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

CANADIAN ARMED FORCES VETERANS AND THE PROCESS OF HAVING AN OSI

During my interviews with Canadian Armed Forces veterans with PTSD, it became gradually apparent that their answers, explanations and stories revolved around perceiving, encountering and navigating barriers. As a concept, these barriers are perceived social forces that inhibit forward momentum in the acknowledgement, management and healing processes. PTSD symptoms can act as barriers with regards to the social functioning and participation of veterans. Lack of understanding on the part of the veteran, dismissal of the veteran's problems by others, fear of losing a job and fear of stigma were all contributing factors when it came to the veteran acknowledging (or failing/refusing to acknowledge) the existence of personal problems. Fear of stigma also acted as a barrier to veterans telling others about their PTSD.

In the Canadian Armed Forces, insufficient mechanisms of detection as well as failures in communication along the Chain of Command acted as barriers in early detection and intervention[16]. Veteran perceptions of the credentials and qualifications of medical professionals can lead to negative evaluations which erect barriers in communication between the veteran and professionals, and finally, interacting with Veterans Affairs Canada generates several uniquely bureaucratic barriers to surmount. Throughout the interviews, participants mentioned the importance of navigational aids to their progression in the process of having PTSD. Worthy of note was the amount of help that participants received from informal social supports. It is easy to list these barriers separately, as though they exist in different stages or in different areas of the

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[16] The Canadian Armed Forces is trying to rectify these issues (see "The Ombudsman Reports" in Chapter Two).

lives of Canadian Armed Forces veterans, but these processes, along with their respective barriers and navigational aids, intertwining and recursive.

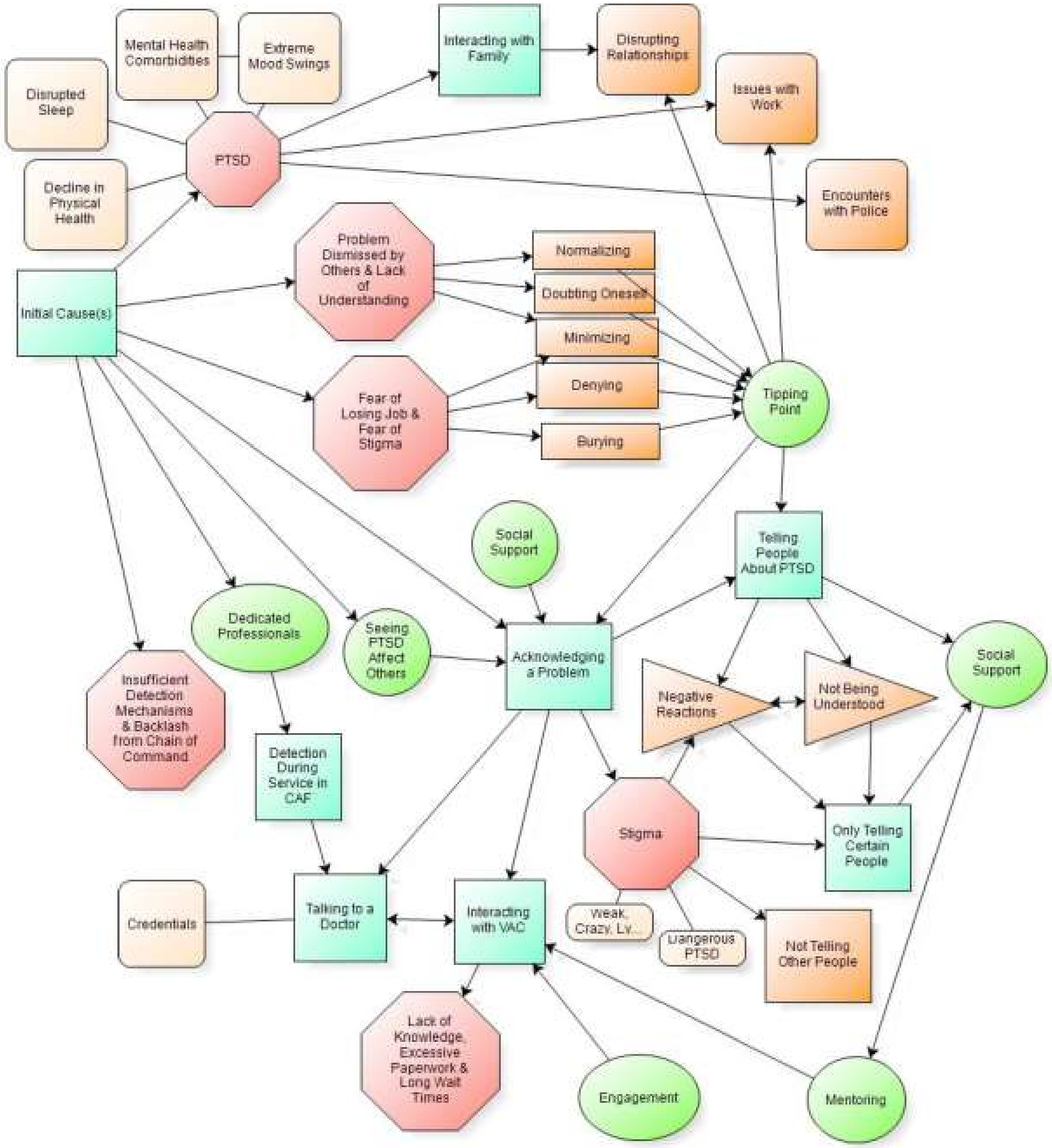

Figure 5: The Experience of Canadian Armed Forces Veterans with PTSD

The process that I have described in my analysis is staggeringly complex – so is, I contend, is the experience of being a Canadian Armed Forces veteran with PTSD. *Figure 5* is a visual compilation of the entire process. There are many different paths of action in this visual, none of which are necessarily occurring exclusively at any given point in the life of a veteran with PTSD. Some participants in this study had their symptoms discovered early in the process – of these, one denied having PTSD while working through the formal support system, while another found the condition impossible to personally deny. Some of these veterans only acknowledged or realized that they had PTSD long after leaving the Canadian Armed Forces, but one was still serving long after the initial traumas, when he finally acknowledged it. One veteran personally acknowledged the existence of a problem and limited his disclosure to medical professionals and those who he felt needed to be 'kept in the loop.' Several of the participants had reached a point, by the time of this research, of leaving the barriers behind and talking to anyone and everyone who would listen, in order to raise awareness.

Whatever the path(s) that Canadian Armed Forces veterans with PTSD travel, they appear to be engaged in a constant process of barrier navigation. Throughout the inexorable, but not exclusively linear, process, these veterans are constantly perceiving, negotiating, and navigating social barriers. During this process, social support is essential. Being aware of other people who have PTSD, understanding who can acquire PTSD, understanding who requires and deserves treatment (everyone, regardless of severity of injury), and being able to communicate with others are all invaluable to veterans trying to move forward in the process. These essentials are often communicated to the veteran through the use of PTSD as a bridging tool by other veterans. Later in the process, the veteran is likely to turn around and extend this bridging tool to other veterans in the process of having PTSD. Barriers in the process of being a Canadian

Armed Forces veteran with PTSD are navigated and surmounted primarily by the social support of other veterans.

ADDRESSING THE LITERATURE

This study served to address several problems with the current state of sociological and social scientific literature on military veterans with PTSD, which were identified in *Chapter Two: Contextualizing the Problem*. One of the primary problems is the dearth of literature on the experiences of Canadian Armed Forces veterans and the Canadian context. This study provides a basis for further study, acting as a pilot for a larger grounded theory project on Canadian Armed Forces veterans with PTSD, and legitimating research that is more focused in scope.

The second potential problem identified was the tendency for academics to focus on spousal and intimate partner relationships (Byrne & Riggs 1996; MacDonald et al. 1999; Taft et al. 2007; Renshaw, Rodrigues & Jones 2008; Solomon & Dekel 2008; Solomon, Dekel & Zerach 2008; Taft et al. 2009; Finley et al 2010; Renshaw & Campbell 2011; Solomon et al. 2011; Taft et al 2012; Kar & O'Leary 2013). Spousal/intimate-partner support was valued by participants in this study who were experiencing the process of having PTSD. The current academic literature rooted in sociology and the social sciences more broadly does not appear to be misguided in its focus on spousal and intimate partner relationships of military veterans with PTSD. However, support that is given and received from veteran to the next using PTSD as a bridging tool is arguably extremely important to the process, indicating that more research should be done on the support systems and relationships cultivated between veterans with PTSD.

The third potential problem identified was the tendency for academics to focus on combat and war veterans, rather than veterans more generally. Several, but not all, of the participants in this study had experienced service in a special duty zone – areas which could in some cases be denoted as theatres of war. This sample was far too small for the question of similarities and differences to be resolved. This study can only attest that some veterans with PTSD are not combat or war veterans.

RESEARCH AVENUES TO INVESTIGATE

This research project serves as an initial sociological foray into the experiences of Canadian Armed Forces veterans with PTSD. It is my hope to utilise this research as a pilot project to legitimate grounded theory-based research on a larger scale with the cooperation of organizations dedicated to the support of the population in question. The line of analysis in this project followed the emerging concept of barriers, but this was not the only category to emerge. Further research would involve theoretical sampling to flesh out emergent categories in this initial project.

The category 'looking after your own' and the *in vivo* category, "suck it up," both harken unto an assumption that I had made before the decision to conduct the study under a grounded theory approach – the importance of military culture in the context of the veteran. I took steps in the research to avoid deduction from this prior assumption. Participants in this research did not speak from a context that was saturated in military culture – however, the grounded theory-derived coding that was used in this analysis, which is designed to stay close to the data, pointed to potential vestiges of military cultural ideals shaping the lives of the veterans after exiting the Canadian Armed Forces. Researchers who focus on current servicepersons have identified several facets of Canadian Armed Forces military culture; Harrison (2006) describes how the military characteristics of 'hypervigilance' and 'unit cohesion' affect military members and their families on an individual basis. Hypervigilance, as Harrison states, "reflects the militaries' reputation for 'taking care of their own,'" (557), and essentially involves the close monitoring of servicepersons in order to keep them in top form for service. At the same time, there is also a view of individuals with permanent injuries being considered expendable, since they cannot be 'fixed' and fit back into the military model, and "members therefore share amongst themselves an interest in keeping illnesses [and] injuries…hidden from the chain of command" (558). This would certainly speak to the analysis, wherein fear of losing one's job becomes a primary concern for the Canadian Armed Forces serviceperson who suspects they may have PTSD or another OSI. There is also a tendency for service persons to cover for each other's flaws and hide potential issues from the chain of command to prevent disciplining that could result in discharge from the military. Harrison calls this unit cohesion "an informal corrective to hypervigilance" that is espoused by the structural policies of the Canadian Armed Forces (563). Harrisons' work is specific to servicepersons, but veterans share the common point of having once been servicepersons themselves. There is a chance that the veteran willingness to use PTSD as a bridging tool is based in these military cultural ideals. At this stage in the research, I recommend further theoretical sampling to see how the commonality of past immersion in military culture affects veterans, if at all, in their day-to-day living.

Participants in this study spoke about learning and skill-building in many different ways, from learning more about PTSD and other OSIs, to learning methods of relaxation and calming, to learning how to play the guitar. The importance of learning about your own injuries, about how to deal with them, and how to learn new skills which are applicable to your current life as a veteran is highlighted by participants in this research. Many of these skills are used as coping mechanisms – increasing the understanding of the condition and learning how to deal with symptoms in effective and sometimes creative ways. Some of these methods were individual, as when Paul practices mindfulness in order to be more aware of his actions and motivations for his way of thinking. Some methods are interpersonal, as when participants spoke to other people, or meditated on scripture, as June did, in the pursuit of answers. Still other methods, as with playing the guitar, are creative, and help veterans like Mark relax by creating a focused mental space that he feels is more resilient to symptomatic intrusions. All participants spoke of learning and skill-building in some way, and all identified the importance of doing so. The analysis so far suggests that the various methods of learning and skill-building can be explored with regards to the relationship between skill-building and veterans' social functioning.

Participants also spoke about affecting other people unintentionally (and usually negatively), because of their injuries. Current literature on veterans with PTSD focuses on spousal and intimate partner relationships, emphasizing tension and, in some cases, abuse. Participants spoke of disrupted relationships, but they also spoke of the social support that they received throughout their experiences. The role of spousal and intimate partner support in experiences of PTSD seems under-examined. Additionally, participants placed some importance on their relationships with their children and some expressed pain at having given their children cause to fear them. It seems important to explore the situations under which these unintentional effects occur (such as unintended violence, and fear in children), the situations that precede these incidents or ongoing problems, and how the other person(s) are affected. There are several Canadian studies that investigate the experiences of partners and children of veterans with PTSD (Ray & Vanstone 2009; Baker & Norris 2011; Kwan-Lafond, Harrison & Albanese; Harrison, Albanese & Berman 2014). Further investigation into the family perception of their household member with PTSD should help identify the points in the process at which the family members become aware of the problem. Identifying how and when some children become afraid of their parents with PTSD, how this fear affects family dynamics, and how the family takes steps to mend such relationships would also be helpful, especially in the case of catering health care and services to Canadian Armed Forces veterans and their families.

This analysis led to the theory that Canadian Armed Forces veterans with PTSD encounter barriers at most points in the process. As an exploratory study, however, this project is not yet complete. There are still many categories that merit more exploring: “looking after your own,” “suck it up,” “learning and skill-building,” and “affecting other people unintentionally” all emerged during the initial coding and could be further pursued for their validity (or invalidity). In addition to these emergent categories, there are several other potential research avenues that the above analysis suggests.

In the analysis of PTSD symptoms as barriers, I highlighted the potential impacts on the veterans’ social functioning and participation. These impacts warrant further research, including an examination of the social consequences of motivational limitations and behaviours due to anxiety, as well as research on sleep disruption in the functioning of veterans with PTSD. Potential impacts extended to veterans’ work prospects: several participants were no longer able to work, even though these same participants indicated that they would rather be able to participate in the work force. Research in these areas would help indicate how some veterans with PTSD integrate back into the workforce, as well as how other veterans become unable to work.

While analysing barriers to acknowledgement, it became clear that an investigation into the knowledge and understanding of PTSD among veterans in general would be useful in order to assess both the levels of understanding and the construction, perception and perpetuation of stigmatizing attitudes. Investigations should also be done into civilian populations’ understandings and attitudes towards military-service related PTSD. Participants indicated that stigma was an important barrier in various stages of the process. There appeared to be distinctions in stigmatic attitudes: a military fueled perception of weakness, and a civilian related stereotype which regards PTSD as extremely dangerous. Since this study indicates that there may be a difference in the two, comparing these types of stigma against each other, and against other mental health stigmas might isolate unique factors in military service-related PTSD stigmas.

As this research was coming to a close, it was revealed in November of 2015 that 59 veterans and servicepersons who served in Afghanistan were known to have committed suicide (Chase & Galloway 2015). William claimed that he was released from the military despite having attempted suicide 20 days prior to release, and Teddy had speculated on the amount of suicides that have been committed while waiting on feedback from Veterans Affairs Canada. Narratives from veterans who sought or are seeking formal or informal support, including situations in which they have been rebuffed, would help indicate how veterans go about seeking help and what kind of situations lead to their success or rejection in the help-seeking process. Furthermore, an examination into the rates of incomplete disability claims filed with Veterans Affairs Canada, as well as the types of claims that are generally rejected, would help with the transparency of the process for veterans while at the same time serving to monitor Veterans Affairs Canada for inconsistencies or potentially problematic rates of rejection.

The theme of using PTSD as a bridging tool came up repeatedly throughout each area of the process of experiencing PTSD. This signals the need for investigation into inter-veteran relationships. If veterans respond to bridging strategies from other veterans as navigational tools for traversing barriers, there could be outreach and formal support implications for the provision of services to Canadian Armed Forces veterans who are being impeded by specific social barriers.

As an exploratory project, this study has already proven successful. This project can be carried forward in pursuit of emergent categories from initial stages of this study’s analysis. Several research avenues were also indicated by the primary analysis, and included: impacts on the veteran’s social functioning and participation; variations in the stigmatic attitudes encountered by veterans; details regarding the process of applying for help through Veterans Affairs Canada; and the nature of the inter-veteran relationship with regards to PTSD. I welcome and encourage any researcher who is willing to take up these research avenues.

FINAL THOUGHTS

The study of Canadian Armed Forces veterans with OSIs like PTSD is very important. Canada’s veteran population is steadily growing and the nature of military service results, for a significant portion of veterans, in an OSI. The Canadian Armed Forces is renowned both by Canadians and international bodies as a peacekeeping force, and is an iconic part of the Canadian identity on an international level. Canadian Armed Forces servicepersons and veterans serve the nation of Canada, and OSIs like PTSD that are acquired in the course of service profoundly affect the individual and their family. Given their service and their struggles, it is important that Canadians in general, and academic communities in particular, contribute to the alleviation of those struggles.

This research has highlighted the barriers that Canadian Armed Forces veterans with PTSD have encountered and navigated throughout the experience of their injury. These barriers are profoundly social in nature. It is important to examine these barriers, which are continually constructed and reconstructed in both, internal and social dialogues. These barriers impede the process of acknowledgement and recovery on the part of the veterans who serve the same society and social context which perpetuates these barriers. By investing in research on the social supports which help Canadian Armed Forces veterans with PTSD navigate these barriers, we can contribute to the effort to leave no one behind.

APPENDIX A: OUTLINE OF INTERVIEW QUESTIONS

Basic Information

- How old are you?
- How old were you when you joined the Canadian Armed Forces?
- How longer were you in the Canadian Armed Forces
- How long have you been out of the Canadian Armed Forces?
- What branch of the military did you serve with?
- What is the nature of your OSI? Such as:
  - PTSD
  - Anxiety
  - Depression
  - Other ___________________

Initial Questions

- Regarding your OSI, could you tell me how you first became aware that you had an issue?
  - Do you remember when you first spoke to someone about the problem?
  - Who did you approach about the issue at first?
  - Did these informal supports help you to decide to get more formal supports?
  - Where did you seek this support?
  - E.g. family? Friends? Professional help?
  - Did you have problems seeking professional supports? How so?

Intermediate Questions

- At what point did you think that your issue might be best classified as an “operational stress injury”?
- How did you come to define the issue in this way?
- What, if anything, did you know about Operational Stress Injuries before you sought help?
- Do you remember how you felt when you were diagnosed as having an Operational Stress Injury?
- How, if at all, have your thoughts and feelings about Operational Stress Injuries changed since your diagnosis?
- Do you think labelling the issue as an OSI can help or hinder people who are struggling with issues like yours? How so?

How does your OSI manifest?

- Tell me about the times you are particularly aware of your injury?
  - How does your OSI affect your everyday life?
  - What helps you manage your injury on a day-to-day basis? What problems do you run into when trying to manage your injury?
- Are other people in your life aware of your OSI?
  - How do people react when they find out?

  - Who have you decided to tell about your OSI?
  - How did you decide to tell some people but not others?
  - Do you think they understand?
  - Is it important to you that they understand?
  - Who has been the most helpful to you with regards to dealing with your OSI? How have they been helpful?
  - Has the formal support you have been receiving been positive in terms of dealing with your OSI?
- Describe what you think is the most significant impact of your OSI on your everyday life.

Ending Questions

- How did you experience the transition from military to civilian life, and how do you think this might have related, if at all, to your OSI?
- Do you think the diagnosis of an OSI has affected your self-concept? Your identity among friends, family, and work colleagues?
- What kind of advice would you give to a veteran or service-person who might have an OSI?
  - Something you would want them to do differently, do the same or avoid?
- Is there something that you might not have thought about before that occurred to you during this interview?
- Is there something else you think I should know to better understand people’s experiences with OSIs?
- What do you think might be improved in terms of services available to those suffering from an OSI in the military?
- Is there anything you would like to ask me?

APPENDIX B: COVER LETTER

Note: Cover Letter was presented on Lakehead University letterhead as per University mandates.

Lakehead
UNIVERSITY

Sociology

e: rlintner@lakeheadu.ca

Project Title: Military Veterans' Experiences of Operational Stress Injuries

Principal Investigator: Robin E. Lintner, Master's Candidate at Lakehead University
Research Supervisor: Dr. Antony Puddephatt

This study investigates the lingering impact of military culture on Canadian Armed Forces veterans with Operational Stress Injuries (OSIs).). Personal narratives will be elicited from interviews with veterans, in order to identify patterns in their personal struggles with OSIs. My goal for this research is to contribute towards a better understanding of what it I like to have an OSI from the perspective of a veteran, with the ultimate aim of improving delivery of care for military veterans with OSIs.

To the Potential Participant,

I am inviting you to participate in my research because you are a member of the growing population of Canadian military veterans with Operational Stress Injuries. My goal for this research is to identify social experiences common to this group so that researchers and civilians may better understand the situation of veterans with OSIs. While there is no immediate community benefit in this research, I believe that if people are more aware and understanding of the experiences of military veterans with OSIs, the results will be better research and ultimately more effective services that are extended to Canadian military veterans.

Participation in this research is completely **voluntary and anonymous** (unless otherwise desired by you, the potential participant). This means that your decision to participate in the study (and your identity) will not be disclosed to your OSISS group, group coordinator or anyone else who is not part of the research team. If you choose to participate, you may still refuse to answer any questions that you are not comfortable with, and you may withdraw at any time. Participation will include a sound-recorded interview (30-90 minutes), where I will be asking you to describe your experience of living with an Operational Stress Injury. Although you will be asked about the nature and development of your injury, I will not be asking you about the cause of your injury unless you choose to speak of it. Given the nature of the research, you may experience some emotional distress or anxiety over the course of (or after) your interviews. I am not a psychologist or a counselor – if you feel distressed I encourage you to speak with your OSISS group leader.

The data collected from this interview will be anonymous, and the only people who will have access to the data will be my research supervisor and myself, the primary researcher. During the research, the data will be stored in a locked filing cabinet and briefcase, and on a password-protected computer. When the research is finished, the data will be stored in a locked filing cabinet at Lakehead University for 5 years. Individual participants will not be identified in published results without their explicit consent; however, **it is possible that other members of your OSISS group might be able to identify you from quotes in the research due to their familiarity with your own story.** I will do my best to minimize the likelihood of peer identification.

When the research is complete, I will attempt to publish it in a sociological journal, preferably of military sociology. Participants' identities will remain anonymous in publication. At the conclusion of the project, I will provide a summary of my research findings to participants who have indicated their interest in receiving them.

If you feel distressed at any point following the meeting I encourage you to contact your group coordinator, or call the Veterans Affairs Assistance Serves at 1-800-268-7708, which provides free counselling to Veterans and their families and can be accessed 24 hours a day.

APPENDIX C: CONSENT FORM

Note: Consent Form was printed on Lakehead University letterhead as per University mandates.

Lakehead UNIVERSITY

Sociology

e: rlintner@lakeheadu.ca

Military Veterans' Experiences of Operational Stress Injuries
Primary Researcher: Robin Lintner
Research Supervisor: Dr. Antony Puddephatt

Consent Form

Please circle Yes or No to indicate the following:

Yes	No	• I have read and understood the information letter for this study.
Yes	No	• I understand the potential risks and/or benefits of participating in the study, and what those are.
Yes	No	• I understand that I am a volunteer and can withdraw from the study at any time, and may choose not to answer any question.
Yes	No	• I understand that the data I provide will be securely stored at Lakehead University for a period of five years.
Yes	No	• I understand that I will remain anonymous in any publication or presentation of the research findings.
Yes	No	• I understand that my participation in the study will not be disclosed to my OSISS group, group coordinator, or anyone else beyond the research team for this study.

Permissions

Please circle Yes or No to indicate the following:

Yes	No	• I agree to have my interview audio-recorded for accuracy
Yes	No	• I agree to being contacted for potential follow-up interviews, knowing that I retain the right to decline follow-up interviews.
Yes	No	• I would like to receive a summary of findings following the conclusion of this project. • If yes, provide a preferred method of contact below.

X ______________________________

Participant's Name and Date

APPENDIX D: CONTACT INFORMATION

Note: Contact Information was printed on Lakehead University letterhead as per University mandates.

Lakehead
UNIVERSITY

Sociology

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