COMING BACK TOGETHER:
VETERANS' CAPACITY AS THE MISSING ELEMENT IN THE SYSTEMS OF TRANSITION TO CIVILIAN LIFE

by

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Abstract

This study used a series of in-depth individual interviews, supported with document analysis, with formerly deployed Veterans, to learn about their transitions between military and civilian life after being medically released from the Canadian Armed Forces (CAF). The study was conducted near the end of Canada's engagement as part of the NATO contingent in Afghanistan. Participants revealed themselves as capable and resourceful in their analysis of the overwhelmed and inadequate transition systems charged with the care of ill and injured troops. The neoliberalist mind-set of the then Harper Government, with its over-reliance on narrow understandings of healing, and fiscally motivated service delivery, particularly in mental health and vocational support, heavily influenced the transition systems. Combined with the effects of stigma, this situation significantly reduced opportunities for fulfilling post-military careers, and ignored the capacity and aspirations of returning soldiers, and the needs of the partners and families who are their greatest resource.

Acknowledgements
&
Gratitude

This thesis is dedicated to the Veterans who consented to share their stories with me.
Their generosity, patience, and knowledge is a profound gift.
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I wish to thank all of the academic mentors who encouraged me to focus my attempts to explore and understand the experiences of transitioning soldiers.

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Section 1 - Reconnaissance: Rationale, Context and Approach

Chapter 1: Purpose and Significance of the Study

This study explores Veterans' post-deployment experiences of transition to civilian life after being medically released from the Canadian Armed Forces (CAF), with a particular interest in recognizing the capacity of Veterans to be included, at the policy-making level, in the processes and systems of re-connection. Veterans are the stakeholders most profoundly affected by the process of transition, and currently they are not represented effectively in the management-model systems responsible for their post-service wellbeing. The marginalization of transitioning Veterans' voices and lived-experience knowledge has resulted in a rift between Veterans and the institutions mandated to serve their needs. Veterans have an intimate understanding of these needs: for meaningful future employment, education that supports their life goals, treatment of their injuries and the ongoing care of their families. They have unique and creative aspirations concerning their potential contributions to civilian society and have mastered a wide variety of skills during their military service. These skills and capacities are evident in the narratives of participants in this study, who have analyzed the transition systems they deal with, identified problems inherent in them, and articulated effective and workable solutions to these problems. In this study, participants' personal examples illustrate their capacity, and this capacity stands up against some of the stigmatizing stereotypes that transitioning Veterans have been described by, in our society and in the media. Stigma is a significant impediment in many aspects of Veterans' transitions. The stories of the participants in this study reveal the care they have toward their fellow soldiers, their high professional expectations for themselves and their peers, their ability to be advocates in their own physical and mental health treatment, and their positive

engagement in family and partner relationships, often in very challenging circumstances. These are the qualities that make them an invaluable, but unrecognized resource in the very necessary redesign of the present, inadequate transition system.

The issue of Veterans' transitions is of significance in Canadian society today for a number of reasons, including: the fear that the concerns of Veterans will fade from media and public interest when they are no longer on the front pages, the human and financial costs of difficult transitions, and the futility of repeating past mistakes.

Timeliness of the Issue

When the deployment in Afghanistan is forgotten, the focus of the media and the public will shift, as it has after past deployments, and this will result in a reduction of resources available to military and public health providers for the care of Veterans. Veterans have added their voices to those of the media and others who warned parliamentary committees about this (Bruyea, 2005), years before the problem reached the levels indicated by the statistics mentioned below:

> The CAF typically releases about 1000 people every year for medical reasons- 16,240 such releases occurred between 1999 and 2013- not including those released for non-medical reasons who subsequently developed physical and mental health problems related to their military service. Those suffering from Operational Stress Injuries (OSI) such as Post Traumatic Stress Disorder (PTSD) tend to face higher unemployment rates, significant declines in income, and are often unable to maintain their standard of living. (MacPherson, 2014, p. 15)

The Human and Financial costs of Transition Difficulties

There are those for whom the transition has proven to be overwhelming; the epidemic of suicides, some of which occurred years after the war experiences of the soldiers involved, point to the despair felt by too many Veterans (Everson, 2013). In order for the message behind these suicides to be heard, attention must be paid to the explanations in

the final notes of the individuals concerned, which include: being forced out of the military and being unable to provide for their families; survivor's guilt; and infrequent, inefficient, symptom-based treatments (Tucker, 2014). Transition difficulties are also illuminated by their accompanying problems: substance use (SU) and interpersonal violence (IPV) (Richardson, St Cyr, McIntyre-Smith, Haslam, Elhai & Sareen, 2012; Bernardy, Hamblen, Friedman, Ruzeck, & McFall, 2011; Najavits, Kivlahan & Kosten, 2011; Walker, 2010; Westwood, McLean, Cave, Borgen & Slakov, 2010); the ramifications of these are added to the effects of combat related psychological stress. Another, very human, cost persists into the future in the form of intergenerational trauma (IGT). Unresolved trauma in a parental generation can 'flow' through generations, having adverse consequences (Pickrell-Baker & Norris, 2011; Bombay, Matheson & Anisman, 2009; Dekel & Goldblatt, 2008).

An attempt to consider the matter quantitatively by using statistical evidence of the effects of transition, such as prevalence rates of what the CAF terms Operational Stress Injuries (OSIs) (Pare & Radford, 2013) and in particular PTSD, is frustrating. Canadian statistics on the effects of transition on mental health, many of which are based upon a large study that employed a "cross-sectional computer assisted telephone survey" with data collected on individuals released before 2007, quote PTSD prevalence rates of 5.3 to 11.1% (Pearson, Zamorski & Janz, 2014, p.1) and 8% (Dallaire & Wells, 2014, p. 9). Pare and Radford (2013, pp. 2, 3), in a Parliamentary Research Report on post-traumatic stress disorder and mental health of Canadian military (CAF) members and Veterans, cite statistics indicating that the lifetime prevalence rate of mental health issues arising from deployment situations in CAF members is as high as 28%, including a 10% risk of post-

traumatic stress disorder (PTSD). Howell (2011) disputes such rates and suggests that an estimate of 60% is more accurate:

> The supposedly relatively low rate of PTSD in the Canadian Forces is often cited as an indication that mental health care for soldiers and veterans is largely adequate. This is highly problematic, however, because PTSD statistics are particularly difficult to compare, due in large part to differences in the ways in which such studies are conducted. In fact, the military does not keep track of the actual number of soldiers or veterans diagnosed with PTSD—despite a recommendation by the former Canadian Forces ombudsman to do so that dates back almost ten years. (Howell, 2011, para. 8)

At the time of this study, the government is spending public funds to battle its own soldiers in court, and thereby allocating resources in a way that directly opposes the welfare of Veterans. Also, as participants point out, Veterans who find satisfying and productive employment in civilian life would willingly pay taxes; while Veterans in ineffective transition programs consume resources without feeling that they have benefitted. This is a serious concern, in light of the $500 million dollars that the Auditor General's 2012 Report (Auditor General of Canada, 2012, p. 1) indicated was budgeted for aid for CAF members in transition programs.

The Futility of Repeating Past Mistakes

Historically, Canadian society has both shunned returning soldiers, and honoured them in tangible ways. Formerly, the treatment of returning soldiers has had an impact on Canadian society, as evidenced by the fact that the contributions of soldiers-turned-civilians after WWII, when they were supported with significant and meaningful medical, financial, educational and vocational programs were remarkable:

> In 1946, seventeen out of twenty Rhodes Scholarships awarded to Canadians went to veterans, and in universities across the country, twice as many veterans as non-veterans passed with honors. (Keshen, 1998, pp. 62, 74)

According to Keshen, such support was the result of three factors: 1) society saw the plight of returning Vets as a social justice issue and did not wish to have the Vets of WWII endure the fate of the 'lost generation' Vets of WWI; 2) the dissatisfaction of returning Vets about their treatment (especially the high levels of unemployment they faced), led them to become involved in the organized labour movement, which the government considered a threat; and 3) political jockeying for the Veterans' vote led to a reform of the transition system which culminated in the establishment of the Department of Veterans Affairs (DVA). Significantly, half of DVAs' employees were Veterans, and remarkably, soon after the creation of the department, they were processing the claims of 40,000 Veterans a month. American researchers have also described the genesis and effectiveness of this type of system-wide, supportive approach after WWII:

> The international approach to psychosocial reintegration is resonant with the one used to reintegrate members of the U.S. armed forces after World War II. The troops came home together, typically on boats, giving them the opportunity to maintain bonds and prepare for the return to a world that was radically different from the one they had experienced in war. Whereas the GI bill provided extensive educational opportunities, "other government programs provided assistance with employment, home mortgages and health care. These programs were immensely successful, contributing to a *sustained period of extraordinary economic growth and innovation* driven by what has become known as this country's 'Greatest Generation' (Hartwig, 2006, p. 3, cited in Wheeler & Bragin, 2007, p. 299) [emphasis added].

Context of the Study

This study takes place at a time where, after Canada's twelve-year (2001-2013) engagement in Afghanistan, a difficult post-deployment transition has come to be defined as a mental health disorder. Two influences specific to this time, situation and population make the present context imperative; they are: the government at the time of the study (Harper Conservative administration 2006-2015), dictated the use of bottom-line oriented

systems where fiscal restraint greatly affected the quality of service delivery, and the fact that the public is not engaged with Veterans' issues as they were after WWII. The stance of the government, which denied the special covenant between the Canadian people and the military, is particularly influential. The covenant describes an understanding that soldiers would be asked, expected and willing to die in order to accomplish the missions that they were assigned, and in return that they and their families would be taken care of. The covenant was never officially legislated but has always been implicitly understood (Social Covenant Equitas, 2014; Equitas Argument, 2013). These issues will be expanded upon in the Covenant Chapter (p. 70) however, it is essential to realize that this understanding is at odds with the nearly automatic medical release of individuals who are no longer deployable, due to mental or physical injury sustained in the line of duty (Brewster, 2014a; National Defence, Defence Administrative Orders and Directives (DAODs)), and that they are released with inadequate support.

The particular transitions of Canada's Veterans in the wake of the recent war in Afghanistan and other United Nations Peacekeeping deployments, do not reflect positively upon our society; for many Veterans the experience has been disempowering and isolating. In spite of this, the stories of Veterans included in this study illustrate how they carry on under extremely difficult circumstances in accordance to the military values they respect, continuing to prioritize the mission of navigating the transition system over their personal needs for expediency, information and respect. Because the participants respect the ideals of the CAF, and honour their fellow soldiers who still serve, it is important to stress that this study is undertaken not to lay blame at the feet of the military, but to explore the experiences of Veterans as they navigate their way through an

extremely convoluted series of transition systems (referred to here by the terms ‘system,’ and ‘transition system,’ unless specified as a particular aspect of the whole series of systems explained in the Covenant Chapter (p. 70).

The mishandling of Veterans’ transitions has resulted in much catch-up, back peddling, and embarrassment on the part of the government in power during most of the war in Afghanistan. The ‘bottom line’ model of governance is evident in many facets of Canadian society (Mintzberg, 2015, pp. 58-70), and for soldiers, it has resulted in some tragic outcomes, represented in images which will be forever associated with the ending of the war in Afghanistan and the abdication of responsibility for Veterans’ care. Such an image is one where then Minister of Veterans Affairs, Julian Fantino, and his aides, literally ran away from the wife of a Veteran who fell through the ‘cracks’ in his department’s service delivery protocol (Brewster, 2014b); another is the rash of soldier suicides around Christmas 2013 (Everson, 2013).

In November, 2014, with Canada’s Auditor General’s Report, Michael Ferguson, reiterated how badly the process has been handled (Ivison, 2014), and additionally, warned against the danger of casting Veterans in the role of victims. Veterans are not powerless victims, and they don’t wish to be seen as such; as discussed in the chapter on stigma (p. 141), the victim construct is a historical artifact, which has been used in the past to marginalize the concerns of Veterans and deny their capacity.

In this study, Veterans explain how their transitional experiences are rife with paradox, as their ‘new identities’ involve being defined by pathologizing diagnoses in order to gain access to services and support. This will be discussed in the Treatment Chapter (p. 197). Veterans who speak out experience having to ‘break ranks’ and break

the military code of silence in order to bring their stories to the courts and the press; the significance of this will be explored in the Culture Chapter (p. 115). Veterans' experiences of having to undergo retraining programs designed to quickly process them through cost-benefit-oriented systems with no regard to their often-remarkable personal and professional accomplishments and aspirations, will be a subject discussed in the Covenant Chapter (p. 70). The Family and Relationships Chapter (p. 255) contains excerpts from participants' stories that reveal how they watch the close relationships that they identify as their most solid support, be considered as secondary to the priorities of the CAF, sidelined in treatment and insufficiently supported in compensation schemes. These experiences occur in spite of much CAF rhetoric about the importance of the military family, and this stands as an example of how the present system repeatedly fails to put theory into practice.

This study asked Veterans about their transitions; their stories showed what they care about, how capable they are of identifying their requirements for moving forward into a meaningful life after service, and their awareness of how misguided the present transition system is. Including soldiers becoming Veterans in the re-design of the transition system, at a policy level, would be an important step toward honouring and acknowledging their contributions and capacity in a way that is not presently happening.

Definition of a Veteran

The various definitions of what a Veteran is, illustrate the need to employ a critical approach to all aspects of this inquiry; as will be discussed in the Methodology Chapter (p. 22), the context around a problem is highly significant in the attempt to understand it. The three definitions below are from a participant, a lawyer's argument in the proceedings of the Equitas Lawsuit, and Canada's Auditor General:

This participant explains being a Veteran as a place of not knowing, an uncertain and uncomfortable place:

> The one thing that's consistent is that they're all changed, they're all different from when they started out- we all are. And you know, when you get to the end, you've got to look at what you were… When I was in uniform it was easy; that was all defined for me-I knew everything, right? I knew where I fit in regards to everybody else, what I did and what I do. And now in retirement… there's nothing- there just isn't anything- you're finished. So…that's probably the hardest, is trying to redefine ourselves and figure out where we are, where we're going to. I suppose we know where we are, we know where we've been, but there's the big wide unknown…

The Equitas lawyer constructs a Veteran as an individual who held up their side of a very serious obligation:

> A veteran, whether regular or reserve, active or retired, is someone who, at one point in their life, wrote a blank cheque made payable to "the Government of Canada," for an amount of "up to and including their life." This commitment to make the ultimate sacrifice reflects their honour in the service of their country. (Equitas Lawsuit documents, 2013, p. 6)

Taken from the 2014 Report of the Auditor General of Canada, Mental Health Services for Veterans, this definition defines a Veteran in terms of eligibility for compensation:

> Veteran—A veteran or other person who is eligible for Veterans Affairs Canada services and benefits. Veterans also include Canadian Armed Forces members

> who may be eligible for the Disability Benefits Program. (Auditor General of Canada, 2012, p.1)

The definitions are obviously situated differently, and they reflect different understandings and priorities. These different understandings are the essence of the problems in the transition system. One of the many significant contributions to my understanding of what a Veteran is came from a participant, who in correspondence he shared with me, indicated that he capitalized the word Veteran as a sign of respect; I will follow his example in my own writing.

Chapter 2: Review of Relevant Literature

In this chapter the rationale for the literature cited will be described. Supporting literature is also interwoven with the discussion of the individual themes. In addition to considering the particular research question, (*what* we look at), and explaining that the question needs to be researched (*why* we look), this literature review will consider the tension between different ways of writing about Veterans' transitions (*who* we are looking at), to answer the question of *where* we look, for answers to the problem. I will cite sources of knowledge generated both about and from within the researched population. This critical approach to the literature is in keeping with the challenge to the present, hierarchical approach to soldiers' transition difficulties that describes a pathology-based understanding of Veterans who no longer fit into either military or civilian life because of problems (disorders) within themselves. This approach will be described and deconstructed further in the Methodology Chapter of this study (p. 23).

Hermeneutics and a Paradigm Shift

Research from past and present will be cited and eventually aligned or contrasted with the Veterans' viewpoints as detailed in the transcripts of the research conversations. This serves three purposes: it points out the need for a new way of considering transitions; it provides the means of knowing how to create such a paradigm shift; and it underscores the fact that this new way is best understood by Veterans themselves. The history of transition from war to home has been replete with examples of how to make the process fit the then-current paradigm. In ancient times this paradigm was based upon returning warriors being honoured as members of society who needed their physical and psychological wounds tended before re-entering the population according to culturally

appropriate rituals and spiritual processes (Jayatunge, 2010; Ben-Ezra, 2010). Today the process is sterile and devoid of meaningful and essential connective processes, and the anger of Veterans about this is one of the signs that the paradigm needs to shift (Abbs, 1996). Other signs that a paradigm is no longer sufficient are that old labels, conferred by one group upon another (often as stigmatizing beliefs), no longer 'fit,' and that once accepted models need too many 'add-ons' to remain relevant because they are insufficient to explain new data. These signs are evident in the current academic literature about post-traumatic stress, along with the disorientation in the field of Veterans' transitions, as researchers and clinicians defend their models as the 'gold standard' and engage in turf wars between individuals and institutions with competing explanations (Abbs, 1996). Adding Veterans' viewpoints will refresh this discussion, fostering an emerging, evolving and dynamic understanding informed by the individuals it most affects.

When we consult previous accounts of military transitions, it becomes obvious that paradigm shifts have occurred before, and that these were generated in response to a need for new understanding. This consideration of the past is important, because when past understandings are re-examined in light of new information, new knowledge, which challenges old ideas and stereotypes, emerges. Jardine (1992) describes this in his discussion of hermeneutics; he explains that simultaneously looking into the past and focusing upon how to move forward helps us become more intentional about how our present decisions influence what we will become.

Choosing an Approach: Present Policy Makers or Potential Policy Makers?

Present policy makers construct themselves as the experts; they enact policy through transition system programs by way of the institutional representatives of the government, in particular the CAF (through its Joint Personnel Support Unit or JPSU) and Veterans' Affairs Canada (VAC). These institutions have been the caretakers of soldiers, and hold the authority with respect to how health, transition and financial compensation services will be delivered to soldiers in transition to becoming Veterans. The rationale for the 'how, where, by whom and when,' of these services, is justified by mountains of quantitative, supposedly objective and evidence-based, randomized control trial (RCT) generated data that is measured and expressed numerically, in outcome research. This approach serves the purposes of a system that defines the problems associated with Veterans' transitions firstly in terms of a neoliberalist 'managed care' model couched as 'responsible financial stewardship of the taxpayers' resources,' and secondly as a 'signature mental condition' called Post-traumatic Stress Disorder (PTSD). Consequently, the transition system is weighted toward fast-turnaround training programs, one-time payouts of insurance claims and brief-format manualized psychological interventions. This approach works well if the only stakeholders are those that have to justify allocation of funds, according to criteria that measure efficiency in terms of symptom reduction, numbers of individuals processed, employment figures and funds dispersed in disability awards, and not in terms of long-term social determinants of health and the subjective well-being of former soldiers and their families.

Although a quantitative measure of transition difficulties identifies and acknowledges specific, clearly delineated areas of the problem, it discounts the agency of Veterans, who

explain that the problem is systemic and more complicated than a specific psychological disorder, provision of a two-year training program, and a fast job. Reducing transition problems to a pathological explanation (mental disorder), casts Veterans as victims of their faulty cognitions and out of balance neurobiological processes (Bowman & Chu, 2000), who need to be treated by medications (van der Kolk, 2014, p. 224), taught to deny their individual meaning-making processes (Hientzelman & King, 2014; Currier, Holland, Chisty, & Allen, 2011), and rapidly shunted into *any* kind of available work. Rigid adherence to hierarchical models of medical care and reductive training programs, locate Veterans at the 'bottom of the heap,' without choice. The adoption of 'top down', patriarchal models of retraining, financial settlement and treatment has resulted in a disconnection between service providers and Veterans and in the perpetuation of the stigma that is a large part of the transition problem.

Another way to look at the transition situation is to ask the potential policy makers- to listen to the voices of the Veterans as they navigate the system using the skills they have learned in the very institution that is now considering them redundant. Veterans use their military skills to advocate for themselves and each other, raise awareness of their issues, connect with their comrades in trouble, and work the best way they can with limited resources. Although many Veterans isolate themselves, others are gathering in person and online, to maintain formal and informal support networks that honour their unique culture. Presently, and often reluctantly, they are speaking out in mainstream media against the government they have served, going so far as to initiate law suits against the Crown on the grounds that the people of Canada, represented by the government, are abandoning their commitment to the care of Veterans (Equitas Lawsuit, 2013.). Even

though policy makers symbolically consult Veterans, and generate numerous reports about these consultations, the goals and aims of these reports have not been acted upon in a way that results in meaningful change for Veterans.

Veterans' most effective work has been with each other, quietly and constantly mentoring each other away from isolation, helping each other to navigate the overwhelming experiences and systems that are part of 'becoming civilians.' In their conversations with me, the participants in this study have spoken about five concerns: the unique culture of the military, their implicit covenant with the people of Canada, the stigma that influences their transitions, the available options for treatment, and the importance of their relationships and families. These are the themes that have been identified from the participants' discussions of their transitions, they are situated within the context of the Veterans' lived experiences, and consequently, they form the backbone of this study.

In addition to the participants' words, consideration of other sources of material such as documents and media accounts is essential in an attempt to understand the experiences of Veterans and to link these to larger contexts. An example of this is provided by the work of Eriksson and Wood (2012), who studied the roles of Canadian peacekeepers in Cyprus in the 1970's; they talk about the importance of using personal interviews with participants in conjunction with newspaper coverage and academic publications:

> Each source has its advantages, but I will argue that without oral history we cannot fully understand what Canadian soldiers experienced while serving in Cyprus. These interviews provide some indication of what it meant to be a peacekeeper and they enrich the current historical record that has largely ignored the role of Canadians in international conflicts. (Eriksson & Wood, 2012, p. 2)

Considering the Sources with a Critical Eye

Traditionally in scholarly work, a literature review examines academic research literature sourced from reference texts and academic peer-reviewed journals. Transition research literature has principally focused upon the physical and psychological injuries of war without sufficient attention to contextual factors that greatly influence how these affect the lives of soldiers, except in terms of health. Consequently, it has become what Eriksson and Wood (2012) describe as 'top down' in orientation, highly clinical, missing the less tangible but crucial aspects of transition: changing self-concept, new meaning-making frameworks, need for family support systems, loss of familiar life trajectories, and reconnection with a sense of belonging in community. These contextual issues are what Veterans talk about in the present study; however, because they are less easily measured, involve ongoing commitment to Veterans, and the use of flexible, individual, relational therapy models and treatments that may be more expensive initially, they have not appeared in the research literature until later in the study of transitions. When these were considered, they were apparent only by the effects of their absence and loss: interpersonal violence (IPV) (Basham, 2008), suicide, and substance use (SU) (Shaw & Hector, 2010). The result of this focus has been that transition difficulties have been overly understood as a personal maladjustment (Horesh, Solomon, & Ein-Dor, 2013; Walker, 2010), and confined to the construct of PTSD, a highly researched mental disorder that has 'gelled' around the observable and measurable symptoms of the disconnection to self, loved ones, and society. Although this study is undertaken to challenge this idea, an analysis of the construction of PTSD is necessary because it explains 'how we got here.'

Notwithstanding the fact that Veterans have had some strong advocates among military psychiatrists who have published academic research, they have mostly been written *about* in the academic and scientific literature through the lens of PTSD and its co-morbid conditions by mental health clinicians and researchers who are deemed to be the experts in this field. In addition to the academic journals, this research appears in government reports and documents, written for the purposes of allocating funds and influencing the opinions of civil servants, and in conference proceedings focused upon military and Veteran mental health service delivery. This literature is dominated by writing about evidence-based practices (EBPs) and symptom-based manualized treatment methods, which are neo-liberalist constructs, designed to be measurable in order to justify the expense associated with them, and standardized, in order to be delivered consistently as though all individuals in treatment were the same. This body of research will be examined in the beginning the Treatment Chapter (p.197), because it illustrates the ways in which the medical model concept of transition came to be the dominant discourse (Young & Breslau, 2007), and as will be further explained in the Treatment Chapter, objectively understanding transition problems has been military psychiatry's best attempt to explain the problem according to the available paradigm.

An important manifestation of the need for a paradigm shift emerges from the consideration of one of the most universally agreed upon barriers to care and treatment associated with transition: stigma. Throughout history, Veterans in combat and transition have variously been described as: saints, heroes, cowards, traitors, anti-establishment dissenters, malingerers, angry and victims of PTSD (Dombo, Gray & Early, 2013; Gruner, 2012; Hooyer, 2012; Ben-Ezra, 2011; Botti, 2008; Summerfield, 2001). Today

these labels are still highly influential, and although they are not often used explicitly, they continue to cast shadows in the form of stigma; because of this influence, their origins will be examined at the beginning of the Stigma Chapter (p.143).

The Veterans' transition story has been taken up in the mainstream media by writers who see Veterans' stories as a social justice issue (Stewart, 2014; Auld, 2012; Smol, 2010). These accounts succeed in locating the problems of transition outside of the Veterans and ascribing them in part to their treatment at the hands of the government, which has helped enormously in raising the awareness of a largely complacent public about Veterans' issues, keeping them in the public eye, and publishing facts and figures in the context of the issues (Eriksson & Wood, 2012). In addition, media coverage is highly accessible, often closely followed by Veterans and easily linked to social media, which is the most common means of disseminating information for many of the technologically aware and competent Veterans in current transition. Media coverage (radio, newspaper and online magazines) will be cited to illuminate how the media have been used as a tool in the social and historical and present-day construction of Veterans' transitions. Because the media can also be used as a tool to manage information according to the agendas of powerful, it has influenced the 'victim construct,' according to which Veterans were portrayed as damaged and incapable of self-control (Lembcke, 1998b, pp. x, 2, 3; Canadian Press, 2015), instead of as well-informed, critical thinkers and capable and committed advocates. The victim construct and media influence upon it will be considered in the Stigma Chapter.

Historical depictions of war transitions have often taken artistic form, depicted in poems, plays or images which describe and depict the very elements that Veterans of

today are feeling the lack of: connection, ritual, and the spiritual integration of war experiences. These depictions range in form, from scenes on ancient pottery (Boardman, Griffin & Murray, 2001, p.51), to the epic poetry of Homer (Stevanović, 2009), to the ethnographies of Herodotus (Roberts, 2011, p.3), and even to modern movies. They serve to remind us that societies once considered the wounds of warriors as their own wounds, were aware of how to receive them back from combat, and honoured a commitment with the soldiers who went to war in the name of all members of a society.

Paradigm Shift

When the academic literature of today approaches the 'cutting edge' understandings of science as if they had been newly discovered, continually changes the name of a syndrome or adds numerous prefixes or suffixes (DPTSD, delayed onset PTSD, moral injury), to a descriptor like PTSD, to keep it relevant, it becomes clear that present treatment models are not broad enough to encompass the multi-dimensional nature of post-traumatic wounding and healing. It is my belief that the most hopeful studies and approaches are those that reveal a confluence, instead of a divergence of understanding between differently generated bodies of knowledge. Such joining is happening between some senior researchers and Veterans' own explanations; this is the most promising wisdom, and it is providing evidence about how current definitions and approaches are insufficient to explain and heal post-traumatic injuries. It is emerging from the fields of substance use (Alexander, 2015) trauma studies (Herman, 2013, 2011 pp.157-170; van der Kolk & Najavits, 2013) culturally relevant practice (Marsella, 2010) military psychiatry (Shay, 2009) and attachment relationships (Schore & Schore, 2008), and I

have chosen to include the work of these researchers, because they combine with the participants' words to underscore the experiential wisdom they contain.

In recognition of the fact that Veterans have always had capacity, whether this was acknowledged or not, the emergence of modern Veteran's advocacy, because it is the area from which change has been generated in the past (Romo, Zastrow & Miller, 2002), will be examined, particularly, but not only, in the Stigma Chapter. It is important to note that this body of knowledge comes largely from the writing of Veterans themselves, on websites, in books (Moncur, 2014; Boudreau, 2008, Bruyea, n.d.), and especially in the transcripts that were co-created by the research participants and the researcher in this study.

Throughout, this approach to the literature will consider issues of power, the culture of the military, the social and historical construction of transition difficulties, and most fundamentally, the importance of connection and knowledge about re-connection in treatment and in relationships. As previously mentioned, one of the most influential social and political forces in the study of PTSD has been the military; much of the research on PTSD in recent history has been conducted by, or situated within the American military or Veteran's Administration (VA) structures, both of which have abundant financial resources (Whealin, Morgan & Hazlett, 2001) and capacity to disseminate their findings. The mandate of military psychiatry has historically been to return fighting troops to war (van der Hart, van Dijke, van Son & Steele, 2001). It will be explained in the Treatment Chapter that this agenda was influential in shaping the concept of PTSD, and continues to be evident in the research concerning screening and resilience.

Although the military has contributed research about Veterans' problems to the body of knowledge, the lived experience of Veterans with war trauma has not been a research interest of the military, nor has the welfare of military families. This is a considerable gap in the literature, and consequently, research about families has been undertaken by the disciplines of holistic treatment and social work. This research points to lacks in the contextual understanding of transitions and how to support Veterans, and it will appear in the Families and Relationships Chapter (p. 255).

As more is understood about the importance of neuroplasticity (Siegel, 2012, p.3), attachment theory and the intergenerational transmission of trauma, these areas are combining to reorient thinking about transition problems away from an exclusive focus upon the medical model. Researchers in the biological, social and psychological sciences are challenging old, exclusively pathology-based constructs of transition and locating the problems outside of individuals and in the institutions and systems of transition (Bryan & Morrow, 2011; Hall, 2011; Skidmore & Roy, 2011). This research, often qualitative, is focusing upon the contexts in which Veterans are situated; it measures outcomes according to broad perspectives, which respect the subjective assessments of Veterans and those with whom they are in relationship. In this study such research is discussed in the Stigma, Treatment, and Relationship and Family Chapters (pp. 140, 194, 251).

Chapter 3: Methodology and Methods

Methodology

An inquiry based upon the lived experience of individuals cannot be supported by objective research methods, which are designed to eliminate the voices of both their subjects and the researchers, and often answer research questions using psychometrics (numbers) (Schutt, 2010, p. 6; Janesick, 2003). Janesick explains that understanding the experiences of individuals within a particular social setting requires a descriptive approach which may "extend discourse over several fields of study," and which focuses upon textual material in order to appreciate the multifaceted, lived experience of the research participants. This agenda indicates a qualitative approach, which is subjective, exploratory and often asks open-ended questions in order to not only to understand a social problem from the point of view of the studied population, but also seeks to improve the circumstances of those researched. Creswell (2009) agrees that such research agendas are best addressed with qualitative methodologies:

> An advocacy/participatory worldview holds that research inquiry needs to be intertwined with politics and a political agenda. Thus, the research contains an action agenda for reform that may change the lives of the participants, the institutions in which individuals work or live, and the researcher's life. (Creswell, 2009, p. 9)

Specific methodological approach. Creswell (2009, p.13) identifies phenomenology as an approach to qualitative inquiry that is appropriate to understand the essence of human experiences as described by research participants. Wizelman (2011), recognizes the importance of such a participant-centered approach in military populations, in her book *When the War Never Ends*:

> …to understand the psychological aftermath of war, we must listen to the warriors and those that share their burdens. Until we do, despite our best professional

> efforts to understand PTSD, we will be no more fit for our own purpose than are sailors who have never gone to sea at all. (Kudler, in Wizelman, 2011, p. xv)

Other researchers, including Ray and Vanstone (2009) have employed phenomenology in their study of the effects of family relationships on healing post-traumatic stress in peacekeepers, and Eriksson and Wood (2012) described how interviews, a phenomenological method, enriched a study of the experiences of peacekeepers deployed to Cyprus.

With a phenomenological framework in mind, there is a need to turn toward theories that incorporate the focus upon lived experience and the primacy of the participant's voice with action-oriented methods in order to improve the social problem being studied. By identifying such theories, it is possible to approach what Miles and Huberman (1994, p.17) explain as a balance between a design that is not too tight and not too loose.

Expanding upon the concept of not too tight, Janesick (2003) cautions against what she calls methodolatry, or becoming overly focused upon the "Trinity' of validity, reliability and generalizability that has concerned qualitative researchers attempting to be accepted in a paradigm dominated by quantitative inquiry. With respect to validity she explains that there is no 'one' interpretation of truth and that it is the co-construction of the participant's and the researcher's interpretation according to the context explained by the participant, that is paramount in qualitative research. She also writes that generalizability is not the aim of qualitative research, although it can have value for influencing policy decisions. Janesick (2003) advises researchers to beware of getting lost in the process of justifying research design, and to consider instead, that the design will emerge throughout the entire research process, extending through the beginning, the middle and the end of the project. She suggests that rigor in qualitative inquiry is

maintained by keeping the focus upon the substance of the findings, and creating a "painstakingly detailed" description of how the data was collected and interpreted, which entails keeping a research journal. Schutt agrees that: "The research question can change, narrow, expand or multiply throughout the process of data collection and analysis" (2012, p. 46). Three methodological theories, which emerged during the early stages of the research process, contribute to the framework upon which this study rests.

The meaning of 'not too tight, not too loose' became clearer to me as I began to have preliminary conversations (pilot interviews) with people whom Fontana and Frey (2007, p. 707) have called informants. These are people with an inside knowledge of a particular culture who are willing to interpret or "act as a guide and translator of cultural mores and, at times, of jargon or language." These conversations helped me to understand that I needed to leave room for participant input into a flexible, responsive design. My original research design involved two sets of participants, and a focus group/interview method, which had originated from my own ideas about how peer mentoring was important to Veterans' post-deployment mental health. I envisioned that the study might someday contribute toward a Veteran-led group therapy model of treatment for post-traumatic stress. Previous to undertaking this study, I was as susceptible, as many people are, to defining the psychological wounds of war solely in terms of the construct of post-traumatic stress disorder (PTSD). As I began to have informal conversations with some very patient, accomplished and generous Veterans, I learned that they had been: 'focus grouped to death,' and considered the focus group as an ineffective 'risk management' tool, essentially part of the 'rhetoric of care' they had been subject to during their time in the military. I decided to reject the focus group as a tool! Veterans in the preliminary

conversations also told me that they were watching out for newer Veterans in trouble in various ways, and that they had great respect for the core values of the military, but not for the transition systems. This made me question my preconceived notions about the military and PTSD being the 'problem' and I began to understand that my initial intent to focus specifically upon one, pathologizing aspect of the transition was perhaps a way to produce a neat and succinct study, but would not reflect the capacity of the Veterans that I was learning about in the preliminary conversations, and could run the risk of merely describing the problem instead of improving the lot of Veterans in transition according to their own ideas.

Foregrounding this capacity of Veterans that I was learning about emerged as an important goal of the project. I realized that in order to highlight this capacity, which I began to see in the pilot interviews, I would need to employ a more exploratory form of inquiry, one that was flexible enough to be refined in response to information the Veterans shared with me as the research proceeded. For example, during a conversation with a Veteran who had a long career as an officer in command of many individuals, I learned about the crucial effect of the Canadian Armed Forces (CAF) practice of medically releasing soldiers who did not meet the universality of service requirements. The Universality of Service Policy entails the need for all CAF members to be deployable, and if they do not meet this requirement due to their physical or mental health, they are medically released. The individual mentioned above explained that medical release constitutes a profound rupture of trust, safety and connection for soldiers. In response to this information, I refined the inclusion criteria for participants in the study to include medical release, enabling me to narrow the study population to those Veterans

who might be having more difficult and complex transitions.

Guiding theories: Power imbalances, issues of voice, naming the problem.

Feminist and critical theory. The research problem seemed most appropriately understood in terms of two ideas: the first is that the contextual influences (which eventually became the themes of the study) around transitions are not being considered by service providers who deal with Veterans in transition, and the second is that this is resulting in an inexcusable power imbalance between Veterans and these providers. At the outset of the study, I understood that these were problems best addressed by some type of critical theory, but I was not certain about which one of the many critical theories this should be. I was aware that critical theories have arisen from feminist theory, in response to post-modernism, which was in turn a response to modernism (Dickens & Fontana, 2015, pp.1-24), and expanded feminist concerns with gender-based inequality to also address inequality based upon race, class and sexuality. Again, Janesick (2003) helped to clear my confusion by pointing out the essential feature of feminist-based theories. She alludes to "post-modernists or post-post modernists," "whatever we end up calling the next wave of critics," and advises researchers to continue to ground inquiry by looking at lived experience and power imbalances and "be thankful for the post-modern questions," indicating that the essential element in research design is a critical stance and not an exhaustive description of the methods, which may need to change. This advice also underscores the previous discussion of hermeneutics, which explains that any understanding of a phenomenon can only be temporary, as it will eventually be defined according to new information (Jardine, 1992). As this 'new information' continues to be generated, a way to contain a study is to ground it in a temporal framework, and for this

study, the temporal frame became the period of data collection and interpretation (2014-2015). This does not mean that the study is not informed by the past and concerned about the future, but that the understandings generated by the interpretation of the data were at least relevant to the time during which the study occurred, and in fact they continue to be so.

A common element of critical theories is that they pay attention to whose voice is being heard, and consequently they illuminate whose is not. They examine the agendas that the more 'heard' are trying to advance, often by studying rhetoric or discourse, and as Brown (1995) explains, they deconstruct these discourses, noticing who gets to name societal phenomena, and how they do this in order to maintain power. The narratives of the participants in this study reveal military discourses and other cultural narratives, and point to the problems and power imbalances within the military and Veterans' systems that affect transitions. The feminist researcher Kleinman (2007, p.13), writes: "words are tools of thought," she describes how the words of research participants can show us what happens in a system if the powerful are challenged; they also expose 'abstract liberalism,' or empty rhetoric that is not connected to a commitment for change. She advises researchers to look at who sets the standards in a system and who bears the consequences of these decisions. It became clear to me that in this study, a feminist analysis and methods would best illuminate examples of participants' resistance to dominant narratives in the military and society, reveal the ways they challenge present understandings, indicate solutions to the problems, and underscore Veterans' capacity.

As a result of the preliminary conversations, I generated a study design with a feminist approach and the following parameters:

- A commitment to remain flexible to the ideas that arise from participants' knowledge honoring Veterans' explanations of the issues of the transition system, and their ideas about solutions to these issues
- Adoption of the inclusion criteria of medical release
- The study would be bounded temporally in the above mentioned period, during which I would continue to monitor media coverage of Veterans' transition issues, be informed by the contributions of participants, and read current academic and professional literature to broaden my understanding

To avoid the risk of the study becoming simply a 'book report,' that only describes the problems of transition without analysis or action, Creighton and Oliffe offer the following guidance in their study of the effects of hegemonic masculinity in the military:

> … imposing a theoretical framework to interpret the experiences of others, without delineating what informs that frame, can unwittingly contribute to the reproduction of hegemonic discourses (Cassell 2005). Conversely, to claim empirical findings without drawing wider theoretical connections and conclusions runs the risk of appearing (and arguably, being) anecdotal. … Needed then are theoretical frameworks that investigate [*the issues*]… in ways that authentically represent and locate study participants' … experiences, both in describing their … problems and thoughtfully informing potential solutions. (Creighton & Oliffe, 2010, p. 410), [emphasis added].

Articulating the usefulness of a feminist approach fulfills the first obligation described above, (to use the research experience to give voice to participants); two additional guiding theories contributed to the commitment to authentic representations and thoughtfully informed, participant-generated potential solutions.

Participatory Action Research (PAR). It was important to attach the study goals to an action agenda that considered the values of the participants, their right to privacy

and the obligations that I am under to produce a Master's thesis that meets the requirements of an academic institution. Additionally, Schutt (2012, p., 19) advises qualitative researchers to work at the weak points and controversial conclusions of prior studies. A particular study by Canadian researchers Evans, Hole, Berg, Hutchinson & Sookraj (2009), describes a methodology that accomplished, by intention and design, a means of providing a bridge between marginalized communities and the large health care institutions that they deal with, in a way that transcended the purely theoretical. Their methodology addressed the same 'weak point' that I was concerned about: the lack of acknowledging individuals' capacity in the large institutions they deal with. Evans et al employed three empowerment-based, culturally sensitive theories to support the collaboration that they were striving toward in their efforts with First Nations communities; one of these is Participatory Action Research (PAR). They explain the appropriateness of this method in a study with similar goals to the present one:

> …researchers employing a PAR framework challenge the historical privileging of Western positivist science…. highlight the centrality of power in the social construction of knowledge and assert an acceptance of alternative and multiple ways of knowing… premised on a set of principles and related practices… that promote a commitment to action and social justice, specifically with the goal of exposing and changing relations of power …(Fals Borda, 1987; Fischer, 1997; Maguire, 1987). PAR emphasizes a collective process where previously considered participants (or subjects) are (re)constructed as col-laborators… (Evans et al, 2009, p. 896)

Evans et al explain that in PAR, there are three commitments: to social transformation, to honouring the lived experience and knowledge of the participants, and to collaboration and power sharing in the research. These commitments make it obvious that PAR is aligned with feminist thinking. Evans et al add: "participatory action researchers are asked to exercise reflexivity to interrogate power, privilege, and multiple and interlocking

hierarchies...” this commitment to reflexivity has been mentioned by Janesick (2003) as a means of ensuring the rigor of a research endeavor; it will be described further in the discussion of specific methods and data analysis.

In the first set of first set of interviews, as participants explained the transition systems they needed to deal with, it became evident that there were paradoxes between the stated goals of the military and Veterans’ service providers and their actual practice. In the interviews, Veterans were pointing out their own issues: power imbalances between themselves and the institutions entrusted with their care, their lack of access: to information, and for opportunities to be heard and to advocate for themselves and others. In addition to pointing these out, they were providing examples of resistance to a dominant social discourse (one that was being exposed by a Veteran-led lawsuit against the current government), of Veterans as angry victims of their injuries, and malingerers (personal communication, Town Hall Meeting, Jan. 2015; Equitas Lawsuit, 2013). Their resistance to the discourse was evident in their continued respect for conduct according to military values in the midst of grossly inefficient transition systems, and their high-level of analyses of transition system problems. In the course of a research interview, a participant and I had a conversation about how this study could help, and we agreed that Veterans needed to be making meaningful, supportive policy, not simply enduring or reacting to the effects of the ineffective top-down policy decisions of bureaucrats. In essence, participants were describing the problems, analyzing them and formulating solutions, which are the characteristics of a PAR-informed methodology, and as I realized its appropriateness, I employed PAR as a second guiding theory.

Narrative Theory. As the study took form, it clearly moved from a description of what's "known and familiar' to one of: 'what is possible,' and the underpinnings of Narrative Therapy, especially the idea of the preferred story, began to seem relevant to me. The preferred story is a way to highlight the way that things could be for individuals, as they connect with a future that aligns with their values and wishes for themselves. During my counselling education I worked with Narrative methods, and as result of this I learned to listen in way that enabled me to hear the preferred stories of the participants:

> …the stories of life and self that are being looked for as alternatives to the problem stories are not being thought of as just any old alternatives, but are seen as stories that represent people's intentions for their lives. These preferred stories ''fit'' with what people want for their lives and what matters to them. The term preferred conveys the sense that we make a choice to search for something other than the problem and that people have preferences about how they wish to live their lives. (Carey, Walther & Russell, 2009, p. 320)

The 'absent but implicit' method, called a map in Narrative Therapy (NT), arose from NT founder Michael White's attempts to understand texts and elicit information about: "how people understand their lived experience and how they can be invited into a sense of personal agency in responding to…problem situations…" (Carey et al, 2009). This map is based upon an understanding of binary opposites, for example, as Carey et al describe, in the binary of isolation and connection, when you hear, or read about one of these, the other is always there; for instance it is impossible to understand isolation if you have never experienced connection. In therapeutic conversations, the therapist employs "double listening," in order hear one side of the binary (called a problem saturated story) and then to reflect to the client questions that might elicit a preferred story that illuminates the other side of the binary. Together, client and therapist endeavor to

develop "…the opportunity to give voice to intentions for their own lives…' (White, 2007, p. 220)." Although this research project was very clearly explained and designed *not* to be therapy, my understanding of Narrative Therapy informed my questioning, listening, interpretation and writing, as well as my intention to keep the participants' own capacity central to the research agenda. The participants' descriptions of the system and the problems of transition were often problem-saturated stories, and their analyses and resistance to these revealed their preferred stories and personal agency. It became clearer to me as I repeatedly listened to the participants' voices during the process of transcription, that the precepts of NT had become the third guiding theory, the one that enabled me to see the capacity of the participants, and provided a framework for me to articulate this.

Method

These theories and practices: critical and feminist theory, Participant Action Research and Narrative Theory, provide a methodological grounding for this study. All of these approaches are founded upon feminist values; they have been employed to address issues of advocacy and social justice, research participant involvement, researcher reflexivity, acknowledgement of cultural values and above all, an intention to leave the participants more empowered toward changes that they have defined as important to themselves. The primary data generation method for this study was the in-depth individual interview, conducted with a sample of Canadian Forces Veterans and soldiers who have been, or were to be medically released, and who had been deployed to conflict or combat areas away from Canada during their careers. In practice, new data was often contributed by the participants outside of the formal interviews; they communicated this by sharing their

personal documentation of their careers and transitions, in emails containing their own summaries of what was important to them, and also links to articles that illustrated their points of view, which I followed up on. This follow-up led to a second source of data, which was a series of reports, studies, parliamentary and legal transcripts and various other documents, which informed my understanding of all of the themes described in this study. This enriched my understanding because these documents often explained the rationale for the dominant discourses that the participants were standing up against, and illuminated the historical and cultural underpinnings of the themes.

Marshall & Rossman (2011, p. 45) note that interviewing as a technique is simple, up-close and personal, capable of answering questions such as; "How do people know what they know?" or "What shapes their world view?" The interview has been employed as phenomenological method with Veterans and is particularly useful where stigma casts a shadow over the research problem. Bragin (2010) writes about using interviews with Veterans to construct narratives in a manner that conveys the acceptance that they may not experience in other settings due to stereotypes from within military culture. Shaw and Hector (2010) employed interviews in their phenomenological study of the transitions of American soldiers returning home from Iraq and Afghanistan. Wiest (2013) used in-depth individual interviews in her exploration of the meaning made by World War II Veterans of their war experiences. She explains that narratives are rooted in culture, and that because of this the process of recounting a narrative to someone else involves implicit decisions about what to tell and what not to tell; it contains ideas about what identity to construct with the interview, by including or excluding 'me/not me' parts of the self:

> Selves do not remain the same across time, however, and selves from the past do not necessarily coincide with those of the present. Thus, "we use narrative as a

> tool for probing and forging connections between our unstable, situated selves ”(Ochs & Capps, 1996, p. 29), or for reorganizing our many selves into a unified whole... (Wiest, 2013, p. 75)

The interview method has been used in populations outside of the military to explore social justice issues similar to those in the current research project. Presser (2004), in a study of incarcerated men, looked at the way that interviews become co-constructed personal narratives providing opportunities for resisting pathologizing labels. Aston (2009) used semi-structured interviews in her study of gendered influences in identity construction in women with substance use problems. In their 2011 exploration, Womersley, Swartz and Maw described the way power imbalances can be reinforced during research interviews; they conducted an in-depth, case-study project using a semi-structured interview with: “broad, open-ended questions aimed at eliciting …[*the participant's*] experience …and her feelings toward the institutions [*the participant*] was dealing with…”

In this study, where the goal was to explore the soldier-to-Veteran transitions, the interview method was appropriate because it respected Veterans lived experience and subjective understanding of their situation instead of that of health care and service providers, providing an alternative to the usual ‘voice’ in which the majority of transition research is written. Additionally, it is a flexible method, and as Kvale, (1996, p.103) explains, in an exploratory study this technique may be adapted in situ, according to new information and circumstances revealed during “responsive interviewing.” Kvale continues to explain that with open questions, there is a possibility that original hypotheses can be modified or refuted as the researcher follows the participant’s answers to uncover new angles (p.106).

This need for modification was evident in the present study. As I began to understand the capacity of the Veterans I was speaking with, the focus of questioning changed from my original "Did you have a successful transition?" toward a more open-ended exploration of participants' experiences in a faulty system. Eventually, the most important data emerged from the question: "Can you describe your support system?" Kvale (1996, p.110), attributes this type of learning on the part of the researcher to the temporal aspect of exploratory studies, where, as: "the interviewer may begin to know more … questions may improve." Aston (2009) explains that her understanding of social issues pertinent to her study population, and also how the benefit of a 'gendered lens' in looking at the research problem, informed her interview guide, and therefore her questions. Aston provides an example of the process that Kvale describes, noting that hers was an emerging, and participant informed process: "The interview guide was informed by a literature review and evolved iteratively as interviews progressed."

Interview protocol. Kienzler & Pedersen, (2007) advise the use of unstructured interviews as opposed to structured ones, to: "learn what questions to include, in the native language," and also describe unstructured interviews as "a good method to build rapport with people." With respect to the number of interviews required, Seidman (2006, p.11) proposes a three-interview protocol, indicating that one interview provides 'thin context,' and explaining that the first interview provides life history information, the second reconstructs details, and the third provides an opportunity to reflect upon the meaning of the phenomenon under investigation, and the participants' opinions. He suggests placing interviews at least a week apart in order to allow the participant time to reflect upon the experience. Caddick, Smith and Phoenix (2015a) took an iterative

approach to interviewing Veterans in a study about nature-based wellbeing, conducting second interviews with only half of their participants:

> …used a semistructured interview guide in a flexible manner to help stimulate reflection on important topics. Half of the participants also took part in a follow-up interview when we required further clarification/elaboration of participants' responses. (Caddick et al, 2015a, p. 78)

The present study used a modified version of Seidman's interview protocol, where the first interview was an unrecorded short 'screening interview,' conducted in person or by phone, according to the preference of the participant, the second interview was unstructured, and, third interviews were semi-structured. The second and third interviews were approximately 90 minutes in length; they were audio-recorded and transcribed verbatim.

Sample strategy and access to the research population. Although the study recruited Veterans on a national scale, actual participants were all from the Atlantic Provinces. This area of Canada has a large per capita representation of Veterans and military personnel, and a concentration of programs and resources that Veterans in transition access, such as retraining, physical and mental health services, Military Family Resource Centers (MFRCs), and Veterans Affairs Canada offices. Most of these services are not readily accessible to the public and to non-military researchers, and for this reason I initially distributed recruitment materials in person at MFRCs on local bases, which are accessible. Recruitment materials consisted of a poster describing the study, my affiliation with Acadia University and my contact information, and also a short description of the study (Appendix B). This information was also included in recruitment emails to Veterans' organizations.

A purposive sampling strategy was chosen as an appropriate method for the study; Berg (2007, p. 32) describes such a method as one where researchers use knowledge about the subject under investigation to select individuals (informants) who represent the study population. Berg describes the suitability of this method for studying "hidden populations" or sensitive topics; this is an important consideration in the present study, because the stigma often associated with medical release can make individuals reluctant to be open about any difficulties they may be experiencing (Horesh, Solomon & Ein-Dor, 2013; Doyle, Strader, Sanders-Hahs, & Nelson Goff, and Peterson, 2008; Doyle & Peterson, 2005; Greenberg, Thomas, Iversen, Unwin, Hull & Wessely, 2003).

As described above in the Methodology discussion, preliminary conversations with informants helped to refine the research design. Such individuals are "nested" within larger populations (Miles & Huberman, 1994, p. 29), and in this study, in addition to shaping the research design, some of them helped to find study participants. This occurred in the course of discussions about the study in a manner much like the referral chains described by Kienzler and Pedersen (2007), and Alyaemni, Theobald, Faragher, Jehan and Tolhurst (2013), where Veterans' organizations and individual health care providers took up the invitation to communicate with potential participants. In this way, research design became intertwined with participant recruitment, as conversations with informants created the trust required for them to pass on information to potential participants. In this study, preliminary conversations took place with:

- A family member who is a Veteran and an active member of several Veterans' associations. This individual helped me understand that Veterans are not a homogeneous group, and that each era of conflict produces its own style of Veteran

with its own associations and outlooks, and that although there is often rivalry between these groups, it is concern for especially the younger, (currently, Afghanistan) Vets that unites them, making Veterans' groups a source of possible participants.

- Individuals on the board of a national, volunteer Veterans' assistance program responded to my application to join their organization by expressing an interest in my research. They offered to meet with me, and although they demonstrated their commitment to the care of their clients with their firm instructions that I did not attempt to access their clients as participants, they generously spoke to me about my research design and offered to speak to me about their own experiences.
- Veterans who were active in advocacy organizations met with me in person, by email and in phone conversations, sometimes several times, and helped me better understand the issues and experiences of transitioning soldiers. We discussed the progress of the study, and they advised me about various Veterans' resources and connections that were often accessible only to soldiers and Veterans. These resources ranged in scope from local to national, including specific health care providers, politicians, and internet-based support groups. Some of these individuals also distributed recruitment materials and information, some gave advice about the study design; in one case an individual organized their feedback in point form, prefacing it with the statement: "You have put your finger on a very serious problem," and extending an offer of help if I got stuck.
- A military mental health professional recommended particular Veterans groups to contact, acknowledged the need for the study, and the difficulty of working in the

military as an outsider. This individual deepened my awareness of how the effects of deployment are shared by families as well as soldiers, and explained the great efforts of Veterans to endure the effects of deployment before asking for help. After our conversation this individual forwarded my recruitment material to potential participants.

- The assistant of a former federal Official Opposition Defence Critic was essential in bringing my study to the attention of the politician she worked for, and subsequently my recruitment materials were included in the politician's nationally distributed Veterans' newsletter. Eventually, the politician called me to acknowledge the study and referred me to the president of a local Veterans' organization as a 'good person to talk to.'
- The national presidents of a two Veterans' organizations, who I contacted by phone and email, agreed to distribute my recruitment materials to their Facebook groups, on email lists and by word of mouth.

Not all military–related organizations were open to receiving the recruitment materials I attempted to distribute. I visited two Military Family Resource Centers (MFRCs); one refused me permission to have a poster on their notice board, and the other suggested that I might be able to post a flyer in the adjacent Canex (military retail store), but not on their bulletin board.

Screening interviews and inviting participants to the research project. Five individuals responded by email to the invitation for research participants, and subsequently, arrangements were made to conduct screening interviews either by phone or in person, according to the preference of the individual. Four unrecorded screening

interviews were conducted by phone and one was conducted in person at a cafe, which was individual's choice of location. One participant reflected to me that he had seen my recruitment materials forwarded by more than one organization, and that for him this was an indication that the study was serious. Another participant was recommended by a trusted individual, and during the screening interview, he made sure that I knew this.

In part, these conversations were an opportunity for me to ascertain if the individuals met the inclusion criteria, which became:

- Having been deployed outside of Canada in any of Canada's peacekeeping or wartime engagements, not necessarily in a combat role, as regular or reserve force CAF members
- Having been, or about to be, medically released from the CAF
- Willingness to participate in two 90-minute individual interviews and to discuss experiences of deployment and homecoming
- Willingness to talk about experiences of transitioning from war to home life, the effects of being medically released and a familiarity with the current issues confronting Canadian Veterans of the war in Afghanistan
- Having access to competent mental health care professionals

These inclusion criteria are clear and simple, aligning with Jensen and Simpson's (2014) philosophy that participants need only to have had the experience in question, and be willing and able to describe it. Their study involved a military population deployed to combat situations; they explain that the decision to have a less-invasive protocol for participant inclusion leaves participants in greater control of the level of information they

share with the interviewer during the early stages of the project, before a rapport has been established.

During the screening conversations, I described the process of informed consent, the concept of the study, its purpose and form as a Master's thesis, and the fact that I would communicate any findings to participants. My plans for protecting the confidentiality of the participants' data were explained and participants were asked about the potentially disturbing effects of discussing their past military experience. Individuals also had a chance to ask questions and express concerns and preferences about the process; during one phone conversation an individual decided he would prefer to meet face to face. Individuals were asked about their support systems, the extent to which they considered their transitions to have been successful, and they were also asked the questions pertaining to the exclusion criteria, which are explained below in the Ethical Considerations section.

Ethical Considerations.

Informed consent. After the screening interviews, the Research Participant Consent Form (Appendix D) was sent to the potential participants electronically. In this document the informed consent process is described as voluntary, informed and ongoing (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014, articles 3.1, 3.2, 3.3; pp. 28-34). Tenets of informed consent are: that participants have sufficient information to understand the purpose of the research, including a clear description of what the researcher is asking of them, an acknowledgement that consent will be an ongoing and continual process, and an awareness that they have the ability to

withdraw from the study at any time without relinquishing the opportunity to receive a copy of the final report. This information was clearly outlined in the document that the participants received, and reiterated during subsequent interviews.

Individuals were asked to take at least a few days to review the participation document and discuss it with whoever they felt should be involved in the decision, and informed that they had a right to withdraw their interview data for a period of two weeks after each interview. According to their decision to become participants, I asked individuals to contact me in order to arrange the first ninety-minute recorded interview. If they decided to do so, this contact was considered to be the first instance of informed, verbal consent. At the first in-person interview, the Research Participant Consent Form was reviewed and signed by the participant and by me and we each retained a copy; this process was considered as informed, written consent (Canadian Institutes of Health Research et al, 2014, article 3.12, p. 60).

Autonomy and exclusion criteria. Individuals with traumatic histories are highly studied populations that may benefit from being research participants, and, as a way of ensuring their safety, a caring intention, theoretical knowledge, practical skills, and a framework of ongoing, voluntary and informed consent must be included as fundamental aspects of the research project in order to minimize the possibility that the process will be re-traumatizing. Based upon research literature which explains that Veterans of combat situations have a higher risk of post-traumatic stress (Garber, Zamorski & Jetley, 2012; Basham, 2008), and considering the possibility that the research process would bring up un-integrated painful memories and sensations, the following exclusion criteria were developed, following Newman and Kaloupek (2009):

- Individuals currently in residential treatment programs for substance use problems would be excluded.
- Individuals who self-report that they are presently experiencing psychotic symptoms would be excluded.
- Individuals who have personal concerns about the safety and suitability of the possibility of discussing traumatic memories with me during an interview would be excluded.
- Individuals who could not describe to me that they have in place a reliable support system including access to a physician and mental health support would be excluded.

These criteria are essential to consider because they present barriers to the informed consent process and because they may indicate that individuals are involved in ongoing therapeutic work of a nature that could include the processing of traumatic material. In accordance with the ethical principles of autonomy and beneficence, (Canadian Institutes of Health Research et al 2014, p. 8; De Haene, Grietens, & Verschueren, 2010; Newman & Kaloupek, 2009; Canadian Counselling and Psychotherapy Association, 2007, p. 2), individuals were consulted previous to being included in the study about their concerns about participation. A copy of the Screening Interview Questions Based upon Exclusion Criteria appears in Appendix C. In this study, there were no individuals who were excluded because of these criteria.

Risks and benefits. Potential risks associated with participation in the research interviews may include discomfort about revealing information about self and others, and the possibility of experiencing vulnerability, emotional arousal and difficult memories.

Newman and Kaloupek (2009) explain that vulnerability in research participants should be assessed individually and not as a result of membership in a group. Contrary to the advice of some other researchers, they explain that research participants should have their capacity for autonomy honored and that there is no need for extraordinary precautions with populations that have experienced trauma, because research questions do not tend to elicit painful memories any more than everyday exposure does. In the present study, individuals had my continuing assurance as to the voluntary nature of their participation and the fact that they were absolutely not required to talk about anything that they were not comfortable sharing in order to continue as a participant. Responsibility for participant safety goes hand in hand with the exploratory nature of the interview conversations, and entailed a degree of mindfulness on the parts of both participants and myself. When I noticed that the conversation had naturally expanded into an area that the participant may not have initially considered as a research area, I asked the participant's permission to continue. Once, when a participant noticed such an incident, he set a clear boundary around the topic with his decision not to pursue it further; another participant asked if we were off track when the conversation opened up in a manner that he didn't see as connected to his transition, and then continued with the topic when we had checked in together about it. These examples indicated to me that participants were active agents in their participation.

Newman and Kaloupek (2009) indicate that experiencing emotional distress does not always result in regret for research participants and may lead to empowerment, insight, feelings of reduced stigma and increased altruism and kinship. The fact that research participants in this study were being asked for advice instead of being the subjects of

pathologizing studies may have been meaningful to them. In fact, willingness to help, and a desire to be heard were reasons that participants were motivated to join the study, which indicates that they feel they are capable of helping and have something to say about the research problem.

Confidentiality. Participants' confidentiality is respected in the processes of data analysis, storage and security, and use (Canadian Institutes of Health Research, et al 2010, article 5.3, p. 60). I explained to the participants that their confidentiality was to be protected in the following manner:

- Only I would have access to information that identified participants and connected them to the data.
- Codes would be assigned during data collection and processing to protect participant's confidentiality; I was the only person with access to this de-identified data
- Interview data was transcribed verbatim by me, in a de-identified manner
- Research materials including notes, audio recordings, data storage devices and transcripts of interviews have been stored in a locked file cabinet.
- Computer files containing data have been password protected and stored on an external storage device, which was kept in a locked file cabinet.
- The data will be used only for the stated purpose of inclusion in my Master's thesis report, unless permission is obtained from the participants for other uses
- I will destroy interview recordings, transcripts and other research materials at the end of seven years after the completion of the study

Safety of the participants. In addition to the above protocols for safeguarding data and respecting the safety and trust of the participants, my own professional qualifications support me in the commitment to conduct the research process in an ethical manner. I am a formally trained counsellor who has met the educational requirements for the Canadian Certified Counsellor (CCC) designation of the Canadian Counselling and Psychotherapy Association. I have had supervised experience in a clinical counselling setting, and have experience with conducting clinical interviews concerning emotionally sensitive matters. I am currently a student of Sensorimotor Psychotherapy, a professional level trauma-informed training program, and have completed Levels I and II: Training in Affect Dysregulation, Survival Defences and Traumatic Memory (www.sensorimotor.org). I understand that the safety of the participants will be enhanced by my attention to signs that they are processing the interview material in the present time, with awareness of present surroundings and communicating from a present-focused state; these are indications that individuals are not emotionally dysregulated (Ogden, Minton & Paine, 2006, pp. 26-40), and that they are capable of making sound decisions about their participation.

During the interviews the following safety protocol was observed:

- I was attentive to signs of distress in participants and used this information combined with participants' self-assessments to ensure that they felt able to continue.

- I was prepared to offer participants who appeared to need extra support as a result of the interviews, assistance in contacting health care providers and

additionally, if needed, I would have conducted a follow-up phone conversation with them.

- Participants have been provided with my contact information in case they wish to be referred to a counsellor or other mental health professional.

Use of deception. There was no incidence of deception during this study.

Compensation. Participants will be given no financial consideration; they will be offered copies of the research report.

Emergent Methodology

An inquiry such as this one must be designed in a manner that is flexible enough to accommodate findings that are generated throughout the study, and it must also be predicated upon the understanding that there may be more questions raised than answered. During the research interviews, I realized that the participants were not talking about what I assumed they would be interested in. Van Manen (2007) explains this research dilemma in terms of how sensitive phenomenological practice not only acknowledges verbal discourse, but also a 'felt sense' that reflects a deeper embodied or 'pathic' way of understanding the experiences of another. The section below describes how this affected my conception of the study.

Research interviews: Conversations about change.

Research interviews were conducted between October 2014 and May 2015, in quiet spaces that were comfortable and accessible for the participants, and suitable for audio recording. Participants were active in choosing these spaces, some offered their own homes or familiar on-base areas that they felt ownership of. This comfort was evident in the way that some participants made the arrangements to book space at base facilities,

and that they chose locations where the staff knew them. Other interview locations were spaces that were commonly used by the public, having no association to anything that would identify participants as other than members of the general public, including meeting rooms at municipal libraries, and a privately owned rental space in a local business.

Issues of confidentiality and informed, ongoing, voluntary consent constituted the introduction to the first of the ninety-minute in person interviews. Participants were at different stages of the transition process, and these interviews were highly participant-led, focusing upon explanations of the elements of the transition system, military structure and culture and Veterans' transition services.

Assumption re-evaluated. My original hypothesis was that if I kept the voices of Veterans central, by asking them about what they needed to have a 'successful' transition, I would hear that they wanted more peer-mentoring opportunities. I soon learned that it is too reductive to ask Veterans about successful transitions because transitions are different for each soldier, transitions can go on for years, and each participant was in a different phase of the process. Although the Vets in the study talked about the same themes, they all had different outlooks and ideas about what successful meant. What they were actually describing was their understanding of the culture, their experiences of working in it, implicit versus explicit understandings about the effects of being deployed, how they coped, and their frustrations with the transition system. What I kept seeing during these first face-to-face interviews, was the capacity for reflection and analysis that all of the participants had. Highlighting this capacity became an informing principle for the second set of in-person interviews, especially in light of the capability

that I was seeing, and my realization that if this was contrasted with the limited scope of the support and transition systems participants were describing, it would be obvious to readers of the study that Veterans had many extremely pertinent contributions to make toward the redesign of the transition system. I realized that I should simply listen to what they thought was important, because as I was hearing, despite what they were facing personally and professionally, they were quite capable of explaining all aspects of the transition to me.

Listening to the first interview recordings, I realized that my task would be to use this opportunity to highlight and support the idea that participants, and other Veterans should be included at the policy making level in the design of their own transition systems. This idea was supported by my own reading about transition systems and problems and also by information that participants began to send me once they knew more about the goals and aims of the study.

After the interviews, transcripts were returned to participants for review; factual and transcription errors were corrected. One participant summarized the important points in his own transcript and sent them back to me with his permission to include them in the study as data. Along with entries from my researcher reflexivity journal, the initial interviews informed an informal interview guide for second face-to-face interviews. Smaling (2002) advises researchers to "pre-structuring your thinking to support an argument" when considering areas to explore with participants. Consequently, I was attentive to examples of capacity that emerged in the second interviews and in addition focused upon unclear areas from the first interviews and on deepening the conversations around preliminary ideas.

In early February 2015, the Veterans' Affairs Ombudsman conducted a Town Hall meeting in order that:

> …Veterans, RCMP members, military members, their families and other interested parties. These meetings are an opportunity for the Veterans Ombudsman to meet with Veterans, talk about what his Office is doing on their behalf and answer questions about the Office and issues of concern to the Veterans' community… (Ombudsman email notification to Vets)

This meeting fell roughly between the first and second in person interviews; I attended and took notes about the Ombudsman's presentation, and especially the Veterans and families' comments (Appendix E). Points raised by the Veterans and their supporters at the meeting mirrored those of the participants, and this agreement helped to reinforce the ideas that I saw emerging from the participants' interviews. The Town Hall experience was also very helpful because in addition to reiterating participants' concerns, it exposed me to the style of engagement that the 'system' (the Ombudsman is definitely a member of the system, no matter what his rhetoric is), uses when dealing with Vets, and reinforced my decision to refine the research problem. A further account of this meeting appears in the Stigma Chapter (p. 143).

In addition to being more focused around the ideas from the interviews, including the information from the Town Hall meeting with Veterans, the second in-person interviews helped to fill in some gaps in the demographic information used to create the participant description. The process of generating these descriptions became collaborative, as participants were asked to review my initial description and add details that they felt were relevant. I also asked them to include citations, medals and awards they had received. This invitation was taken up in various ways, as participants showed me how they had documented their careers in log books and in memory, helped me understand some of the

various deployments and conflicts they had participated in, and shared their awards and decorations. The collection of these details informed the process of data analysis because the collective participant description, generated from the details and experiences of four soldiers, when contrasted with the details of their experiences of medical release and the transition systems, *is shocking*.

In this study, data generation was not a separate process from data analysis; it was continually connected to and refined by the ideas that participants raised. Participants' ideas were my touchstone; for me they remained a measure of what was pertinent in a time when there was a plethora of media coverage of Veterans' issues. In this manner, once again, participants helped move the design away from one that was simply descriptive toward one that was more generated by a new, capacity-based theory. This aligns with Sandelowski's (1998) discussion of the way that the process of data analysis can be transformative, moving from a reliance on *thick, rich description*, facilitated by *heaps of data*, which continually describe the problem, toward new, connected ways of making sense of an experience grounded by *faithful representations of experience*, which honor and foreground the participants' points of view, and the researcher's efforts in knowledge construction.

Chapter 4: Data Analysis - Participants, Themes, Researcher

This study presents the voices of a sample of men whose experiences are sometimes similar to each other's and sometimes divergent. These individuals will be described as a group for two reasons: because their collective achievement and experience, demonstrated by this sample of only four individuals illustrates a high level of competence and capacity, and to protect their anonymity and confidentiality (Jensen & Simpson, 2014; Shaw & Hector, 2010).

Description of Participants

The research participants were all male Caucasians; at the time of data generation they ranged in age from thirty-seven to fifty-eight years of age. Three of them were married, and one was single. Their service history includes being deployed or assigned as part of all three arms of the Canadian Forces: Army, Navy and Air Force. This entailed service in submarines, onboard navy vessels, in ship and land-based aircraft, as large and small weapons systems operators, instructors and designers, in operational and support roles and as specialists in various trades. The lengths of their service in the CAF ranged from eight to thirty-five years; at the time of the study, three had been medically released and one was awaiting his medical release.

Over the course of their careers, all of the participants were exposed to combat experiences and conditions as peacekeepers, operational support and specialist staff, combatants in Cyprus, Bosnia, Somalia, the Persian Gulf and also in the war in Afghanistan. Their experiences included submarine hunting, fisheries patrol, search and rescue missions, travelling in and providing security for convoys transporting refugees, troops, diplomats and equipment; clearing and disarming roadside bombs or improvised

explosive devices (IEDs) and sometimes, due to the nature of their jobs, being considered as ‘high value targets’ for snipers. Participants have been apprehended and held by force, and deployed or assigned to areas where the practices of ethnic cleansing (mass murder of civilians, mass rape) had been perpetrated against civilians. Participants assisted in investigations during recovery, humanitarian and wartime operations in Canada, Haiti, Somalia and Afghanistan, by gathering and documenting evidence in the aftermath of natural and manmade disasters involving civilians and insurgent attacks on their fellow soldiers. Their experiences also include constructing, maintaining and dismantling remote forward operating bases in combat zones in Afghanistan, operating in extreme weather conditions during recovery and sovereignty missions in the North Atlantic Ocean, and providing disaster relief during floods and forest fires, avalanche control, and security for national events in Canada.

During their careers, participants were recognized and decorated for their service with (at least) the following honors: General Campaign Stars, indicating deployment in the presence of an armed enemy; Canadian Forces Decoration, indicating particular lengths of military service with good conduct; Queen’s Jubilee medal, indicating special recognition of service in an important field of Canadian society; United Nations and NATO Peacekeeping medals, awarded for both campaign specific and general missions; Commander in Chief Unit Commendation, awarded for extraordinary service under extremely dangerous conditions of war; Sacrifice Medal, which recognizes having been wounded as the result of hostile action; Order of Military Merit, which recognizes exceptional individual merit; Meritorious Service Medal, which recognizes a particular

deed, performed by an individual, that brought honor to the CAF; and the Star of Courage, awarded individually to honor great bravery and conspicuous courage.

Participant's reasons for participating in the study include: "to help people like me", "not sure how we can help, willing to try", "willing to help, but not sure how I can be of help", "glad to help", and "hopefully to help Veterans". Given their accomplishments, experiences and caring intentions, they have much to offer in the way of influencing new thinking about transition.

Influence of the Researcher on Analysis

In this study participants explained the context, and the significance of the context to their transitions, and my role was to analyze the research conversations according to the meaning the participants gave to it in their discussions. As a result of this analysis five themes emerged from the interviews with participants; they are: 1) Covenant, 2) Culture, 3) Stigma, 4) Treatment, and 5) Families/Relationships. These will be described and discussed individually in the following chapters, because as Kleinman, (2007, p.7) explains, "a list is not an analysis," and: "The point of understanding systemic inequity is to learn how to undo it." The process for transforming a list into something useful, with the process of analysis, involves understanding the context around the problem.

Janesick (2003), writing about data analysis, says that after immersing oneself in the research setting over time, the researcher becomes the instrument of analysis; she explains: "Qualitative researchers do not hire people to analyze and interpret their data. (p. 390) " Schutt (2012, pp. 6-11) advises researchers to examine their personal assumptions and perspectives in order to be clear about the way in which these provide a particular lens through which all of the research decisions are filtered. In addition to

providing a justification for the chosen methodology, and detailing specific methods so that the means of generating data can be open to critical examination, rigorous qualitative research acknowledges that the effect of the researcher extends to all areas of the research endeavour, from the conception of the problem to the dissemination of the findings. As a way of ensuring that this effect is subject to critical analysis just as the methodologies are, Nelson and Gould (2005) discuss the importance of the researcher engaging in personal reflection as a means of assuming responsibility for how their understandings and interpretations affect their studies.

Aspects of my personal narrative that inform my interpretation of the data, and my approach to the research problem, are my interest in inter-dependence and connection, and a personal intent to understand the effects of deployment to combat situations for soldiers as a result of my own family experiences.

My study of ecosystems and yoga philosophy, combined to orient my interest toward ideas about connections in living systems. Combined with this, my educational background in biology provided a framework for the understanding of how the systems of the human body and mind function as an ecosystem. As a yoga teacher I saw this especially in the way that some students processed psychological trauma through their bodies, and then had emotional and cognitive reactions to past or ongoing significant events. I endeavoured to understand these somatically mediated psychological (intrapersonal) reactions through the medical model. This study introduced me to the concept of PTSD, from a pathological perspective.

My father's stories of interpersonal connection with his army buddies from the Korean War taught me the importance of the bonds between soldiers. He has also spoken to me

about his experiences of disconnection upon coming back after the war and experiencing a lack of awareness on the part of old friends who had little knowledge and no understanding of where he been and what he had been doing. These stories have informed my understanding of the effects of connection to other people upon the wellbeing of returning Veterans.

When my son joined the CAF, just before the Canadian deployments to Afghanistan, I began to read the scientific literature about PTSD, which was a discouraging process; I recall my horror at the description of prolonged exposure therapy, one of the military's primary treatments. The clinical descriptions of 'trauma narratives' and the repetitive desensitization process that this method relies upon seemed particularly insensitive. Conversely, while continuing my formal education in a graduate-level counselling programme, I learned about change models that acknowledge the capacity of individuals in their own healing. The respectfulness of these models inspired me. When combined with the concept of neuroplasticity, which explains that positive human interactions offer the most promising possibility for the healing of even the most serious psychological problems, and attachment theory, which elucidates the framework in which this happens, they constituted an approach that made much more sense to me.

I began to read the accounts of Veterans who have written about their experiences, especially the ways that new meaning emerges from a profound re-evaluation of their self-concept after war, and their generous written examples of how this can happen. These stories explained how a difficult transition process eventually resulted in an expanded understanding of self, and led toward a way of life characterized by greater congruency between individual's values, and their decisions and actions. This was a

process I recognized from yoga philosophy, and also from the concept of self-authorship, two models of human growth and potential that I have been inspired by.

As the result of my intention to align my personal beliefs with a model of therapy that is gentle, interdisciplinary and respectful of the importance of connection in healing, I began the study of Sensorimotor Psychotherapy (SP). This model holds the concept of organicity as one of its foundational principles. Organicity is the understanding that individuals have an innate capacity to heal themselves, and that they have implicit and explicit understandings of how this can happen. My study of SP has reinforced my beliefs in the importance of connection and capacity in healing, and also taught me to recognize these resources in the narratives and implicit somatic communication of others.

I was predisposed by my upbringing to listen to Veterans' stories. My concern about my son (and eventually my soldier daughter-in law) oriented me toward a less pathological approach than I was seeing in the medical model. My attempts to understand traumatic experiences taught me to look at many forms of connection as a means of healing, and to understand psychological injuries as a possibility for growth and re-evaluation, not an indication of insufficiency. The critical-feminist example of my academic mentors illuminated a framework that clearly situated problems outside of individuals and within the systems they encounter.

Originally, my understanding was theoretical, based mostly upon the writing of researchers and a few outlying Veterans' accounts. During the research interviews, I was continually reminded that we were having conversations about problems and constructs that had emerged time and time again in the experiences of soldiers returning from war, that these are problems that had been studied and analyzed according to society's

capacity to understand them at a particular time. Essentially, despite 'progress,' in terms of stacks of symptom-based randomized controlled trials (RCT) studies, we were having conversations in 2014 that could have occurred in ancient times. Hearing the participants' own experiences, within the context of the historical and social construction of post-traumatic stress (outlined in the Stigma Chapter, p. 143) helped me to recognize their descriptions of the effects of stigma, systemic accusations of malingering, and the influence of homecoming reception on their transition experiences. Marshall and Rossman (2011, p. 46) explain that a "pervasive quality of … experiences across time and culture," makes certain ideas stand out from the rest of the data, and this "standing out", in addition to the participants' own emphasis, was evident in the case of capacity, stigma and the other themes.

Emergence of the Themes

The themes first emerged as I began to organize the initial interview data according to the protocol described by Turner & Cox (2004):

- Transcribe interviews verbatim and employ an intuitive process of reflective listening. Use "minimal manipulation" (punctuation used only for clarity and preserving participant's emphasis) and make decisions about including information such as identifying details and passages about participants or family members, with respect for confidentiality.
- Reread transcripts to be fully immersed in the contextual features of the participant's narrative (use of self-deprecating humour, minimizing, degree of literality, or use of symbolism).

- Using the contextual information as a guide, note revealing phrases and passages and cluster these as sub-themes.
- Sub-themes indicate larger ideas that appear across the transcripts of most participants; these larger ideas are named and constitute themes.

Marshall and Rossman (2011, p. 164) caution the researcher to consider 'the pitfalls of assuming that the written word parallels the spoken one," and that judgments involved in placing punctuation are complex, shaping the meaning of "the written word and hence the interview itself," the conventions of language, such as gaps and pauses, may mean different things to participants and be difficult to interpret for a transcriber. These difficulties must be acknowledged, the researcher needs to provide strategies for handling the judgments and interpretations of participant's words:

> The ethical issues that arise in transcribing and translating other's words center on how we represent our research participants, how we demonstrate respect for them in transposing their spoken words into text that we then manipulate and write up. (Sandelowski, 1998, p.167)

Transcribing the interviews verbatim, immediately after they occurred, kept the voices of the participants in my head for days at a time, and I became familiar with their unique speech patterns. I annotated the transcripts, initially outlining all passages that stood out for the participants, as indicated by their explicit and implicit communication, for example: presence of emotion was often indicated by raised or subdued tone of voice; an urgency of cadence and long explanatory passages seemed indicative of the need to get something said. The use of indicators that were repeated, such as: "sadly, unfortunately,

this is important, that's a major problem, here's the problem, cut and dried" and meaningful images or expressions such as: "blood in the water, exit ramp, 100% broken," drew my attention to passages that were meaningful to participants. These unique meanings and often-repeated expressions are indications of significance according to Miles, Huberman and Saldana (1994) who also caution against drawing conclusions without verifying them with participants: "The human mind finds patterns almost intuitively; it needs how-to advice…Patterns need to be subjected to skepticism… to conceptual and empirical testing…" (Miles, Huberman & Saldana, p. 278). The testing that these authors refer to happened in the processes of participants checking their transcripts, and in the naturally occurring email correspondence that occurred as a result of my asking for clarification of demographic details, responding to participants providing me with current updates about Veterans issues. This correspondence was entered into generously by all of the participants, who did not hesitate to answer my questions and provide any information they felt would help me.

Through the process of extracting significant quotes from the interview recordings and transcripts, and then clustering them into sub-themes with descriptors such as 'isolation', 'good leader', 'networks', 'knowledge', 'no-victim' etc., it became clear to me that although all participants did not discuss categories of ideas in the same way, they all spoke about significant larger concepts. Initially grouping the sub-themes into themes according to paradoxes, which is an approach from Narrative Therapy (for example participants' capacity in the face of the broken transition system), seemed like a good way to attempt to discuss the data. After the first set of interviews, I sent a document to participants describing the paradoxes:

- Paradoxes between what you once understood about your relationship with the military (family, support, honoring your service) and what your transition experience has been (overwhelmed systems, bottom line oriented programs, uninformed service providers, no investment on the part of the service providers, experiences of isolation).
- The paradox of having learned in the military how to get through tough times by carrying on (sometimes with limited resources), and then needing these same skills to advocate for yourselves during your transitions out of the military (as you deal with systems that limit your access to information and resources).
- The paradox of needing to have a diagnosis of PTSD in order to access medical and mental health benefits, (when reactions to readjustment are seen as symptoms of a disorder as opposed to reactions to a profound life reassessment and values shift) and the fact that a diagnosis of PTSD guarantees that you will lose your job and career.
- The fact that you willingly 'served' (this word is insufficient to explain what this entailed) in defence of a country whose people (some of whom you love), were sometimes unaware of what you were doing, and why- and that this can complicate the transition to civilian life (clash of values, extremely unique experiences, knowing that things can't, and maybe shouldn't be the same after deployment).
- The fact that each individual experiences life, transition, etc. uniquely, yet some of you have mentioned cookie-cutter treatments being offered to you by therapists who you don't identify with or trust, and some of you have had different experiences.

Feedback from those who chose to reply (three out of four participants), included that it was interesting and comforting to see that their ideas were similar, good to know that they were not alone and that others agreed that the system was broken.

As the second set of ninety-minute interviews progressed, it became clear that all sub-themes could be grouped under the same general headings. This is what Shaw and Hector (2010) call theoretical saturation, it occurs when there has been enough data collected that: "…findings are redundant enough to recognize core meanings. (p. 130)" They indicate that three to five interviews are often sufficient to identify common themes. Using the eight interview transcripts, the confirmation of the notes from the Town Hall meeting and the feedback from the participants, five themes, which encompassed the sub-

themes, were generated. These themes comprised the way that the participants described their transition experiences.

Section II – Navigating the System: Influences, Obstacles and Resistance

Chapter 5: Approach to Findings and Discussion of the Themes

Highlighting Capacity

As I related the themes to the research problem, I was guided by the advice of Marshall and Rossman (2011, p. 164), who urge researchers to anticipate the usefulness of their findings. The participant's knowledge, and ability for critical thinking and analysis is evident in each theme. As these Veterans described the problems with the transition system and also their own solutions, they challenge the stigmatizing representations and narratives of soldiers with post-traumatic stress. Fine (2006) explains that when accounts show this evidence of "theoretical notions moving from one context to the next," it is a form of theoretical generalizability. Although I initially considered capacity as one of the themes, I came to realize that capacity is not a theme but a tool for paradigm change; it brackets the themes, and is the context in which they should be discussed. This decision aligns with my personal beliefs, my professional training and the methodology I have chosen for the study.

Polyvocal Format

Sandelowski (1998) explains that ways to honor the fact the participants' voices are most important are, not reducing them to one voice and not confusing (being unclear about), their voices and the researchers**.** She adds that this is accomplished by using a polyvocal format and juxtaposing text. An example of this is provided in the following discussion, where participants talk about their support systems. One participant explains: "Older guys have wives and kids. …younger guys not so much….it definitely plays a role I think….they don't have any support at home, so they're by themselves; that's a major problem…" revealing the importance of army buddies *and* family. Another participant

has a differing understanding which entails not including family in the sharing about difficult aspects of transition: "I would be reluctant to share within a personal relationship. To me it's just that, you know: "We don't need to talk about that." Juxtaposing text in this manner reveals that all participants did not feel the same way about close relationships, but that the theme of Family and Relationships provides a place to discuss their experiences. In addition to the practice of participants checking their transcripts, maintaining a polyvocal format helps to maintain the integrity of the participants' meanings.

A Powerful Chorus: Veterans' Alignment with the Understandings of Senior Researchers

As I annotated transcripts, highlighting passages that stood out for me, I noticed that in many cases, the words of participants were echoing the words of senior researchers, or individuals who have had long careers in their particular fields and are considered to be the elders in their research communities, and that these two knowledge sources strengthened each other. In much the same way that historical knowledge exposes "dominant, cumulative misrepresentations" adds depth to understanding, and enables contextually specific generalizations (Fine, 2006, p. 92), the work of some senior researchers exemplifies intersections in the understanding of the problems between them and the participants, and bolsters the argument for change in the direction that participants indicate is necessary. The following quote, from the review of a psychotherapy text that applauds a pluralistic approach, captures the essence of how powerful this alignment could be in moving the research agenda forward:

> This is not some smooth political offering but a very human, very rich compendium of research, thought, feeling and experience. The many quotes and

> references mean that probably a hundred or more voices are all singing the same song: a powerful chorus. (Coulson in Kalisch, 1998, p. 48)

Recalling Marshall and Rossman's advice to anticipate the usefulness of the research to the population, when I noticed the parallels in the work of senior researchers and Vets in the areas that Veterans were identifying as important to them, I saw that new understandings about the elements of Veterans' transitions were being generated inside the research community. This was happening mostly in the work of mature (long-time, older) researchers as a result of the paradigm shift described above in the introduction to this study. I began to conceptualize the present study as a space where Veterans' own ideas could co-exist with this type of reflective commentary by researchers, about Veterans, and this seemed to me to be an extension of the polyvocal format mentioned above. The two types of knowledge enrich each other instead of existing in opposition to each other, as quantitative research about Veterans and ideas of Veterans' capacity do in the present system, in clinical writing and in training programs.

The fact that I was seeing converging interpretations in the words of the participants and researchers was initially surprising to me, and it offered hope in terms of several possible outcomes: 1) the effect it could eventually have on policy, 2) the effect it could have on clinical training of mental health practitioners, and 3) the possibility that this confluence would support the redesign of transition systems that too often construct Veterans as victims. Veterans and senior researchers are, in many ways, on the same side of the problem, and I hypothesized that locating them so in this study acknowledges Veterans' capacity, challenges the hegemonic discourses responsible for the victim

construct, and also the hierarchical medical model of treatment that will be described in the following discussions about stigma and treatment.

Veterans' Voices Heard in the Arena of Policy Change

Dickens and Fontana (2015, pp.1-24), in their explanations of how qualitative research challenges grand theories that are based upon essentialist and reductive positivism, advise researchers to look at lived experience and power imbalances. They cite Seidman (p.10), who explains that societal stories that "carry moral, social and ideological" themes can influence policy. In their discussion of the politics of inclusion and exclusion centered around the DSM-5, Cotten and Ridings (2011) indicate that in the service of policy change, it is advantageous for marginalized and pathologized groups that desire change, to find 'insiders' with whom they have a 'good fit' philosophically. Because of the lived experience shared in the accounts of Veterans and researchers, both participants and senior researchers will be cited in the discussion of the themes.

Chapter 6: Covenant

Our Covenant with our Soldiers

"*We were the guys that never, ever, ever, for any reason- ever- didn't go do our job!"* (Participant)

"... we've always sent ourselves, our people into places where most Canadians wouldn't even dream..." (Participant)

Ancient conceptions of covenant date back to the Bronze Age, and were based upon relationships of unequal power, where a lord undertakes an obligation to provide refuge and asylum to individuals who will obey his command (Bradshaw, 1998). These agreements were sacred, witnessed by the gods, and signified by rituals and oaths. In Biblical times covenants were also based upon the sacred relationship between humans and their God. Covenants were the understandings that conferred meaning on the lives of those that accepted the responsibility to enter in to a special relationship with the Divine, and are referred to in all of the major Western religious traditions as binding promises between an omnipotent, loving Lord and the people he chose. Originally, this promise was unidirectional, an obligation given by God, in his power, to the faithful and obedient (The meaning of "Covenant" n.d.). Hebrew scriptural tradition understands covenant (B'rit) as one of the most important concepts, preceding all other arrangements, whereby God will protect and provide for his people in acknowledgement of their obedience (Berit, n.d.). The Islamic understanding of covenant (Mitha') describes that the chosen people accept the responsibility to be worthy of membership in a just community guided by the value of trust, that treats all members, especially the most vulnerable, with absolute respect (Armstrong, 2002, p. xi; Islamic World, n.d.). Greeks translated the Hebrew

word for covenant as promise, or agreement between two parties (diatheke), and Romans as testamente, to bear witness. Christians refer to the Old Testament meaning of covenant as "how God communicates with the faithful," and by the 19th -14th century, the Old French term *convinir*, to agree, is used (Slick, n.d.).

In today's society a covenant is commonly understood in terms of financial or legal agreements between two parties. Although vestiges of the profound and sacred relationship this term once described remain in terms such as witness and obligation, today the meaning of covenant has been reduced in scope according to the values of the neoliberalist paradigm, described by Mintzberg (2015, p.12) as "a creeping meanness."

The 2014 Department of National Defence document entitled Caring for Our Own, which describes the CAF strategy for supporting injured personnel, outlines the level of obedience expected of soldiers:

> CF members serve voluntarily, and as such, willingly accept the statutory authority of the chain of command to compel members to perform any lawful duty at any time. This includes accepting the risks to health and life of performing hazardous duties or being placed in harm's way. (Duty with Honour: The Profession of Arms in Canada (National Defence, 2014, p. ii)

In the introduction to the same document (National Defence, Director casualty support…Caring for our own, 2014, p. 4), then Chief of the Defence Staff, Walter Natynczyk, quotes a Standing Defence Committee, which in 1998 recognized the presence of a moral commitment on behalf of the CAF: That suitable recognition, care and compensation be provided to "veterans and those injured in the service of Canada."

In spite of this recognition by the former Chief of Defence, today Canadian soldiers do not have the assurance that they and their families will be taken care of in case of their death or injury.

In this chapter, the 'covenant' refers to an agreement or social contract between Canada's soldiers and her citizens, whereby soldiers are expected to be willing to die in order to further the goals set by the Government in times of war and conflict (National Defence Ombudsman, 2010, p. 2), and to do this in the name of the Canadian people, in accordance with Canadian values. Information provided to Canada's newest citizens, immigrants to our country, describes these values as: equality, peace, respect for cultural differences, freedom, and law and order (What Are Canadian Values? n.d.). According to the CAF, the values of duty, loyalty, integrity and courage are also part of a soldier's code of conduct (National Defence, Canadian Forces 101 for civilians, n.d., p. 45). Members of the CAF are bound to these ideals and values by their own beliefs, by military sanctions, and until 1998, by threat of death. This level of commitment to duty is far beyond that which is asked of ordinary citizens and therefore a special social contract is understood to exist between CAF members and the Canadian public. This contract, or covenant, ensures that soldiers who are wounded or killed in the service of Canada (and their families) will be taken care of for the rest of their lives (Solomon, 2010; Equitas lawsuit, 2013). Military personnel do not have an employment contract, but many of them consider the Statement of Ethics, principles and obligations reflected in their oath, and the multiplicity of laws, rules and regulations they 'sign on to' when they join the military, to be legally binding (Canadian Forces 101 for Civilians, p. 47).

At the time of writing (November, 2015) CAF members still do not have a legal covenant with the CAF (Drapeau & Juneau, 2013), in fact the Government of Canada is challenging their

right to assume that they do in court (MacGregor, 2014). From its origins as a sacred obligation, where the obedient servants of a powerful lord are taken into community and supported when they require refuge, the meaning of covenant has devolved to a situation in our country where the Canadian government is fighting its wounded soldiers in court over the existence of such a promise.

Veterans' Understanding of the Covenant: "A Weird Relationship"

> "*I always wanted to be in the military- ever since Junior High."* (Participant)

> "*…my resume… my history- it's always been to assist others kind of thing. I found that I got the greatest satisfaction from that… whether it was…providing security to folks in Afghanistan, or you know- safeguarding lives and making a difference…"* (Participant)

The social contract has circumscribed Veterans' entire military careers, as indicated in this excerpt from the New Veterans Charter (NVC) challenge (described below), including an individual's decision to become a soldier:

> AND WHEREAS the Social Covenant was enshrined in every piece of veterans' legislation until the NVC, and found its way into the *representations that were made by recruiters* to those members who agreed to risk their lives in exchange; (emphasis added). (Equitas Lawsuit Documents, 2014, p. 8)

Participants explain that for them, an understanding of the social contract was elemental to their service in the CAF; it formed the premise that they worked from for their whole careers:

> We always used to have that mantra that: "Just do your job boys, don't worry we'll look after you… you'll be looked after: You know there's no life like it because we ask you to do some terrible things, we put you in harm's way willingly- knowledge at the forefront- it's all there… you know we're going to do bad things to you, you're know you're going to be put in harm's way, you know you're going to have some issues from it, however- don't worry when all is said and done if you're broken we will fix you, we will help you, we will look after you- there will be a community there, you will be supported.

Gradually, their commitment to the covenant they understood, became part of their identity:

> …you always had to step up to the plate. I mean when it was serious and when it was necessary- I mean there were times… otherwise you were creating hell just for the sake of having something exciting to deal with. We were always in shit, we were always, throughout our whole career in the air force we were always- seemed to be the same ones standing on the mat front of the commanding officer yet he also knew- we were the ones that they always protected, because they knew we were also the only ones that always came through. It was a weird relationship, but that's what we were- and that's what we are.

Honouring the covenant has had costs for Veterans, and these will be explored in the discussion of all other themes, especially as they relate to stigma, treatment and family. One participant explains the cost in terms of his self-definition: he was shaped and molded by the military into an 'operational guy':

> For us…we joined this life- we were stripped down and we were rebuilt the way the military wants us to be. We all live a regimented life in the military; and it doesn't matter what rank you are, it doesn't matter where you end up, everybody starts the same, they begin this regimental way of life …it's all about survival- we're taught how to survive, in whatever environment we find ourselves in, that's what it's all about. An operational guy- you've spent too many years on the edge of aggression, on the edge of being lit up, you know, all this adrenalin flow going through you for no reason- you'll never be the same, and you'll never re-classify as civilian again.

He describes the time after his medical release, when the profound changes in his base-line level of arousal caused problems as he re-entered civilian society:

> … for years when I first got out I didn't know what the hell was wrong with me…When we enter a career with the military, we're no longer suited for civvy life; you spend ten years in the military, you're no longer a civvy, you can never be classed as a civvy again.

Veterans' discussions about the covenant rest on the moral and ethical commitments outlined above and also upon historical precedents, most notably the speech made in 1917 by Conservative Prime Minister Sir Robert Borden to Canadian troops on the eve of the Battle of Vimy Ridge. In this speech the Prime Minister said:

> You can go into this action feeling assured of this, and as the head of the government I give you this assurance: That you need not fear that the government

> and the country will fail to show just appreciation of your service to the country and Empire in what you are about to do and what you have already done. The government and the country will consider it their first duty to see that a proper appreciation of your effort and of your courage is brought to the notice of people at home... that no man, whether he goes back or whether he remains in Flanders, will have just cause to reproach the government for having broken faith with the men who won and the men who died. (Borden, 1917, in Brewster, 2014a, paras. 8, 9)

This quote and other parts of Borden's speech formed the foundation of Canada's legislation concerning compensation to Veterans from World War I to 2006, when the New Veterans' Charter (NVC), or Canadian Forces Members and Veterans Re-establishment and Compensation Act was voted into being by Parliament.

Government Denial of the Covenant

The Government, on behalf of all Canadians, purports to honour their part of the covenant in recognition of the gratitude and debt that the country owes to its soldiers and Veterans. Previous to the war in Afghanistan this was accomplished through various acts of Parliament, most commonly the Pension Act, (Adams, 2014, pp. 30-33) and presently through the administration of the NVC. In practice, the enactment of the covenant is a highly contentious social issue that has resulted in Veterans suing their Government in 2012 through a class action lawsuit that challenges the NVC as being in contravention of their constitutional rights according to the Canadian Charter of Rights and Freedoms. With the challenge, Veterans are seeking the middle class lifestyle they argue would have been possible if they had they been compensated under a scheme such as the Pension Act, which provided long-term financial support. They are asking for larger lump sum payments and life-long pensions without taxes and claw-backs (penalties for working and pension income) that are indexed to cost-of-living standards, and are comparable to workers' compensation benefits received by other members of Canadian society (Equitas Society, 2012, p. 15). In the province of Ontario, these benefits are

described as no-fault, comprehensive, flexible and connected to emotional and psychological as well as physical work-related injuries (Community Legal Education Ontario, n.d.).

The NVC challenge has spanned the duration of the war in Afghanistan (2001-2014); it is emblematic of the problems that Veterans are experiencing during their present transition. In addition to highlighting this challenge, during research conversations, participants have explained that other court challenges by Veterans such as Dennis Manuge, over the Government's claw-back of financial benefits (Tutton, 2015; McInnis Cooper, n.d.), and Sean Bruyea, over the Department of Veterans Affairs invasion of his right to privacy (Brewster, 2010; Solomon, 2010), are significant because they pertained to many Veterans, and have provided examples of the ability of Veterans to advocate for themselves in courts of law against government institutions, and of the level to which the present transition system has descended in its treatment of Veterans. Veterans find this insulting and indicate that it is the reason for some of the serious and debilitating consequences that they live, and die with (Stewart, Feb. 7, 2014; Moncur, Jan 21, 2014).

The court actions provide touchstones in the attempt to explore the disparity between the Veterans' understanding of the covenant and that of the government. They involve two entities that loom large in Veterans' interactions with the government: Veterans Affairs Canada (VAC) and the Service Income Security Insurance Plan (SISIP), these two organizations or programs were the focus of much discussion in the research conversations. In addition to the court challenges, participants highlighted the actions of particular Veterans, mentioning Barry Westholm, Pat Stogran and Sean Bruyea, as honourable examples of individuals who paid a high personal cost to illuminate problems in the transition systems. Stogran and Westholm used their resignations from positions within the military or government as a means of garnering

support and public attention for Veterans' issues. Bruyea, a very vocal critic of the NVC, sued the government over VAC breaches of his confidentiality, which resulted in more circumspect practices regarding the medical records of all Veterans (Solomon, 2010; Sean Bruyea/Voices, n.d.; CBC News, 2010). Each of these individuals has effectively and publically advocated for changes at a policy level, and been transparent about the personal and professional price of doing so. Some of them have also shared the fact that they live with one of the most stigma-laden conditions that results from military service: post-traumatic stress disorder, thereby challenging pervasive assumptions and stigma about the abilities of individuals who live with the effects of this condition.

Finally, a discussion of the recently released Fynes Report and the government's stated position about stigma in the military will be used as a further example of the disparity between the government rhetoric and actual practice around support and respect for families, transparent communication and the efficiency of its systems for Veterans' care.

The court challenges.

> *"… I feel it's important to highlight that at present, there are more lawsuits pending against the government and more advocacy groups exist than ever before. Veterans concerns are not being addressed by this government, and they refuse to listen to them so they are taking their cases before the courts and to the media."* (Participant)

The court challenges are important to the participants, some of whom are involved in the lawsuits, for obvious reasons, and also because they provide examples of the 'right way' to address issues according to the soldiers' understanding of the priority of the mission over individual needs, and the value of personal sacrifice for greater good. The Equitas Society (NVC challenge) and SISIP (long-term disability) lawsuits were initiated with the support of a community of Veterans and Veterans' allies that raised funds and

established websites that provide up-to-date information such as summaries of proceedings and legal documents. The challenges have been covered extensively in the national news media, and have been the subject of much discussion on Veterans' social media and advocacy websites; they exemplify the lengths that Veterans have had to go to in order to have the government honour its side of the covenant.

The SISIP lawsuit was launched in 2007 by Veteran Dennis Manuge over the NVC reduction of long-term disability benefits by the amount of the monthly VAC Disability Pension Veterans receive under the Pension Act (referred to as claw-back). The result of the claw-back was that the most disabled Veterans received very little or nothing from the SISIP plan, despite having paid into it for their entire career. Over the remainder of their lifetimes, this could cost injured Veterans hundreds of thousands of dollars. There had been previous warnings about the importance of this issue; in 2003 the Department of National Defence's (DND) own Ombudsman released a report advising changes to the SISIP disability coverage (Marin, 2003). Notwithstanding this, according to a Veterans' advocacy website: "The Government had taken the position that it would see our veterans in court" (Leave no vet behind, n.d.). This suit was supported by a Veterans' group called Leave No Vet Behind; it eventually became a class action suit which, when settled in 2012, resulted in an 887.8 million dollar settlement, potentially affecting 14,000 Veterans (Tutton, 2015; McInnis Cooper, n.d.)

Equitas Disabled Soldiers Funding Society was formed in 2011, by a group of Veterans who were concerned by the changes to long-term financial support resulting from the government decision to transition from the Pension Act framework of support for Veterans to the NVC (Adams, 2014, pp. 30-33). The aim of Equitas was to raise

awareness of the resulting financial inequalities, and support young soldiers who were injured; one of its main strategies was to have the government acknowledge its covenant with Veterans. The 2012 NVC lawsuit, which named six Afghanistan Veterans as plaintiffs, was taken on as a pro bono case by Vancouver law firm Miller Thompson, and eventually became a class action lawsuit.

The initial response of the government to the Veterans' challenge was to attempt to have it denied**.** According to court documents, Crown lawyers argued that the plaintiffs seek to advance a pure economic interest (article 81) and to dismiss their claim against the NVC by saying that a benefit scheme cannot be said to amount to a deprivation merely because the claimants are not satisfied with it (article 85). The Crown attempted to discredit plaintiffs by pointing out that they were currently receiving pensions, arguing that this disqualified them from being able to speak on behalf of all Veterans, and also denied the existence of a social contract. (Equitas Argument, 2013; Brewster, 2014a; Everson, 2014) Essentially, the government's initial response to the claims of six seriously wounded Afghanistan Veterans relied upon marginalizing tactics that labeled these individuals as malingerers, and denied both the validity of their concerns and the Canadian peoples' responsibility to them**.**

The government's stance on this issue has insulted Veterans and has further entrenched the idea that it continually fails to live up to its own rhetoric of caring and valuing Veterans and their families. On behalf of its more than 320,000 members and a coalition of fifteen Veterans' associations, the Royal Canadian Legion has responded to the governments' stance:

> The Veterans Consultation Group representing various Veteran Organizations… is outraged that Department of Justice lawyers representing the Government of

> Canada reject the view the Government has any moral or social obligation to Veterans and their families. (Legion News Release, Aug. 12, 2013, para. 1)

Bruyea's warning. What is remarkable, but perhaps not surprising given the history of Veterans' issues in Canada is that in 2005, before the war in Afghanistan, there were discussions about the precursor to the NVC, Bill C-45, which included input from Veterans' groups. Sean Bruyea, a Veteran of the Gulf War, and a former intelligence officer trained by the CAF to gather and evaluate information, testified as an individual before the Standing Senate Committee on National Finance. He pointed out specific concerns, especially the long-term, system-wide ramifications for Veterans of many of the aspects of the proposed NVC. These were issues which have subsequently cost Veterans much personal distress, time and money; they include the effects of providing lump-sum payments to young transitioning Veterans, the long-term inequities between the Pension Act coverage and the NVC, SISIP claw-backs of benefits, the expediting of Bill-C-45 without sufficient analysis, and its imposition on a 'workforce without bargaining power.' Bruyea, in 2005, raised a question about the committee's need to have the bill passed into legislation without sufficient consultation and reflection, asking:

> What is the rush to pass this bill so quickly? If there truly is widespread support from all Canadians and sympathy for the plight of the veteran, especially the disabled one, a bill would pass any time of year and under any government. (Bruyea, 2005, p. 23:44)

As a result of his own post-deployment experience, which included being medically released, Bruyea predicted that: "The new group that will be discriminated against, in spite of the publicity to support them and in spite of the valiant efforts of Senator Dallaire, are operational stress injuries, post-traumatic stress disorder and depression,"

and concluded that: "… what has upset veterans most is probably the fact that they were not made aware of the process from the very beginning." (Bruyea, 2005, p. 23:49)

Bruyea's comments were sidelined by the then Liberal Government, however the subsequent Conservative Government did more than simply sideline Bruyea. His treatment at the hands of Veterans Affairs Canada (VAC) is a remarkable story of betrayal of confidentiality and abuse of power. His private medical files were widely disseminated and viewed by more than 800 VAC employees, as he became more vocal in his criticism of VAC, his diagnosis of PTSD was used to marginalize and stigmatize him in an attempt to discredit his capacity for critical analysis, which the media had come to recognize and rely upon. Bruyea's story is significant not only because his predictions turned out to be accurate, but also because it reveals the extent to which the government was willing to go to silence him, and it exposed the personal price that Bruyea paid for his challenge of the VAC violation of his, and all Veterans' rights, to privacy and respectful treatment. In 2010, Bruyea sued the federal government and particular individuals at VAC; in this undertaking, he was advised by eminent Canadian law professor, Veteran and international expert on privacy and freedom of information, Michel Drapeau. One month after his suit was launched, Bruyea received a formal apology from the Minister of VAC. His actions exposed the lack of diligence of the federal Public Sector Integrity Commissioner and resulted in the disciplining of a number of VAC employees. (Bruyea, n.d.; Bruyea, 2010; Brewster, 2010)

Much Government Rhetoric, no Action

Ten years ago, in his initial critique, Bruyea (2005, p. 23:42) warned that "the devil was in the details" of Bill C-45, and since then Veterans have become all too familiar

with these details. Since the 2005 Report on Bill C-45, in addition to court actions of Manuge, Equitas, and Bruyea, there has been a bewildering assortment of reports, summaries and reactions published in response to the problems with the NVC. They include Legislative Summaries of the issues with the NVC, Library of Parliament Research Reports about the status of Veterans; Senate Standing Committee Reports and Senate Sub-committee Reports containing and explaining testimony from the lawsuits, Ombudsman Reports reacting to the testimony (available from Veterans Ombudsman, Reports and Reviews, n.d.) Auditor General Reports warning of impending problems with Veterans' mental health services and inadequate, overwhelmed systems (Auditor General of Canada, 2014, 2012, 2007), and VAC and DND publications, summaries and guides to help their clients navigate the system.

Veterans have attempted to help each other translate this information and explain its ramifications by writing articles in association magazines (MacPherson, 2014; Adams, 2014), conducting discussions on social media, postings on websites, and having dialogue with each other. Over the past ten years since the proposal of Bill C-45, countless news media interviews have provided insight and analysis attempting to explore and explain Veterans' issues.

In my attempt to understand Veterans' transitions, I was overwhelmed by the amount of information that needed to be integrated. Participants have faced this problem too, and they patiently helped me understand specific areas of the system, sharing information, which they gained the hard way, after repeated attempts to navigate the system on their own and others' behalves. One participant repeatedly stressed the need to understand, always coming back to the concept of knowledge. He explained:

> Knowledge. Soldiers need to know what routes they're allowed to take, what they're entitled to and how long it's going to take, the knowledge- at least when I got out was... I found it out…Ok the most important thing is knowledge- a lot of people who go through this don't realize how the system works, what they're entitled to until after the fact… cause the system is sort of overwhelming so it's sort of up to you to find out.

Another participant expressed it in terms of the way that the system was devoid of any opportunity for him to use his own capacity to navigate:

> My biggest concern has been that there has been such a void, such a vacuum… I felt I had no voice, pushed along, no clear path, my statement … about no checks and balances, I feel strongly about… again that the providers are simply filling their obligation as quickly and cost effectively as possible with more a mind on the bottom line, than the well-being of the Veteran.

By reading the stories of the participants, I learned to look at reports and summaries with a more critical eye. Without this critical analysis, reports, summaries and service manuals can be misleading; they often include moving testimony from wounded Veterans and dedicated advocates, and are generated by the efforts of well-intentioned and respected Veterans turned civil servants who have dedicated their lives to the welfare of their fellow soldiers by working inside the system they wish to change. All of the reports seem to be addressing the important issues, however they repeatedly generate recommendations which are put in place much too slowly and in such a manner as to address what Equitas council Donald Sorochan, in a 2014 radio interview, calls low hanging fruit, meant to assuage the ire of Veterans with what Bruyea (2005, p. 23:42) terms "comforting, reassuring language." VAC and DND publications perpetuate this language in their publications, however the barriers to care that are evident in the lack of opportunities for input and interaction for Veterans, the inaccessibility of services, and the adoption of exclusionary and stigmatizing review processes do not align with the 'comforting language' message. As a result, meaningful change has been slow and costly

for Veterans. These disparities will be illuminated below by the participants' experiences and further discussed in the exploration of the government rhetoric about stigma and suicide.

The Transition System

"*The void, the exit ramp…"* (Participant)

At a time when soldiers were often physically, emotionally, psychologically and economically vulnerable, the transition support system did very little to inform, include or inspire them. Participants explained that they were disconnected and isolated from their previous jobs, their fellow soldiers, and the understandings that once provided them a sense of connection, meaning and security. This was not news to the Canadian Government: a joint research endeavor between VAC, DND and Statistics Canada, the Life After Service Studies (Thompson, Van Til, Poirier, Sweet, McKinnon, Sudom & Pedlar, 2014, Appendix I), states that social determinates of health include: income, social status, social support networks, education, employment and working conditions, and culture. Part of the LASS, The Regular Force Income Study (MacLean, M.B., Van Til, L., Thompson, J.M., Poirier, A., Sweet, J., Pedlar & Dionne, 2011) had previously summarized these results; this clearly indicates that the government understood links between financial compensation and quality of life for CAF members. The government's own data explains that medically released CAF members experience a reduction in income of twenty-nine percent and indicates that younger vets are in the most trouble, echoing the concerns of the research participants, Sean Bruyea, Equitas Society and Leave No Vet Behind. Associate Director of the Canadian Institute for Military and Veteran Health Research, Stephanie Belanger (Belanger, Aiken & CDA, 2012), reports

about her post-deployment interviews with soldiers in transition, that after having experiences in combat situations:

> …when they are forced to release due to a medical condition, they are allowed to do what they consider as the most menial of tasks, in which they find no dignity. Their sense of power and authority is expunged and is replaced by nothing… (p. 290)

Belanger's words indicate that the importance of being meaningfully employed is also understood by those with the ability to make changes in the transition system.

Barriers and obstacles to the social determinates of health are evident in each of the components of the government designed support systems available to Veterans in transition, these can be traced back to the central fact that the elements of the system rest on a commitment to financial expediency and a utilitarian mindset. Essentially, the government chose to make a covenant with the financial bottom line instead of with Veterans. Participants described the NVC-framed 'safety net', especially through their experiences of four programs: Joint Personnel Support Unit (JPSU), SISIP, VAC and the Veterans Review and Appeals Board (VRAB). The first three will be discussed below; VRAB will be discussed under the theme of Stigma.

The Universality of Service Policy: The business of putting boots on the ground.

"We're paying you to produce a result- you're no longer capable of producing the result." Economics- let's go!" (Participant)

The criteria for medical release from military service is described by a policy called Universality of Service, which dictates that all CAF personnel must be deployable. If individuals are deemed to be in 'Breach of Minimum Operational Standards,' the consequence is: "the CF member shall be:

- released from the Reg[*ular*] F or P Res[*erves*], or a recommendation made for release, as applicable; or
- retained subject to employment limitations on a temporary, transitional basis." (National Defence, Defence Administrative Orders and Directives, (DAODs), 2013) [Italics added]

The process leading to medical release is characterized by change and uncertainty for some Veterans, as this participant explains:

> Well, you're just coming back off tour and automatically you're just getting pushed right out the door, whatever, that might… it's nice to come back from tour, do your leave, go back to work, you know… I don't think guys want to get out at first, it takes a while, you come home, I guess it depends what your problem is- the physical or the mental, so maybe you don't want to get out, don't think you need to get out, things get worse after you've been home for a year or six months or whatever.

Participants explain that the time immediately before and after medical release is dominated by experiences of inefficient systems that focus on expediency at the cost of all else. One participant explains the process of waiting through "a six-month period of temporary category where the medical professionals are determining your long-term viability":

> We could fix you, we might fix you, we might save you and then you could rejoin us and then we'll go from there." The first one is the confusing message and basically condenses down into a 12-month period where "Can't fix you- you're done- we have no more use for you, we value your service, thank you so much however- we are in the business of putting boots on the ground- we cannot use you- you're no longer of service to us, away you go, enjoy your life." So they might be hurt, they might be self-medicating they'll do whatever it takes to get through that period to try and establish: "I'm valuable, save me, I'm valuable, save me!"
>
> Everyone's experience varies, I can only speak to my own, and that was that I felt I belonged in the organization, I felt I had a place in the organization- not so much! [Laughs] But then when the determination was made for me I- as most folks do: "Ok I have to put groceries on the table, what am I going to do, what's next, where do I go from here? I was really good at this job. I can't do this job any more, I must find new job!" The equations are pretty simple and most folks are able to process it quickly, however there was no mechanism to help me explore

> how I could take my almost 30 years of institutionalization, and transition that to the outside world or even: "What was I supposed to do?

Although it is true that the military is in the business of putting boots on the ground, and that many other fields of human endeavour run their institutions using a financial management model, few if any, institutions ask as much of their members as what is entailed in the soldiers' part of the covenant by 'putting themselves in harm's way.' For other individuals, this was not the way they anticipated ending long careers:

> Medical release? … So it's a pretty acute thing I think for anybody who's in essence being told "You're no longer up to the physical standard, we have to let you go," that's the reality behind it…Here I am, when I get out I'll have 36 years behind me, and it's- being 'kicked to the curb' is a little bit more acutely felt with having more time in.

Step one: Joint Personnel Support Unit (JPSU).

"…certain individuals if they aren't fit to meet the obligations of service, may or may not have the coping skills necessary to sink or swim when thrown into the deep water." (Participant)

The answer to the question that one participant asked: "What was I supposed to do?" was meant to be provided by the JPSU sections that were 'stood up' near major military centers across Canada. A participant explained the term stood up:

> P: Ottawa knew there was a problem… I know that there were sections created … for people that could not deploy or could not meet their universality of service for whatever reasons- medical, mental. They were temporarily dropped there with the impetus to get better or to get on with their transition, and so there were places… stood up to place these individuals in a common organization and try and provide resources to help them either get better or transition.
>
> D: So it kind of means created and it kind of means cobbled together?
>
> P: Absolutely, and god love them- as an organization their primary concern is mission oriented- to complete the goal. For a lot of them it wasn't their primary task, so they did the best they could with the resources they had and when they

> were asked to stand up- the culture… is that you just do with what you had- you can ask, you can beat down the walls, you can beg, you can plead, you can scream… my experience is that you gotta do with what you've got… we could teach corporate Canada volumes as to how to accomplish with the bare essentials… folks were assigned and put in there- young reserves were given temporary contracts- two to three years- to become people managers and their job descriptions were written and they were dropped in there.

The intent of JPSUs was that they were created to provide work, training and assistance to soldiers who are in transition to civilian life and to: "give hope and help to the flood of physically and mentally injured soldiers coming home from Afghanistan and those still damaged from previous missions" (Cobb, 2013, p. 1). The experience of individuals in JPSUs did not align with this intended purpose, and eventually as soldiers of all ranks, states of physical and mental health, levels of initiative, and length of time post-deployment, were lumped in together, under the supervision of poorly, quickly trained and overwhelmed staff, problems arose.

One participant, who previously explained that his continual attempts at self-advocacy were dismissed by the insufficiently trained staff at the JPSU where he was assigned, reiterated:

> P: And again: "Was there meaningful work given to me? *No!* Was the flow of information extremely limited? *Yes!* Did I get a lot of responses to the questions that I asked? *No!* Was I told that they were behind me 100% and that every support would be given to me? *Absolutely!* Did I find that I did most of the work? *Yes!* I mean transition is a living breathing process itself; however there seems to be this rush to fill this process, this need, this void and yet there's no clear path for anyone to follow whether they be the providers or anyone- to have oversight of the financial implications, or any opportunity, as I said, to provide feedback for the end users to feel they were active in the process, other than just being…
>
> D: You're making a herding motion with your hands like a chute.

Inexperienced young reservists who were hastily assigned and insufficiently trained, staffed JPSUs. Individuals whose fates were in the balance marked time in these units and were given no meaningful work, no access to information, no sense of momentum, and no counsel about the reality of the reduced financial support that the future might hold for them. This culture of 'no' extended from the individuals who were assigned to wait in JPSUs to the individuals who ran them, and this was made explicit by the actions of yet another Veteran, one who two participants pointed out to me: Barry Westholm.

Barry Westholm was a Master Warrant Officer who was appointed Regional Sargeant Major of the Eastern Ontario Region JPSU; Cobb (2013, p. 2) described Westholm as: "a veteran with three decades of tough soldiering under his belt and the emotional scars to show for it." Westholm recognized the gravity of the problem; he repeatedly asked for help with the understaffing and lack of qualified personnel at his unit: he described his dilemma when faced with the "persistent refusals from superiors for extra help":

> I couldn't collect a paycheque to be part of that anymore… We were overwhelmed and had senior medical staff telling us that a wave (of mental illness) was coming. So I said we have to get busy to prepare for these troops. They said 'no way.' I thought that if I cc'd enough people someone would say 'hey, what's going on?' (Cobb, 2013, p. 4)

Westholm's 2011 resignation letter was widely distributed, "to a range of influential government and military people" (Cobb, 2013, p.1), it explains:

> Our HHQ's long-standing opposition to staffing this Region appropriately, even while the supported personnel continue to increase past 100%, defies all logic and is by any measure a formula for tragedy. (Kirkup, 2013, para. 3)

In another effort to point out the Government's abdication of its part in the social covenant with Veterans, Westholm resigned his membership in the Conservative Party

after VAC Minister Fantino's public fight with Veterans, and an incident where Member of Parliament Cheryl Gallant stated in parliament that services at JPSUs were available to Veterans with mental health issues, and concluded that it was the fault of Veterans who had 'self stigma,' that they were not being seen by their own choice. Westholm explains the effects of this type of public devaluing of Veterans by politicians:

> Many soldiers have committed suicide since my first email to you, and I can only ponder those that could have been better supported, assisted or saved if action was taken — but no action was taken. Canadian soldiers are expected to fight on foreign land, not their homeland. (Cobb, 2014, p. 4)

Step two: Service Income Security Insurance Plan (SISIP)

"*I guess they got the contract so…"* (Participant)

SISIP is described in the 2014 edition of the CAF guide to benefits, programs and services (National Defence, Director of Casualty Support Management, 2014) as an entity of DND; SISIP insurance programs are premium-based plans underwritten by a private insurance company, Manulife Financial. The services offered to CAF members and released individuals include long-term disability insurance, vocational rehabilitation, financial management and financial counselling.

Participants who have demonstrated much capacity throughout their careers (see participant description in the Methodology and Methods Chapter, (p. 23), and who were promoted and decorated because of their leadership potential and dedication to duty, describe being rushed through SISIP re-training programs that ignored their own priorities and goals:

> And I feel that although they will probably say that their programs that were offered to me are to get me into the workforce as quickly as possible so I'm not caught in this transitional void, and productive, and returned to work…. However I cannot help but feel my experience was that I was channelled into a quick-fix program and that when I questioned it I was offered even more quick-fix

> programs that involved relocation out west- 16 weeks- operate this piece of machinery- and there you go, you're working in Fort Mac, making good coin! ...Might have been all right when I was twenty, but I'm not twenty anymore, and I was thinking that I would lead a "gainful and meaningful life."

When considered adjacent to current VAC and DND research, which explains that social determinants of health include education, employment, social status and income level, this account provides another example of the discrepancy between theory and practice in the government's commitment to transitioning Veterans.

SISIP's Vocational Rehabilitation Program (VRP), as described in The Guide, a information resource for CAF members, states:

> …VRP prepares a member to obtain gainful civilian employment by enhancing existing education, skills, training and experience, if required… Once approved a VRP counsellor will assist the member in determining the best training plan and program. These plans are approved on an individual basis. (SISIP Ltd., n.d., Mission of the VRP, para. 3)

The individual quoted above and below had been trained by the military in an occupation where he gained skills and experience far beyond those required for the option offered to him by his SISIP counsellor. He had aspirations to translate his previous experience into a civilian profession, one that he was excited about, and he outlined these plans to his SISIP counsellor. As he describes below, there were limitations, however these limitations had nothing to do with his potential, his military record provides irrefutable proof of this; the limitations were the results of the caveats, boundaries and guidelines of the program:

> My take from my interactions with SISIP and god love them- I've only had two actual physical meetings with them and three or four phone calls-…once the program started I've had no follow-up from them, no feedback from them. I was told that they would check in on me periodically and see how things are going. SISIP administration basically is: "Here's what we can do, we can give you up to

> $24,000, it has to be started and completed within a two year period from when you leave." 'Well what can I do?" "Well it has to have a diploma or a certificate attached to it at the end…

Recall from the Introduction to this study, that after WWII, soldiers who were supported with programs that allowed them flexibility in their choices of education and career options, made great contributions to post-war society, including making up seventeen of the twenty Canadian Rhodes Scholars in 1946; apparently the Harper Government had no such lofty goals.

Mission: Transition.

"Roger out" (Participant)

Participants explained to me that in their military careers they had learned how to accomplish their missions in the face of shortages and limitations; one participant used the term "Roger out" as shorthand for what I learned means: 'I understand and I'll get it done, no matter what the circumstances are.' This expression stayed in my mind as I continued to listen to this description of how, once again, a participant encountered the 'culture of no,' this time while trying to match his aspirations with the VRP program described above as 'best training plan and program… approved on an individual basis.'

> … well my actual physical release from the forces will be in January, schools tend to work semester to semester, starting in September. I only have 24 months- how's that going to work if I couldn't take the semester I wanted to in September, I'd have to catch it the next September? "Oh, we can't pay for anything beyond two years." So okay, "I would get one year of a two year program?" "No you wouldn't get that because it doesn't come with a certificate after only one year." "Huh-?" So I found that to work within the constraints of the insurance program a bit challenging- I was told that there could be no foundation work or no build-on like, i.e.: take a simple college diploma and turn that into a university degree. No, I couldn't start a three-year advanced degree… because it expired 24 months into it. They wouldn't pay for two years and expect me to … 'cause I had offered. "Why can't I use my own funding to pay for my last year? Why couldn't I pay for funding for the first two years? What about academic upgrading for my situation,

> I've been out of school since 1986, Hey guys- I don't even know if I have transcripts- they might have turned to dust!

Eventually, the participant accomplished the mission, however in keeping within the confines of a very limited program, he had to reduce his hopes for a career that aligned with his talents and aspirations:

> I ended up feeling very channelled into a program- when I asked…"Can I catch my breath and think this through because originally I had a plan and you just told me that this plan was 86'ed, I need to come up with a new plan." They were sympathetic in so much as they listened, they did offer me other opportunities, or made me aware of other programs. However, upon reflection, they may have had a slant to the programs they were offering, with the end result always in mind that I get "gainful employment"… their answer to me was: "Just pick a program that works for you and just get into that." They actually advised me of one of their private colleges so I did a quick reassessment, I looked at existing skill sets that I had and I chose a program… and I was hopeful that that would work. Once I made them aware of: 'Ok I've applied to this." "Surprise, surprise- a private institution has no concerns about my previous academic history and is willing to take the cheque. I'm accepted, go figure that!

The words of another participant underscore the SISIP preoccupation with expediency at the cost of all else, and call into question the long-term efficacy of such an approach. This individual has been in the release/re-training process for seven years; in this time he has spent one and a half years waiting for schooling due to SISIP administrative errors, has been employed in a position he which he found for himself and later had to leave because of his service related injuries. He is now completing a training program funded by an organization outside of the SISIP mandate that he finds interesting: "I actually want to do this," and that fits into the post-military life he envisions for himself and his family.

> The other problem with getting out is the duration; it takes so long to get anything done… its so slow…SISIP will fire you into school. Here's the main problem: so you get out of the military, you go over to SISIP they make you pick a course almost instantly about what you're going to do with the rest of your life –they give you all these stupid aptitude tests…garbage! Then they send you off to SISIP- SISIP pays for your nice college education whatever you want to go to do.

> But you had to decide right when you get out of the military what you were going to do, so I don't know what the stats are but the people I talk to … everybody who took a course under the SISIP program is no longer in that field. They're all doing something else- just working, or back to school in another thing.

Once again the short-sighted 'exit-ramp' processes participants describe seem designed to funnel individuals out of the military without proper commitment to the 'best training plan and program… approved on an individual basis' that government-sponsored rhetoric describes.

Step three: Veterans Affairs Canada (VAC).

"A simple, open, generous model of service" (Guy Parent, Veteran's Ombudsman, describing the goals of VAC service delivery, Town Hall meeting in Feb., 2015)

"*A comfy bureaucracy*" (Veteran, describing VAC, at the same Town Hall meeting)

"They call you once every 3-4 months and say "Hey how's it going?" and if you're not like -a nut job, then they just hang up the phone…" (Participant)

"They didn't consider me for a case manager until they realized that I was at a heightened risk- they thought I was going to kill myself." (Participant)

Eventually, all medically released individuals need to deal with the department responsible for their welfare: Veteran's Affairs Canada (VAC). Veterans have long known that dealing with VAC is an uphill battle, in the words of one participant:

> … then when you are out you don't really have a clue what you're entitled to and in the past Veteran's Affairs was not one to volunteer programs or services, and I think it depends on the case manager too but…

The public face of VAC.

"Delay, deny, (hope we'll) die"

Throughout the war in Afghanistan, the government persisted with its 'close to the bone' business model style of service delivery, closing regional Veterans Centers, cobbling together transition programs in a reactionary manner, and delivering inefficient, limited option re-training programs. Concurrently, the number of Veteran suicides was rising; in 2014, it exceeded the death toll of the war. Concern about soldier suicide was evident in society, as the holiday season of 2013-2014 approached (Everson, 2013; Campion-Smith, 2014), astonishingly, despite this climate of concern, the country's highest ranking civil servant responsible for the care of Veterans, VAC Minister Julian Fantino made some crucial and very public choices on behalf of the Conservative Government, further isolating Veterans. Conversely, during a media interview just before Christmas (CBC Radio, 2013), former Chief of the Defence Staff for the Canadian Forces, Rick Hillier described how his family had been part of his support system when he was having transition difficulties. He then responded to the epidemic of suicide among soldiers by repeatedly using the phrase "don't be alone," as he encouraged individuals with PTSD, who he described as mentally ill, to seek help through a twenty-four-hour hotline.

At this time, Minister Fantino was avoiding engagement with Veterans, he failed to attend or was late to show up at face-to-face meetings with Veteran advocates (Galloway, 2014), seeming to prioritize travelling to commemorate the battles that Veterans fought in, over speaking to the Veterans themselves. Although Fantino was the 'public face' of VAC (July 2014- Jan 2015) for only two years of the Harper Government, he will be remembered by many Canadians as the minister who ran away from the wife of a Veteran who was attempting to speak with him about his refusal to address the serious medical

issues of her husband (Brewster, 2014b). In addition to living with the isolation and stigma, loss of income, changing identity and physical and mental health, Veterans and their families were being publically dismissed by the Minister of VAC. In March 2015 Fantino was demoted and replaced by Erin O'Toole, a Veteran turned politician, who later would succeed Fantino and be constructed by the Harper Government (Brewster, 2015) as the 'Veterans' friend,' however one year previously, in February, 2014, O'Toole was arguing alongside Minister Fantino in support of the closure of Regional Veteran's Centers (Galloway, 2014).

The bureaucracy! ... death by a thousand paper cuts.

… so you don't really know what you're entitled to – like anything -you have to figure it out yourself... but they don't even tell you- you talk to so many guys they have no idea…" (Participant)

"Essentially, I'm going to be taking on the role of Veterans Affairs," (Bruce Moncur, Veteran and Veterans' advocate, CBC News, 2014)

VAC has long had a reputation for being inaccessible to Veterans; I remember my father's frustrations with needing to have doctor's reports about injuries he suffered in the Korean War, worded just right, so that his claims wouldn't be dismissed. I also remember him helping other Veterans who had never accessed benefits they were entitled to because they were daunted by the process and complexity of the procedures. Recommendations in the 2014 Auditor General's Report on Veterans' mental health focused on the complicated system employed by VAC and the disheartening wait times for services (Auditor General of Canada, 2014). The complicated online application process has been explained by VAC as a problem that particularly affects older Veterans; this construction of the problem separates older Vets from younger Vets by focusing on

differences between Veterans instead of the problem with the system. The VAC website explains that Veterans who are not comfortable with technology can get help at some of the Veterans' Centers that remain open, however initial interaction with VAC is usually virtual and multi-use centers are often not nearby, or not focused solely upon Veterans' needs. Bruce Moncur, a young Veteran and founding member of the Afghanistan Veterans Association of Canada is emerging as a vocal critic of VAC, he explains that although he is highly computer literate, he encountered problems with his online interaction with VAC:

> But the website isn't easy to navigate… Moncur said he banks and does other transactions online, but it took him a whole afternoon to figure out the Veterans Affairs site. Moncur described starting an account on the site, then waiting a day for it to be activated, and waiting another week to get the paperwork he requested…"Something that I could have gone to the office for, that would have taken 10 minutes to get, ended up taking me a week. And that's indicative too of what's happening with these closures is that the service is going to [be] even slower. I never thought it would be possible, but it is," he said. (CBC News, 2014, para. 19)

Veterans have been taking up some of the responsibilities of VAC themselves by assisting each other with the onerous application and documentation processes, analyzing the problems in the system and advocating for policy change. Participants have explained that a lack of consistency in support through the process, and access to information is a major difficulty. (N.B. the term 3B refers to medical release):

> D: If you could design that job; like if your job was to design that job and you didn't have any barriers what would the person be like; person or persons, would it be a team?
>
> P: It would have to be a team yeah.
>
> D: What would they have to know- this team?

> P: They would have to know the complete release process from the minute you get on your 3B, even for guys who don't get out on 3B, just a normal release- right through to the end till you're done with SISIP and off to VAC.
>
> D: The first component, like you said- what needs to be there is the knowledge?
>
> P: And consistence.
>
> D: Consistency of?
>
> P: People. Because you have your base case manager and then your SISIP case manager and your VAC case manager; and some people, it depends on the person, I had this problem too- I had six case managers in a year and a half.

A Veteran's experiences with VAC often extend over much of his or her life, and eventually some of them find ways to help each other by forming their own networks to take up the slack in the system. That is what they do because that is what they have needed to do to get through, however not everyone is connected to these informal support networks. In addition to the above problems, the protocols of the department are stigmatizing and dehumanizing:

> P: … see this is what kills me, is goddamn VAC, they don't look at the big picture- all they care about at the end of the day- I mean the only person that looks at the big picture, and for them the big picture is a number that says 180% disabled; that's their number! All that means to them is: "Send that number to the finance guy," they'll make sense of that. But otherwise there's no one in VAC, other than my case manager that knows anything about me- nobody! I mean yes there's analysts, that have worked on past claims, that know *of* [participant's name] and know that yes, he's got a whatever-busted joint or busted bone, because that's what this claim came through, and I can see that he's got five, ten, a hundred other claims. So I know all of those parts of the body are probably broken, but all I care about is this little two per cent or five per cent, whatever the hell it is. Ahhhaaa…and they're too disjointed; so now you've got- after the claims have been actioned one way or the other, their interest in this is completely dissolved.
>
> D: So, there's no consistency and they're not – they're considering you as a series of isolated incidences, which they call claims…

The problems that participants have described in their dealings with VAC constitute considerable barriers to some individuals; this is acknowledged in the 2014 Auditor General's Report, however unless the policies and procedures that guide the service delivery model are changed, dealing VAC will continue to be a ponderous, stress-inducing and exclusionary process for Veterans.

Veterans Ombudsman

"It shouldn't be a numbers game" (Veteran and former VAC Ombudsman Pat Stogran)

To address the mounting concern over Veterans' treatment at the hands of VAC, in accordance with a suggestion from the 2005 review of Bill C-45, the position of VAC Ombudsman was created. Former Colonel Pat Stogran, an Afghanistan Veteran, was Canada's first Veterans Ombudsman, and he was another individual that the participants made sure I knew about. He served as Ombudsman from 2007-2010, when, on November 10th, one day before Remembrance Day, he was relieved of his position. Theoretically, the role of the Veterans Ombudsman is to report directly to the Minister of Veterans Affairs about matters concerning compliance with the Veterans' Bill of Rights (Veterans Affairs Canada, n.d.), which was passed by Parliament in 2007. In practice, Stogran's experience illustrated that when he challenged the system, there were few benefits to this direct access to Canada's highest-level civil servant in charge of the care of Veterans. Early in his time as Ombudsman, in adherence with the protocol of the parliamentary system for addressing change on a policy level, Stogran wrote reports to the Treasury Board and to Privy Council Office voicing his concerns about what he would later call the "penny-pinching insurance company mentality" of VAC (Stogran, n.d., para. 5); he received no response to these reports. Stogran began to bring Veterans' struggles with the system to the media, resulting in the Veterans Ombudsman and Veterans Affairs Canada publically contradicting each other in the media. His strategy was not appreciated by VAC bureaucrats, and as the relationship deteriorated, Stogran was told by VAC to find answers to his questions concerning Veterans, in press releases intended for the public (Pugliese, 2010); in effect his access to information was curtailed by VAC. At the

same time that VAC officials were explaining in the media that Canada treats its Vets among the best in the world, Stogran was quoted in the Ottawa Citizen by reporter David Pugliese:

> …Veterans Affairs and the Veterans Review and Appeal Board, which helped retired military personnel redress disability claims, had forgotten who they were there to serve. Veterans were being treated like the enemy…(Pugliese, 2010, p. 2)

Pugliese continued:

> It stuck in Stogran's craw: the same bureaucrats who supported the decision to send soldiers into battle seemed unwilling to support them when they returned home… At the same time, VAC bureaucrats had created the New Veterans Charter, which Stogran considered flawed and motivated by the desire to save the government money. (Pugliese, 2010, p. 4)

Eventually Stogran's capacity for focusing media attention on Veterans' causes resulted in the government's reversal of a decision to claw-back disability payments from Veterans' families, the overturning of the government's decision that the medical condition ALS was not eligible for compensation, and the release of both long-term and immediate funding for Veterans. One participant has praised the actions of Stogran, indicating that he handled his position "the right way," which means that he drew attention to his own struggles only to benefit others. Although Stogran is no longer a civil servant, he continues to advocate against the de-voicing of dissenters (Stogran, n.d.), and for Veterans, testifying as a witness before Senate Committees reviewing the NVC, as an advisor to the Equitas Society and a media commentator.

In a 2013 news interview, as Canada's final troops were due to return from Afghanistan, Stogran had this warning:

> It shouldn't be a numbers game… Does the government have a quota that they're going to fill before they react? We should be doing everything we can to stop that kind of a trend…. Let's not wait until the requisite number of suicides occur before they flick the switch. (Carreiro, 2013, para. 15)

Stogran's level of commitment to the Covenant, and level of personal sacrifice exemplifies the commitment of soldiers to the wellbeing of all Veterans, and his treatment at the hands of VAC exemplifies the abdication of their commitment to what Stogran's successor Guy Parent called "an open, generous model of veteran-centric service." (personal communication, Town Hall Meeting, February 4, 2015)

The Cost of the Broken Covenant

"*You lose a little bit of your humanity… and you need to, to survive."* (Participant)

" I can't tell you how many times I wished that I was killed, or lost a limb 'cause you know why? They don't see the crime that's been self-committed inside- it's just you've hurt yourself and you don't know how to fix yourself and some of these gaps that you're trying to identify or have identified…?" (Participant)

One of the direst consequences of the marginalization of Veterans in trouble is suicide. Perhaps as Pat Stogran suggested above the 'requisite number' has been reached: in 2014 the number of deaths of CAF members from suicide (160 confirmed by the DND as of March 31, 2014) during the war in Afghanistan was greater than the number of deaths in combat (138) (Campion-Smith, 2014). Although there is no sure way to insure that these directly result from transition experiences, it does indicate that there is a level of despair in the military population, and this emerges very strongly in soldiers who have been released, especially involuntarily (Zamorski, Rolland-Harris, Jetly, Downes, Whitehead, Thompson & Pedlar, 2015; Brunet & Monson, 2014). The number is also probably much greater than reported, and in the past the CAF has been criticized for not

including women and reservists in their data about suicide rates. This has been rectified, but Veterans' advocate Michael Blais says that neither the CAF nor VAC keeps data about Veteran suicides: "We have people who are getting out [of service], and within a year, committing suicide…so many times, you find out about a suicide literally months after it's happened." The CBC reporter who quoted Blais, mentioned in his article that he made several interview requests to VAC concerning this and did not receive a comment (Mayer, 2014).

The suicides.

"… the welfare of your men first and foremost, didn't matter what element I was working with at the time-whether it be army, whether it be navy- 'welfare of the men, welfare of the men, welfare of the men'. It was drummed into you…" (Participant)

The death by suicide of soldiers and Veterans has drawn the attention of the public, including Veterans, perhaps more than any other aspect of the war in Afghanistan. One participant, whose work involved "being part of the public affairs machine" explained:

> …here our governments at the stroke of a pen will dedicate 5 or 6 thousand troops to an endless mission in a chunk of desert where the culture… everything's completely backwards, it's 180 degrees difference, and so it wasn't until we got people coming back, when the need became apparent with just the sheer number of suicides that were suddenly starting to make their way- not from page three, but to the front page.

Some of the participants have shared their own struggles with the effects of post-traumatic stress, including substance use, emotional distress and suicidality; some have explained that they understand how the transition processes and systems contribute to the risk for others, especially younger people:

> One person had a substance abuse problem that I can't help but feel that manifested because of being a younger folk transitioning- "Here's some money,"

> and not having guidance, counselling or mentoring and dealing with the physical injuries- yeah, that's probably how the substance abuse started- you can't take young guys and give them money, we've seen enough of that …

The above comment was made in reference to the NVC practice of issuing lump sum payments to individuals with the expectation that they will seek the financial advice available through SISIP in deciding how to manage what may seem like a sudden windfall. The 'wise management' of lump sum payments is another theory- an overly simplistic idea that makes sense only when taken out of context of the reality of some vulnerable Veterans' lives during transition; according to participants this reality may include being recently medically released, self-medicating, being younger and feeling suddenly wealthy and therefor invulnerable, or being older and feeling shame around the effects of post-traumatic-stress. One participant shared his thoughts about the cost to Veterans of this dichotomy between the theory that transitioning soldiers are being well supported and soldiers lived experience, which he refers to as "the biggest challenges":

> You know as you progress through the ranks my experience was- the welfare of your men first and foremost, didn't matter what element I was working with at the time-whether it be army, whether it be navy- 'welfare of the men, welfare of the men, welfare of the men'. It was drummed into you, and after almost 30 years it became a way of life- it does. And yet [Laughs] here you are in perhaps the biggest challenges, and yet I… I don't find that there's a mechanism to look after the welfare of the men, and it's fine for a lot of us older folks, but my concern is the young folks coming behind me. I mean, if we can't have lessons learned from this what hope do they have?

A participant who has been very articulate about the personal cost of his own service-related experiences, which he explained as including the consideration of suicide, also expresses his concern for his son, who is a Veteran of the war in Afghanistan:

> …and I didn't want him to necessarily experience the same…. and I couldn't…. but he found out didn't he? And unfortunately he is experiencing the same thing I experienced. And…so…it is what it is: that's life.

It was very clear for me that as this individual described his concern for his son, knowing what he knows about military culture and the transition system that he felt proud of his son as a fellow soldier, and also deeply worried for him as a father.

The gravity of the suicide problem was acknowledged in joint CAF, VAC and Statistics Canada research endeavour, the 2011 Canadian Forces Cancer and Mortality Study. This report illustrates that the government has generated data indicating that being released from the CAF is associated (the report does not explore the connection between deployment and suicide) with suicide rates that are 3.5 times higher for males and 2.5 times higher for females, than the rates observed in the general Canadian population. It also indicates higher rates in particular subgroups such as male, non-commissioned soldiers who are non-voluntarily released after short periods of service (Statistics Canada, 2011, pp. 8-10; Zamorski et al, 2015). Brunet and Monsor (2014) expand the thinking about the higher rate of suicide in released CAF members and explain that in military populations, suicidal ideation leads to completed suicide at a much higher rate than in non-military populations, and that individuals that are diagnosed with PTSD have high rates of suicidal ideation. Recalling that having a diagnosis of PTSD results in medical release, and that released individuals are either in the transition system, clients of VAC, or managing alone underscores the gravity of the situation that participants have explained.

The circumstances around the death of Cpl. Stuart Langridge, a twenty-eight year-old Veteran of Bosnia and Afghanistan, and specifically the manner in which the military handled communication around this tragic death by suicide in 2008, provide an

illustration of the way that the CAF has initiated policy that is not enacted in practice. They are also not reflective of a caring intent toward soldiers and their families, or an intention to honour the covenant with these soldiers and their families.

On the Government of Canada website, under Canadian Armed Forces DND section, there is an article which clearly links stigma to suicide risk, titled *Suicide and suicide prevention in the Canadian Armed Forces*, which explains:

> The CAF remains committed to reducing the barriers that may interfere with obtaining timely mental care. Stigma is one of these barriers. Through dialogue, training and leadership, we can create a culture in which care seeking is encouraged and facilitated. (National Defence. Suicide and suicide prevention in the Canadian Armed Forces, 2015, para. 4)

In a 2014 article published in the Canadian Military Journal, the official peer-reviewed journal of the CAF and DND, entitled Combating the Impact of Stigma on Physically Injured and Mentally Ill Canadian Armed Forces (CAF) Members, authors advise a three-pronged intervention for the elimination of stigma, which includes protest, education and contact, especially face-to-face interaction (Arribito & Leung, 2014, pp. 28 & 29). The article encourages CAF members to take a stance against stigma by challenging inaccurate information about mental illness with accurate information, and concludes that positive experiences of contact reduce stigma. The article credits former Chief of Defence Staff Walter Natynczyk with initiating a campaign to combat stigma, citing his actions as an example of leadership that fosters a culture of change (p. 31). This campaign holds the potential to be significant in the effort to reduce stigma and suicide in the CAF, because the Chief of the Defence Staff is the link in the chain of command between the Minister of Defence, who he advises, and other CAF institutions such as the

Canadian Forces Provost Marshall's (CFPM), the head of the military police, thus ensuring that the anti-stigma message is disseminated.

In the case of the investigations surrounding the death of Stuart Langridge, a soldier with grave mental health problems, accurate information did not flow up (or down) the military chain of command, and positive contact was not extended to Langridge's family. In fact, this death, and the conduct of the Government officials and agencies concerned, provided an example of the flow of information and contact was controlled and shut down, resulting in a missed opportunity in the CAF's initiative toward changing the culture of stigma it professes to recognize as affecting the mental health of its troops.

The Fynes Report. The Fynes Report is named after Stuart Langridge's mother, Sheila Fynes. This report was issued in March 2015, as a result of a Public Interest Investigation launched in 2012, originating from a formal complaint filed in 2011 with the Military Police Complaints Commission (MPCC), against the Canadian Forces Provost Marshall (CFPM), by Sheila and Shaun Fynes. The Fynes' filed the complaint in order to address the inefficiencies that occurred during the three separate investigations conducted by the military police into the post-deployment suicide of their son, including the fact that their son's suicide note was withheld from them. In a television interview, Michel Drapeau, the Fynes' lawyer explained:

> They just want to make sure that the pain and suffering, the loss of a son, that they've gone through, they want to make sure that lessons can be learned from it and corrective action can be made so no other family will suffer the same fate… (CTV News, 2015, p. 2)

Initially, the Fynes had to fight to have their concerns recognized as valid; eventually, the complaint was allowed and upgraded to an investigation, which heard evidence until

Jan 2013. An Interim Report was submitted by Glenn Stannard, chairperson of the MPCC, to the Military Police, CAF and DND on May 1, 2014. In December 2014 the CFPM and DND attempted to prevent the release of its response to the recommendations in the Interim Report (MPCC, Chairperson's Speaking Notes, 2015). Due to this attempt to deny public access to information, on March 4, 2015 the Commission filed an application to take the CFPM to Federal Court:

> The military originally tried to keep its response to the recommendations secret and out of the public eye, and only backed down last Friday after the commission launched court action. (Campion-Smith, 2015, para. 25)

Soon after this threat of legal action by the Commission, the full report was released with the responses to the Commission's recommendations (called the Notice of Action), redacted. The redacted portions contained the DND response to the Commission's report; they include allegations of blame against the family of Stuart Langridge, and the poorly prepared military police who conducted the investigations into his death. Stannard, in the interest of transparency, provided the media with copies of the redacted portions and said in his briefing to the press that the "Notice of Action is a statutory document the parties and the public are entitled to see in its entirety." He added that the CFPM, who is the head of the military police, and advisor to the Chief of the Defence Staff (who in turn advises the Minister of Defence, then Peter McKay), has "no right to attempt to control whether, how or when" the findings of the report will be published (all quotations extracted from: MPCC, Chairperson's Speaking Notes, 2015).

During the time of the inquiry, Sheila Fynes was told to stop calling the Defence Department and asking about her son's pension, but to make her inquiries through her lawyer. The Minister of Defence, Peter McKay, also refused Stannard access to

documents relating to the Langridge case and told him not to attempt direct contact again, but instead to go through Justice Department lawyers (Campion-Smith, 2010). Essentially, the Minister of Defence shut down communication between his department and the very concerned parents of a young soldier, and quashed the attempts of Stannard to expose the circumstances of Langridge's death and the investigation, by resorting to the now familiar tactic of engaging the courts and justice system to deal with Veterans' issues instead of positive face-to-face contact and the sharing of accurate information as the anti-stigma policy concerning mental health in the CAF suggests. Trauma therapist and Harvard psychiatry professor Dr. Judith Herman draws a very clear link between stigma and suicide (Herman, 2013), which points out, once again, the dangers of having policy that is saying one thing while practicing the opposite. The fact that Langridge was never assessed and treated for post-traumatic stress, but publically described as resorting to cocaine and alcohol use and attempting suicide repeatedly (Campion-Smith Oct, 28, 2010; Parry, 2015) adds to the stigmatizing effects instead of, challenging inaccurate information about mental illness with accurate information (Arrabito & Leung, 2014, p. 29), as the DND's anti-stigma campaign stresses.

The Notice of Action accuses the military police of incompetence, and points out that they were not sufficiently trained for such serious investigations. This is significant, because it lays the blame for the mishandling of the matter at the feet of a few individuals who were not well enough trained for the grave situation that they found themselves in, and takes it off of the organization which was responsible for their training. The DND tried to cover up the mishandling (Brewster, 2015) and additionally, the report indicates that the family was not treated with respect or consideration, but: "They were often

ignored and the information provided to them was at best inadequate and at worse potentially misleading,"(Campion-Smith, 2015, para. 12).

On March 10, 2015, Walter Natynczyk, Canada's Chief of Defence Staff apologized to the Fynes and acknowledged that the military could have done a better job of handling the case of Langridge. On March 12, Michel Drapeau, the lawyer representing the Fynes family, indicated in the media that his clients want to see the entire board of inquiry report, not just the partial copy the military has provided. A news article quotes Drapeau as saying: "nothing in the report offers any insight into whether the military could have done more to prevent the corporal's death or how it can prevent other suicides in future. To him, it seems aimed more at clearing the military of any responsibility." (Parry, 2015, para. 25)

The Canadian Military Journal article on combating the impact of stigma advises: "An important principle is to treat physically injured and mentally ill members as they [you] would want to be treated" (Arribito & Leung, 2014, p. 34). The Commission of Inquiry that resulted in the Fynes Report dealt with the interface of the military legal and investigative systems with the family of a soldier who at the very least was having a difficult transition from combat. The fact that this soldier was not properly diagnosed, but publically described by his symptoms, illustrates that the military has a lesson to learn about the elimination of stigma concerning mental health issues and challenging inaccurate information with accurate information, as its own senior officers and mental health professionals advise.

An unfortunate consequence of this series of events is that the blame deflected to the investigating police adds to the burden already carried by those who were required to

witness and document the end of a soldier's life. One participant explained the ramifications of this aspect of his own service:

> I just think there was more unnecessary, uncalculated and unforeseen harm that was done on the peripherals of combat. It's just not the bullets that you're dodging or losing a leg or an arm; it's all the other junk that goes with it… Yeah, I was involved in a situation where one of the vehicles in a convoy was hit with an IED…So when it came time to do the investigation… it's not good … ah, just miserable. The visuals are one thing… And Haiti was like that; Sarajevo was like that…

The death of Stuart Langridge and his family's treatment, have become very public lessons about the extent to which the Harper Government was willing to side-step its commitment to the covenant. These events were watched by other soldiers and their families, who learned that ultimately, open respectful and face-to-face communication was not extended to the Fynes. Instead, the government, at its highest levels, initially denied the existence of the problem and the public right to clear communication about it, delayed the solution in the courts and blamed a young soldier in trouble, his family (Parry, 2015), and the military police who will now live with this blame in addition to the effects of investigating Langridge's death.

Neoliberalism and the Covenant: Clash of Cultures

"I am very, very sure that the Canadian psyche is not at all in favour of sending its young men and women into places where gunfire is ever-present, mystery bombs are everywhere, and people would want to cut your throat." (Participant)

The words of the participant quoted above indicate his belief that if people really understood the experiences of Veterans in combat zones, they would want things to be different. Brian Stewart, a seasoned CBC journalist who has covered many of Canada's conflicts reflects:

> There's a strong sense among those who have seen war up close that the rest of us "just don't get" what it does to soldiers, and that the politicians who send troops into combat get it least of all. (Stewart, 2014, para. 11)

In the face of such comments from people who have lived experience of transition and war, the question: 'How did this get to be ok?' arises. The problems with transition systems did not arise with the present government, however they have been intensified by what self-described media and think-tank researcher Donald Gutstien calls Harperism, which is the present government's edition of neoliberalism. According to Gutstien: "Harper's moves… are subtle, low-key, incremental, hidden from view" that "treat(s) everything as an offshoot of the economy"(Gutstien, 2014, p. 5). An in-depth discussion of Harperism is outside the scope of this study, however as Gutstien explains it is "changing Canada's DNA" and has affected all government departments (CBC Radio, 2015), which makes it significant to this study.

Participants' words have indicated that their experiences of transition are the direct result of the effect of neoliberalist government policies:

> P: And that happens with any organization though, they could walk today in and tell me to clear out my desk and then I'll feel hurt and disappointed, that's just natural. I'm sure from their viewpoint it's strictly a business kind of model in that…
>
> D: But that might be one of the…that's what the paradox hinges on- right, that that wasn't the understanding in the first place?
>
> P: No- it was a culture, as we talked- I would be looked after, you would be looked after- therefor we would willingly shelve the instinctive reactions to putting ourselves in dangerous situations and go forward and accomplish this task, mission, job, whatever we were given because we will be looked after- that is your safety net.

The Way Forward

"Seen it-lived through it- don't need it to happen again." (Participant)

"You know, when you believe in an organization so strongly, so strongly that it's the ultimate- in servitude, really, just to find out in the end the sons of bitches felt the need to bullshit you, all this time, rather than just tell you the fucking truth…that's the difficult part to deal with right? Because you still would have done what you did anyway, probably, 'cause that's who you are…" (Participant)

It is obvious that the system is broken, to Senate Committees, to the Attorney General, to the Veterans Ombudsman, to the research community, and most importantly to the Veterans. The present transitional experiences of research participants indicate how, in practice, the system enacted by the present government, as its part of the covenant is broken as a result of its neoliberalist philosophy. The participants' words explain their own experiences, and also their concerns about the future, as they speak about the soldiers yet to transition, those who will continue to honour their side of the covenant and eventually pay the price for doing so.

Conclusion

In her 2014 Massey lecture series, and Adrienne Clarkson describes the way that our country has established a tradition of acceptance that allows newcomers to "imagine themselves into becoming citizens" (pp. 111-112), she exhorts us to understand each other's various realities and explains that many immigrants have a history of loss (p. 114), just as many Veterans do. Assuring the quality and relevance of transitions systems for healthcare and education offers proof that we value our Veterans as citizens who have maintained their part of a special covenant. It is our country's responsibility to understand Veterans' realities and to offer them the refuge of community, to honor their accomplishments, the chance to grieve their losses, and to help heal their wounds. With

this support and acceptance, it is possible that Veterans will move toward their own imaginings of citizenship as civilians.

Chapter 7: Culture

Marsella and Yemada (2010) define culture as:

> … shared learned behavior and meanings that are socially transmitted for purposes of adjustment and adaptation. Culture is represented externally in artifacts (e.g. food, clothing, music), roles (e.g., the social formation), and institutions (e.g., family, government). It is represented internally (i.e., cognitively, emotionally) by values, attitudes, beliefs, epistemologies, cosmologies, consciousness patterns, and notions of personhood. (p.105)

This definition illustrates that the elements of culture both locate and define persons or groups of persons as belonging to, or being outside a particular culture; these inclusive and exclusive meanings and artefacts are the means by which cultures 'shape' people. Marsella and Yemada continue:

> What is relative is the social contexts in which we exist, and the content and process that serves as the foundations for our constructions of reality…. Culture determines, among other things: standards of normality and deviance… (p. 106)

Cultural Narratives

The content and process referred to by Marsella and Yemada includes the stories people tell about themselves and others in a culture, and the way that these stories interact with each other. Cultural stories, or socially circulating narratives, convey meaning; we use them to understand each other and to establish and police behavioral norms (Caddick, Smith & Phoenix, 2015b). We cannot understand military culture without understanding the narratives against which it unfolds. Veterans, who are defined by the warrior narrative, align with the military values described by this narrative; they also monitor those who contravene these values. They do this in various ways: with pervasive attitudes, language conventions, and sometimes very explicitly on Internet sites such as Stolen Valour (www.stolenvalour.ca), which is a forum for exposing soldiers displaying

unearned honors.

Narratives interact with each other in different ways; they can exist in opposition to each other, overlap and contain other narratives, or exist beside each other with very little interaction. For instance, one participant simultaneously challenged the warrior narrative injunction against treatment seeking by seeking help when he needed it, and aligned with it as he referred to psychotherapy as: "cuddle time and … stories." The importance of these interactions makes it imperative to do more than simply describe the characteristics of narratives within a culture; they must be analyzed through a lens that illuminates whether they exacerbate or decrease problems for Veterans in transition.

Two studies illustrate the ways that resistance to an influential cultural narrative (dominant discourse) is recognized as evidence for the possibility of change (change talk). Berger (2014) provides an analysis that challenges the illness narrative and how it ties individual problems to larger contexts, and Carey et al (2009) explain a technique from Narrative Therapy that reveals the seeds of positive change in personal narratives. The work of these scholars informed the framework that is used in the analysis of the narratives in this study.

In addition to describing the uniqueness of military culture, an analysis of participants' stories reveals that military culture contains embedded narratives, including those that influence and describe stigma, family relationships, and treatment. Although researchers have discussed these themes previously, in this study, the participants' own experiences illustrate the experiences and consequences of being 'between' the narratives of military culture and civilian culture during transition. Below, participants and researchers explain influential aspects of military culture; additionally, pertinent documents and reports

reveal cultural narratives (dominant discourses). Most importantly, examples of resistance to entrenched cultural practices and signs of new understandings will be highlighted from the participants' explanations.

Military Culture

System that defends democracy but is not democratic (Hall, 2011, p. 8)

The publication CF 101 for Civilians (National Defence, n.d.), provides the following description of military culture:

The profession of arms is uniquely distinguished by the concept of:

- Service before self.
  Service before self is the lawful, ordered application of military force as directed by the Canadian government.
- The acceptance of unlimited liability.
  All members accept and understand that they are subject to being lawfully ordered into harm's way under conditions that could lead to the loss of their lives. In no other profession in Canada, including the police and fire services, can a member be legally ordered into harm's way.

  The profession of arms is more inclusive than many other professions, as it can only be practiced collectively. Every member in the Canadian Forces must work together as part of the team. (p. 58)

The most unique feature of military culture is the covenant, or the special relationship between the Canadian people and the military, which has been discussed in the previous chapter. The definition above explains that this culture is unique, and that one of the most obvious aspects of this uniqueness is the legal obligation to obey orders that put them in harm's way, that CAF members serve under. In accordance with the clear values that the covenant is based upon (dignity, loyalty, integrity and courage), and the above description from CF 101 for Civilians, participants have indicated that a strong

collectivist ethic, with good leaders who adhere to a hierarchical power structure built around the care of the troops, are important parts of military culture as they understand it and have lived it. Their stories reveal how they continue to uphold military values with uncomplaining dedication (roger out!) to their mission, and maintain or challenge the cultural codes that dictate self-reliance, solidarity and not 'breaking ranks.'

In addition to explaining these cultural practices, participants' stories have pointed out the transient military lifestyle and special, acronym-filled language that are part of military culture. Other, more obvious features of this unique culture are the wearing of uniforms and the fact that soldiers often live and work apart from civilians on military bases, both in Canada and abroad. Participants have discussed certain beliefs about the culture; for instance, that the military is a good place for a young person to grow up and also that military life once conferred a sense of belonging, purpose, identity and stability to their lives. Others have explained that they understand the military culture to be just as enigmatic to civilians as civilian culture is to them. Along with these understandings, participants' words allude to the cost of aligning with, or challenging cultural practices. They do this by explaining the sacrifices that they made over their careers, and by speaking about times when they feel the separation between themselves and civilians, and when they don't fit into, or understand civilian culture.

With its values, artefacts, beliefs and hierarchical structure, military culture tells both insiders and outsiders: 'this is who we are, this is how we act.' Some of these cultural artefacts are as explicit as the guardhouse at a military base, which separates civilians from the military; or the rules about who salutes whom, which reinforce the hierarchical system called the chain of command, and symbolize the difference between

commissioned officers and non-commissioned officers and soldiers. Some aspects of culture are implicit. For example, although CAF members have the right to free speech, as do all citizens; one participant described his understanding of what it is appropriate to speak about, and how this is to be done:

> Well, in the military you don't go to the media, so, some guys … there's a backlash, and others are praised for it- it all depends on the way you do it- if you're going to go be a whiner then …

The participant explained that being a whiner was the antithesis of speaking in accordance with the collectivist ethic, and that there is another culturally sanctioned way, where it is honourable to break silence if it is for the good of other soldiers as well as oneself:

> There's been a few- kind of looking out for everybody, even if they're using their own personal experience but they kind of want it to change for every body instead of just one guy trying to get something for himself.

These cultural practices delineate that there is space for some things and make it clear that others do not belong. Caddick et al (2015b), describe the way that military cultural norms are policed by language, using labels to describe those who do not conform as expected. They refer to the banter that communicates military cultural values, indicating that it must convey a positive tone to be considered not whining (2015b, p, 104). One participant describes the type of banter that was used at his workplace, where dangerous experiences were part of the job:

> P: You know there are clichés all throughout: "It's all pensionable time boys," jokes like that, you know: "What are you bitchin' about- you get paid for it? C'mon man it's the experience!"
>
> D: That's how you diffuse…?
>
> P: Exactly, it's gallows humour…

Gallows humour is a defence against danger and overwhelming situations such as war and disease; it acknowledges the intensity of shared experiences without explicitly discussing emotions, it is not meant to be understood by outsiders. Watson (2011), a biomedical ethicist who writes about the use of gallows humour as a coping mechanism among medical personnel, explains: "It's how they talk when it's just us," (p. 38) indicating that it confers a sense of belonging to those who have been in difficult situations together. Participants have understood the implicit message in these language conventions, and their adherence to the message that it is not acceptable to speak out about individual needs and concerns or emotions is a reflection of their respect for the military chain of command, the collectivist ethic, and the quality of forbearance that are crucial to the making of a soldier. The participant below is speaking about this aspect of the culture and also his awareness that Veterans are affected by attitudes from outside the military (civilian's perceptions) as well as from inside the military:

> P: … I'm concerned that their reluctance might be to bring it forward… there's a reluctance to make noise or to be seen as the squeaky wheel, the complainer, the whiner or the person that: "What are you crying about- we're giving you something!"
>
> D: So this is the perception of the public about you, you're talking about?
>
> P: Exactly, and I think that's why there's a culture or there has been a culture of quiet or silence you know- "We shouldn't push our issues…

Participants repeatedly explained their understanding of two core military tenets: 'mission above all else' and 'attention to the good of the men.' One participant commented: "there's a lot that you sacrifice together to survive whatever it is that you survive." These sacrifices extend to the transition process that soldiers being medically

released find themselves in, as they continue to use the understanding of mission first to navigate this process:

> I'm thinking that it goes back to that culture- you make do with what you have and if that's all that's currently available- yes, we will scream and kick to make ourselves heard to hopefully get the process better, but in the short-term this is what I've got, I have to make the best of what I've got.

Care for each other. The collectivist ethic continues to influence the transition after medical release, and is reflected in the way that soldiers often continue to look out for each other after they leave military life:

> P: Those of us that know each other, respect each other, work with each other, got all this shit behind us- we have a tendency to help each other. When we hear or know of somebody who's getting good treatment, or better treatment or different treatment, or whatever the heck it is- doesn't matter, that you know that this person could benefit, we pass it along, it's just what we do.
>
> D: You watch.
>
> P: Right- you see the effects, you pay attention and you help out where you can.

This care for each other extends into the lives of some Veterans after their release, and takes many forms, such as in-person gatherings and on-line support groups. One participant described his informal support group of crewmates that regularly meet at coffee shops:

> … once you move on to the other side the old boys network is your group of people that you know, that you served with, that you want to spend time with after the fact, that you'll socialize with– now.

Two Veterans of Bosnia and Cyprus, explained to me that, with their own resources, they host monthly suppers where they make sure that individuals they are concerned about have an opportunity to reconnect with the support of their regiment in a setting outside of the military. They connect with serving soldiers and Vets from Afghanistan

and other deployments by watching an informal Internet group, and when they recognize someone in trouble, they extend an invitation to talk one-to-one: “these guys just need to talk, and sometimes for hours” (personal communication, August, 2014). In response to my question about what the new Vets need, they explained: “They need to talk to each other; we weren’t there but we’ll talk to them, they need to talk about their emotions” (personal communication August, 2014). They explained to me that these (mostly) young men are watched all of the time at work, and that they exist in a culture of competition, where they can’t show emotions, especially those that might indicate they are in trouble. These two individuals spoke to me in a preliminary phase of the study, and I understood their willingness to talk with me, and their vigilance, as expressions of continuing care for the soldiers they see in difficult transitions.

These types of informal Veterans’ connections exist alongside social media sites such as those maintained by Veterans Emergency Transition Services Canada (VETS Canada), a national organization that was started by a single Veteran and his wife due to their concern about the problem of homeless Veterans. Organizations as diverse as Military Minds, Afghanistan Veterans Association of Canada, and Marijuana For Trauma, all groups that were initiated by Veterans concerned with issues arising from the transition from military life to civilian life, maintain social media sites and platforms where Veterans inform, connect and advocate for, and with each other.

For some soldiers, camaraderie was the most enjoyable aspect of being in the military. Mantle, (2013, p. 3) describes the “immensely profound friendships forged through shared, often dangerous, experiences,” as one of the benefits of a military life.

The experience of camaraderie in the military is often assumed to be universal, but in the experience of participants, it has been situational and job-dependent. Shaw and Hector (2010), explain that in their study of returning Veterans from Afghanistan and Iraq, participants described that different jobs exerted a unique influence on their experiences. One participant in the present study, who often worked alone and outside of the regimental structure of the combat arms trades explained:

> D: So this camaraderie thing that you keep hearing about hasn't been your experience?
>
> P: No. When I've ever been away, every time you go to say, Somalia or Haiti or Rwanda or these sort of places, you're just the guy in the back with the [specialist equipment], who gives a shit about you? It's: You just [do your job] and lets get the hell out of here!" you're not part of them, you're in the back.

Other exceptions to the camaraderie of military culture include the experiences of remustering (leaving one trade or unit for another) or sometimes, medical release. This means that, the experiences one participant describes as: "…those kind of events that are shared between buddies, crewmates, whether it be army, navy, air force, whatever…" may come to an end and there is a disconnection, and possibly judgement from those who see the breaking ranks as a betrayal. He continues:

> It's about what it means to serve I guess and… you just need to do something to survive, so some of us re-muster out and as I say when you get there- you're lost, you don't have anybody, you don't have any of your crewmates that you can relate to.

Upon breaking ranks, individuals have received explicit and implicit messages from former colleagues about how they no longer belong. For participants these included being warned by a superior not to show up at the mess any longer, or being denied access to information that is available to all 'insiders':

> … sadly now that I have transitioned out of the organization… there are those that are currently serving... once you're on the outside. Once you're on the outside anyone that was willing to supply you with information is very nervous, in that- not that they're going to violate the Official Secrets Act but: "don't let this get back to me."

The military has other explicit ways of shaping its members during the rigors of basic, and ongoing training. A participant who rose through the ranks to the position of senior instructor explains this reshaping process: "…in the military we have a tendency to try to break everybody of those qualities [*that were instilled by their upbringing*], to instill our own, it's only natural." The most obvious form of shaping is the military's emphasis on demanding fitness regimes and feats of endurance; participants indicated that during deployments these were useful in coping with long periods of waiting, and in transition and after release, these same practices help with stress reduction. The shaping of minds is also a feature of military culture; this is accomplished in part by adherence to the chain of command, which is a crucial feature of military life.

Chain of command: The container.

"Welcome to the big organization. We'll do the thinking for you…" (Participant)

The chain of command refers to the military top-down model of organizing power, responsibility and decision-making. Hall (2011) describes military culture as having a rank structure which is a class system (p. 10); CF 101for Civilians (National Defence, n.d., p.25) explains that it begins with the Chief of the Defence Staff and proportionately assigns authority to a series of increasingly subordinate and carefully selected commanders. A participant explains how information is managed by this hierarchical structure where there are explicit and implicit messages about the sharing of information,

which he sees affecting the choice of soldiers with post-deployment problems to speak about these in public, especially to the media:

> … because of the culture- that is very much drilled into you- hence the reason why my concern is that younger folks be, you know "Welcome to the big organization," we put them through the indoctrination that: "We'll do the thinking for you, we'll tell you what's fair and what's not fair, we'll tell you what's part of the culture and you just either accept it and make do and struggle and get over it or choose another form," so hence I'm concerned that their reluctance might be to bring it forward." There was an illusion that everyone has an agenda and the media's agenda may or may not be to showcase your specific operation and or task in a positive light. Therefore… [Laughs] "To avoid confusion it is highly advised that you do not engage."…and it was veiled that there would be repercussions, should you choose to put yourself forward.

In addition to the chain of command, there are other aspects of the military that maintain it as a separate, closed system; it maintains its own medical, legal and justice systems, which are almost completely separate from those of civilians. This separation makes the culture unique and has also resulted in the perpetuation of some of the serious problems of military culture. The Fynes Report, which provided an unfortunate example of how this system enables a lack of transparency, was discussed in the Covenant Chapter (p. 70). Recently (April, 2015), an external review of sexual misconduct and sexualized harassment in the CAF acknowledged the marginalizing experiences of female soldiers who attempted to report and seek redress for sexual abuse at work. This report drew attention to the CAF culture of silence, to the level of compliance with it that extends up the chain of command, and it also pointed out who is paying the price so that this façade of sexual equality in the CAF can be maintained (Deschampes, 2015). This closed information management system has also affected the experiences of individuals in transition and participants highlighted the case of Barry Westholm (Cobb, 2013), which will be discussed in the Stigma Chapter (p. 143) as an example of this. The command

structure of the military provides a tight container. In deployment situations this creates safety for soldiers, however it can also be a tool for intimidating individuals who wish to speak out against problems in transitions systems.

Hegemonic masculinity - the dominant military social narrative.

"They need you when they need you." "... and they need you to disappear when they don't" (Researcher and participant)

The most highly influential cultural narrative in the military is that of the hegemonic male; also known as the warrior narrative or hero myth; these terms will be used interchangeably to reflect the preferences of the specific researchers being cited. Woolf (2012), explains that the characteristics of a hero involve: being male, strong and physically fit, heterosexual, brave, and in control of oneself and others. As one participant explains, this was very clearly the way he understood his role for most of his career:

> I think anybody who has an element of self-control is goal oriented. If you don't plan something you're just doomed to fail, if you don't plan and set out goals. If I'm not strong enough to go 13km every day with 50 pounds on my back, well: "You're not making the mark," that's just the way it is.

Caddick et al (2015) explain that hegemonic masculinity is only one performance of masculinity, however it is the expression that the military shapes, expects, and requires; it is embodied, action-oriented and positive. According to Caddick et al: "military socialisation demands service members adopt a 'hegemonic' form of masculinity that defines what 'real men' are like and what they can (and cannot) do" (p. 98).

It must be noted that this emphasis on the qualities of the archetypal warrior in the military is a considered strategy that attempts to maximize the potential of soldiers to

survive during combat and, especially, to attain mission goals. In combat situations it is necessary, and to dismiss the value of it under these circumstances would be naïve and disrespectful. Hegemonic masculinity has been constructed as a problem by outsiders writing about soldiers in transition, and this is a valid viewpoint. However, as an outsider to military culture, and a female researcher, I am aware that I will never have an embodied, experiential understanding of the warrior narrative, or the lived experience of being in combat. Participants do have this experience, and they were generous in their explanations of this to me:

> Well, I don't know how you're looking at us, I don't know how you see us, but I wrote these things down because I just wanted to remind myself. For us, there comes a point that it's just a matter of survival, because we joined this life- we were stripped down and we were rebuilt the way the military wants us to be. We all live a regimented life in the military; and it doesn't matter what rank you are, it doesn't matter where you end up, everybody starts the same, they begin this regimental way of life in an operational role typically. For those of us that live in this operational role, it's all about survival- we're taught how to survive, in whatever environment we find ourselves in, that's what it's all about.

Other researchers have tried to capture the experiences of warriors in combat: Mantle (2013) has collected examples of the experiences of soldiers deployed in Afghanistan in a collection of narratives called In Their Own Words. He explains: "What it was like to fight in Afghanistan can only truly be understood by those who actually fought in Afghanistan." Mantle discusses the core military values of duty, loyalty, integrity and courage that underpin the daily lives of soldiers; he describes how difficult it is for an outsider to fathom such experiences:

> …"intangibles" upon which success so often depends…especially in the face of traumatic events … It is simply impossible to replicate in words the sheer emotional power of such an event with complete accuracy or totality… (p.3)

These intangibles may describe the things that participants have seen that those outside of

military culture will never see, and the term 'success,' as used above by Mantle, may allude to the fact that they have seen such things in the course of defending an ideal that they believe, or believed in. Their dedication to this ideal ensures that some civilians can live as though, as Burstow (2005) explains in her critique of the diagnosis of PTSD: "The world is a safe and benign place" (p. 434) while those who have experiences trauma, cannot. One participant explains that for him, there have been costs to his military duty that few others can understand, including the culture and society that dictated his duty:

> For the most part, and those kind of events that are shared between buddies, crewmates, whether it be army, navy, air force, whatever- it's immaterial-there's a lot that you sacrifice together to survive whatever it is that you survive and sometimes you have to do things that are probably not seen in the best light… In my opinion Westerners will never get it.

Heroes are a select group, outside of the mainstream social narrative; they are not associated with the need for help, nor do they fail; they protect others, stand for high ideals, have overcome great odds and are willing to use aggression. Woolf explains how, because the hero narrative fits within the military culture and that consequently, military society constructs heroes by providing opportunities for those individuals who 'fit':

> Hero status is symbolically guarded and access is regularly restrictive. Military service, however, is one such avenue to access the cultural resources and social privileges associated with heroism. The military, as an institution, offers unique resources for constructing masculine identities characterized by emotional control, overt heterosexual desire, physical fitness, self-discipline, self-reliance, the willingness to use aggression and physical violence, and risk-taking qualities (Higate 2007; Hockey 2002; Siebold 2001). (Woolf, 2012, p.13)

Warrior status is an enduring feature of military culture; Mondini (2014), who examined the autobiographical writing of soldiers from World War I, explains how notions of masculinity are transmitted intergenerationally:

> …they handed down the meaning of intervention, mobilisation and sacrifice. They are characterised by …the recurring theme of self-sacrifice. At the core of all war stories there is the experience of fighting and death… The most powerful leitmotiv… is the metaphor of the military community as a 'family'. Young officers … consistently referred to their admission to the 'family' of soldiers at war as a life-changing transition ...brotherhood in arms is so deeply felt … (abstract)

Hall (2011) agrees that to understand military culture, it is useful to understand the motivations that cause individuals to join the military, and how these are influenced by masculine ideals originating in the past, including merging their identity with that of a warrior, following their fathers to war, and passing the ultimate test of manhood. One participant expresses his understanding of this test in the following manner:

> …there's no better way to find out- in my opinion, what you're made of than joining the military, you got to test yourself and once you learn those boundaries, well you spend the rest of your life trying to extend those boundaries literally that's what you do.

For individuals who have been able to attain the status and maintain the high ideals described by the warrior narrative, transition time raises fundamental questions. Participants are attempting to answer these questions in accordance with the ideals of the warrior narrative that still influences them. As self-reliant individuals, participants are looking for landmarks that indicate how civilians operate. In his attempt to navigate his transition, one participant chose to seek counselling (information gathering) with an organization that seemed to him to have elements of the old framework: "…apparently people within the organization are Veterans, and they have this peer to peer thing there, I guess an ex-case manager from VAC works there..." In the quote below he expresses his questions about the differences between military and civilian mindsets:

> P. … things come down and they get done- there's no gray!

D: Right.

P: That's what I'm kind of worried about, all these gray people. [Laughs]

D: Yes, and how do the gray people operate with each other that's not…

P: How do they get anything done, if they're talking about doing it the whole time!

D: Process- the process is negotiated instead of mandated?

P: Yeah, so it'll be interesting. The military's been doing things the same way--- everything is just done- it's done.

This participant, also a self-reliant individual in the early stages of navigating the tension between military and civilian cultures, expresses concerns for those he sees around him (looking out for the good of the men) that are less well-equipped people who have previously needed to rely upon the military framework that they are being released from:

> …very much a sink or swim process, so in ways it's good for the individual because it weans them off the reliance of being in an organization like the military where things are very structured. It puts more emphasis on the individual, which is good, however certain individuals if they aren't fit to meet the obligations of service, may or may not have the coping skills necessary to sink or swim when thrown into the deep water.

Another individual, now active as a Veterans' advocate, sees the way that his understanding has come full circle. He expressed his ideas about the public discomfort with what the military is asked to do on behalf of our society, and his memory of the way that as a boy, he saw older soldiers ignored, now, as he analyzes his own experiences, he draws upon the quality of stoicism that has served him in his career:

P: … this time is no different than any other, people need to feel secure, and it would appear that at the same time people need something to bitch about, always.

> ... And it seems like the military is always the best tool or the best focal point for people to get both at the same time.
>
> D: The people who are in it or people who are looking from the outside?
>
> P: People who look at us from the outside- people that need us.
>
> D: Right, they need you when they need you.
>
> P: And they need you to disappear when they don't; it's always been like that, I had no illusions otherwise.

Intersecting Cultural Narratives

Military culture and the rest of society.

"...too many movies." (Participant)

Military culture is embedded in Canadian culture; during the transition to post-military life, the narratives of military culture and civilian cultures interact. Participants are aware that civilians have a stereotypical image of military life and especially of combat, and this can affect their engagement and integration with civilians on many levels. The participant below explains that for him it is easier in social situations, not to tell others that he is a Veteran:

> Most people don't understand …- all they understand or know is what they see on TV and they don't understand the reality of living in those environments and we judge everything by what we know and compare it to what we know…
>
> P: …you get the typical civilian stupid question: "Did you shoot anybody?" you get all these dumb questions, so…
>
> D: People ask you that?
>
> P: Oh, my god, they ask you a million dumb questions- they watch too may movies… So I just tell them I'm a student…

Woolf (2012, p.11), has explained that this narrow veteran narrative is due to assumptions that civilians hold in regard to Veterans, such as: "they have highly prized personal qualities; have made uncommon sacrifices for society; have fought for a greater cause against a powerful social villain and; have voluntarily done so at great personal risk." Other socially circulating beliefs include: Veterans make good employees, Veterans are victims of mental conditions such as Gulf War Syndrome and PTSD, and even Veterans cannot be antiwar activists (Romo, Zastrow & Miller, 2002; Lembcke, 1998).

The selective attention of the public to some of these narratives and not to others, creates a disconnect between civilian and military society. Shaw and Hector (2010) have written about the misconceptions of the public about returning soldiers and like the Veteran above, attribute this disconnect in part to the way that soldiers and Veterans are portrayed in mainstream media and especially in movies:

> …participants mentioned how the American public does not fully understand what is going on in Iraq and/or Afghanistan, and what the military members are doing there. One participant pointed out, "That's a misconception the public has is, everybody is over there day to day pulling out bayonets, firing and shooting. But, most people did not fire their weapon." The participants discussed how the news and other media do not portray the full story of what is happening in Iraq.' (Shaw & Hector, 2010, p. 132)

Another participant describes his understanding of being a soldier situated within Canadian culture and his frustrations in the face of the system and a public that is often unaware and misinformed:

> …we live in a very, very sheltered society, large continent, been very self-reliant over the decades, strong backbone, strong willed, determined people- hard working, faith-based, industrious… We were in a real serious shooting war, so coming back we learned a lot of lessons hard and tough, and the Canadian public wasn't prepared for that. They weren't prepared for all these people with limbs blown off, multiple amputees, bodies in boxes; the Canadian public was not at all

> aware of really what we'd gotten ourselves into, and then when we made our move down to southern Afghanistan the carnage only escalated, and I think when I was told about me going over, it was about that time that the general public had an element of perception, but they also had a huge element of mistrust because it seemed now that the country was being a little more aware in recognizing that there was a need to look after our people. There was also a huge distrust in government in general; it didn't matter if it was the Liberal or Conservative or NDP, they just weren't getting the facts. There is the need still, but Joe Public I don't think have a full appreciation, so when I say that there's a need to have a full appreciation before you recognize the need, I really don't think that Joe Taxpayer really knows. These little sound bites or these little cut-lines under pictures and these eight seconds of video here and a couple of news pictures here and there, they really do not connect with the average Canadian, they just don't.

When he was asked about the effects of coming home to a disengaged public that has unrealistic ideas about what soldiers' experiences of combat were, the same participant answered:

> …I either hurl off to the side and let the bus get some distance or get in front of it… I avoid crowds because somebody in there could have a vest-bomb. Seen it- lived through it- don't need it to happen again. It's just the way it is. Joe Canada, or Joe Canadian, or Joe Taxpayer, they don't recognize those things and quite frankly, I think they got sick of the idea of front-page news being another serviceman being carted into a Hercules aircraft to have his body hauled back to Canada. Even my neighbours asked me about that sort of stuff when I first came home for the first couple of years, well: 'We don't hear anything- what's good going on" and then I'd ream them off a whole pile of all the good things that Development Canada people, the Government of Canada is throwing money at, and us to help them do it safely… that story is gone!

This Veteran is experiencing the very concrete psychological consequences of what he has witnessed during his career, and the fact that the people he is surrounded by each day do not appreciate or realize the larger story that the experiences of soldiers are connected to, adds to his frustrations upon 'coming back.'

Military culture and the illness narrative. As we have seen, when the narrative that describes: "this is who we are, this is how we act," clashes or colludes with other narratives, there are consequences. Mantle (2013, p. 2) explains that in order to

understand the 'mind of the soldier,' or, why he or she does the things that he or she does, there needs to be a "deeper and sympathetic investigation." Sympathy entails striving for mutual understanding, and looking at the intersection of two of the most influential cultural narratives describing transitions after medical release: hegemonic masculinity and the illness narrative, will lead to the deeper investigation that Mantle prescribes.

In writing about post-deployment transitions of soldiers with post-traumatic stress, researchers have juxtaposed the hero and illness narratives (Woolf, 2012; Caddick et al, 2015) in a way that problematizes military culture, and more specifically, soldiers. Woolf indicates that in the context of a readjustment to society that is constructed as illness, as the medical model does, hegemonic masculinity is problematic. Caddick et al explore another understanding: they see that in 'safe company' hegemonic masculinity can be somewhat fluid and therefore provide a resource. Their research illustrates that an essential point is the context in which hegemonic masculinity is embedded. Woolf writes that in general society there are expectations of Veterans that construct help-seeking behavior as weakness, due to the influence of the illness narrative; he concludes his thesis with the recommendation:

> We might also ask how divergent meanings which accompany these two contradictory yet coexisting narratives can be re-conceptualized to begin work towards resolving damaging issues produced in these narratives (p. 69).

Caddick et al are trying to find a way to do this; they conducted their research with a group of Veterans living with post-traumatic stress that included surfing as an embodied, masculine activity, which provided a respite from being defined by the symptom-focused illness narrative. These researchers noted that talking about positive emotions, having respite, concern for the wellbeing of others but not oneself, and using surfing as a coping

strategy, were acceptable in the group and aligned with the physicality, use of masculine forms of humour, and focus upon positive emotions as opposed to negative emotions, that are characteristic of hegemonic masculinity. Discussions about surfing 'nudged' the illness narrative aside, and co-existed with the narrative of the military male; in response to this Veterans in the program reported that their feeling of wellbeing increased. Caddick et al use their knowledge about how narratives interact to identify one narrative (respite narrative) that aligns with the dominant military narrative (hegemonic male) and also stands up against the pathologizing illness narrative and results in a positive outcome for their participants. The ways that participants in the present study have also challenged the medical model, illness-based discourse in their stories will be discussed in the discussion of the themes of stigma and treatment.

Invariably, academic research articles refer to the influence of military culture on treatment; this is vitally important because, as we have seen above, hegemonic masculinity has great benefits for healing in terms of its positive outlook and focus on both connection and self-reliance. Where a problem arises is when clinicians understand military culture solely in terms of a barrier and fail to recognize its strengths. Often clinicians advise each other about 'how to deal with soldiers and understand their culture' (Shaw & Hector, 2010; Beder, 2011, Hall 2011; Jordan, 2011; Skidmore & Roy, 2011; Bryan & Morrow, 2011; Yarvis, 2011) as though soldiers and Veterans were a curious and unfamiliar life form. This literature advises clinicians about 'multicultural competencies,' which reflects a level of bewilderment in the treatment community about their military clients. Hall attempts to address this lack of awareness, and advocates that her clinician colleagues strive to understand the "standards, jargon and beliefs" (the

narrative elements of military culture) of their clients, incorporate these into practice and use a strengths-based approach, with a more 'cognitive modality' over an emotionally focused one. She addresses the fact that many clinicians are female social workers (schooled in feminist and illness narratives) who may overlook the deeper meaning behind such military jargon, as 'Soldier up,' which means: be a (hegemonic) man and do it on your own. These failures to appreciate that in military training certain beliefs, such as lack of emotion as a survival strategy, were instilled because not to do so was dangerous, do not honour the culture of military clients.

As mentioned previously, soldiers' adherence to the warrior narrative and other aspects of military culture have been understood as 'barriers to treatment', or 'non-compliance,' when they intersect with the medical model of mental health treatment narratives. It must be understood that the language of the medical model, and those who practice it, also contribute to these marginalizing conventions. In the abstract to his article, Yarvis (2011), a noted military scholar, soldier and social worker, writes: "PTSD has been designated one of the signature wounds of the Iraq/Afghanistan War." This glib term exists alongside descriptors of clients such as 'treatment resistant,' which are dismissive, and often perpetuated in the writing of researchers (Hall, 2011). Additionally, the rhetoric of the medical model of treatment, in particular the understanding of post-traumatic stress as a disorder in need of a diagnosis, (an illness or mental health narrative) constructs the reactions of individuals to overwhelming events and circumstances as pathological symptoms (American Psychiatric Association, DSM-V, 2013).

In her analysis, Burstow (2005), a feminist scholar and anti-psychiatry activist, sees the reactions of individuals who live with post-traumatic stress as valid, natural,

intelligent and logical adaptations to intense experiences. Extending this type of thinking creates an understanding where the warrior narrative becomes a resource to individuals with military training, as it helps to avoid negative emotion, increases the capacity to focus upon self-preservation and the accomplishment of a goal, and reliance upon inner strength. It must also be remembered that the warrior narrative can be a double-edged sword, because it also stigmatizes individuals having transition difficulties. One participant describes himself as 'fucked-up,' which illustrates that although he knows that he is highly effective in many areas of his life, he continues to label himself with the pathologizing language that is a result of the combination of the warrior (no asking for help) and the illness narrative (adaptations are symptoms) in the understanding of post-traumatic stress problems.

When treatment and hegemonic male narratives collude instead of colliding as they are beginning to do in the efforts of clinicians who respect and work with the warrior mentality, treatment can be enhanced. In-unit mental health interventions that are practiced by the entire unit, including clinicians, are embedded in other training regimes, and not described using the illness narrative, avoid triggering negative stereotyping and preserve unit cohesiveness (Bryan & Morrow, 2011). Bryan and Morrow's philosophy of reframing adjustment difficulties as being on the way back to health, is accepting of individuals with post-traumatic difficulties, as opposed to being exclusive of them. Their attention to the way that language creates meaning, and its practice of using military skills language to describe tasks, challenges the manner in which treatment providers usually interpret the warrior narrative as a deterrent to help seeking. Bryan and Morrow have created the Warriors Edge program, which is based upon these principles; they

explain that this program challenges a dominant discourse in the treatment culture by eliminating the need to pathologize warrior culture:

> Because the warrior identity is based on strength and elitism, the use of clinical terminology is at odds with the warrior mindset and reinforces the disconnect between service members and mental health (p. 17).

Resistance to Prevailing Narratives

Standing up to the labels and practices that constitute the culture containing the medical model requires the qualities of the soldier: dignity, courage and integrity, to resist the dominant discourse which dictates extreme self-reliance in the face of personal difficulties, and in order to deal with the consequences of breaking ranks and seeking help. Participants, some of whom have faced their mortality in a very concrete manner, recognize the tension between being defined by the military male narrative and reassessing their priorities:

> Yeah, up until I was overseas I would be pretty much characterized as an alpha male. You know, pick your weapon up, quit crying and get on with it- that sort of thing, and had been that for many, many years you know, going to the gym being the best you can be, lifting more than you can lift, go farther than you can go far and the whole nine yards. It's not until you get in a situation where death's got a sign in front of you and it's your name on it- you have a whole different perspective on things very quickly, or in a short time, in a less than gradual way you find out "Wow what I was and the dork I probably was, [one of those types?] doesn't amount to a hill of beans when compared to your family and your mates.

Such a reassessment has been termed 'post-traumatic growth' and this acknowledgement is one of the ways that the research community is opening up pathologizing narratives to describe its changing understanding of how individuals can integrate intense and difficult combat experiences into renewed and expanded self-concepts (Tedeschi & McNally, 2011). This entails making room for perspectives, such

as the one described by the participant above, that are not encompassed by the illness narrative, and that require a more comprehensive understanding of the transition process that reflects the nature of healing in a manner that is connected to Veterans own ideals and capabilities for self-determination.

Stories of resistance are especially important in the changing of culture; in the context of a life transition they can lead to new ways of thinking that are more congruent with the emerging sense of self that can follow trauma. Caddick et al. (2015b) speak about resistance as a "cultural 180" in the following quote about the surfer Veterans in their study:

> …taking responsibility for how I feel is actually being able to say 'Actually, I need help.' Which I don't always do … but I never even realised I could ask for help, I think, in the past. So that's kind of – in a way, turning my thinking round 180 degrees – everything I kind of believed was true maybe wasn't. (p. 108).

Resistance appears in the participant's narratives in the form of paradoxes or 'outliers' and exceptions to the usual story, which raise possibilities for challenging dominant discourses and narratives. These new possibilities are seen when individuals or groups step forward with courage in the face of powerful systems such as the military, which have intentionally 'designed out' opportunities for dissent.

Michael White, a therapist and co-founder of Narrative Therapy (NT), dedicated his career to learning and teaching about how individuals find the 'seeds of change' in their own stories of resistance to dominant societal discourses. He based his work on the ideas of Foucault, who explained: "…in every site of power there is a site of protest and resistance. People are never just passive receivers of what life throws at them, there is always some point of resistance" (Carey et al, 2009, p. 322). Carey et al in their discussion about techniques of NT, explain that 'exceptions,' or examples of what is 'not'

the problem in peoples' stories, indicate what will help people through unexplored territory and toward personal agency.

Looking at exceptions occurring in narratives by describing what the problem is not, or as Carey et al. (2009) explain it, what is 'absent but implicit,' is in accordance with Kleinman's (2007) ideas about feminist analysis, which encourages contextual exploration. Drawing out the context within which a problem arose is a 'stepping away' from being defined by pathologizing narratives; it challenges stigma by understanding that 'the person isn't the problem,' and by naming examples of resistance as strengths and skills that are present and apparent in the narratives of individuals, it unearths existing resources. This leads to a new story, much like the above story of post-traumatic growth, which emerged as the participant wove elements of his own warrior narrative into a new narrative aligned with a heightened sense of the importance of connection to others in his idea for his future.

In such examples of what Narrative Therapy calls 're-storying,' the language of the descriptive narrative changes. The remarkable transition of Veteran Sean Bruyea, exemplifies this. Bruyea sued the Canadian government after his personal medical details were made public by VAC employees who were attempting to pressure him into being silent about Veterans' problems. Bruyea's narrative reads differently now than it did when his dissention resulted in him being labeled as a troublemaker with mental problems by a large powerful system:

> Today, Mr. Bruyea, a married father with one son, is continuing his advocacy as a writer, having published editorials in all of Canada's major dailies. He also volunteers as an adviser to two veterans' organizations and is a vice-president of Canadians for Accountability, a group which helps other whistleblowers. He is currently working on a master's degree in public ethics at St. Paul's University in Ottawa (Vongdouangchanh, 2014, para. 50).

His own words reveal how his courageous resistance has opened up his sense of what is possible for him in his post-transition life:

> My thesis is on, you guessed it, Veterans Affairs and its treatment of modern day veterans," he said. "I spend most of my time with my family healing the wounds of the war I fought overseas and the war I had to fight with my own government (Vongdouangchanh, 2014, para. 51).

Participants have similar 'exceptions' in their narratives; these include stories about particular individuals who helped, such as the VAC case manager who went above and beyond the confines of her job, and the highly dedicated and trustworthy doctor who helps reconnect Veterans to a support network. Participants also reveal their own personal examples of challenging the dominant discourse by putting a commitment to fatherhood above personal career advancement goals, and showing the capacity for analyzing systems at the 'executive' level. Such examples are also apparent in their resistance to the medical model of treatment, as they challenge debilitating mental health diagnoses, refuse to be defined by an illness narrative that does not reflect their lived experience, and use the skills they learned in the culture of the military, and have found within themselves, to cope with transition difficulties. These examples will be further explored in the discussions of other themes.

Conclusion

An exploration of the way that military culture, with its unique narratives, codes, rituals, and structure, influences the meanings embedded in the participants' stories is vital to understand transition experiences as the participants explain them. The themes of Covenant, Stigma, Treatment and Family/Relationships are situated within military culture. Marshall and Rossman (2011, p. 215) describe this nested and interconnected

relationship in their discussion of the complex process of elucidating themes from data, which involves categories that are not mutually exclusive or exhaustive but salient and grounded in the meanings of the participants. In order to explore these meanings, the discussion of the theme of military culture included a description of dominant narratives, and an analysis of how these shaped the experiences of the participants. Interactions between other societal narratives, including those of institutions, contextualized participants' stories.

Chapter 8: Stigma

"The reality of breaching the policy of Universality of Service is the loss of a job and the end of a career. The stigma associated with a condition and the loss of a career is forcing personnel to hide their issues." (Participant)

Stigma is evident in participants' stories of their past, present, and ideas about the future in both explicit and implicit form. Stigma emerges from their stories in all of its permutations, including: 1) societal, 2) from within military culture 3) self-stigma and 4) as anticipated stigma. Below, an analysis of the social and historical construction of the Veterans' narrative and an exploration of how it combines with research about mental health issues adds context to participants' experiences of stigma. Discussing stigma not only as it is experienced by participants, but also in a contextual manner, reveals where stigma originates, and also what reduces it. With this approach, it becomes evident that attitudes and understandings that have been circulating throughout stories of transition since ancient times appear in the participant narratives today, and more importantly, so do examples of the ways in which the participants are resisting stigma in all of its forms. Such examples highlight Veterans' capacity and ability to be influential in the reduction of stigma by challenging stereotypes associated with perceptions about why soldiers are medically released from the military.

A juxtaposition of research literature, CAF policy and current events illuminates the ways in which, although stigma has been identified as a threat to the wellbeing of soldiers and Veterans, the military continues to define it as a cultural problem while practicing in

ways that make it an individual's responsibility. This paradox is significant, and attention to it will 'background' participants' comments as they point out that the experience of stigma is an isolating one; indeed, the terms 'rejection' and 'exclusion,' are included in both of the definitions of stigma as it pertains to military transition, included below. Crucially, and despite the efforts of anti-stigma campaigns, stigma is continually conflated with the topic of mental health, and in the military the effects of this are exacerbated by entrenched stereotypes and limiting policies. This situation provides additional support for the need for a contextual, historical analysis of stigma to explain the limitations of the military's anti-stigma efforts. To this end, the analysis will conclude with the Veterans' example of the transition system's most stigmatizing symbol and process: the Veteran's Review and Appeals and Board (VRAB).

Definitions of Stigma

Besterman-Dahan, Lind and Crocker (2013), in a study of the effects of stigma on the post-deployment transitions of American military chaplains who served in Iraq and Afghanistan, employ the following definition of stigma:

> Stigma can be understood as an overarching term that includes problems of knowledge (ignorance), attitudes (prejudice), and behaviors (discrimination), which work synergistically to fuel social exclusion… (p. 110).

Hinshaw and Stier (2008), in their comprehensive investigation entitled Stigma as Related to Mental Disorders, explain that stigma results in "decreased life opportunities," which is especially significant for transitioning Veterans who are dealing with a system that offers limited and limiting options for them educationally, vocationally and financially. Hinshaw and Stier advocate a multidisciplinary approach to the investigation of stigma and define it as follows:

> Stigma involves stereotypes, referring to cognitive labels that characterize members of devalued groups in blanket terms; prejudice, the negatively toned affect that often emerges toward such individuals; and discrimination, the curtailing of rights and life opportunities of those who are degraded. Stigma processes transcend these phenomena, however, given the global nature of the characterizations made, the shame and degradation foisted on those who are stigmatized, and the deeply troubled nature of ensuing social contacts—including anxiety, hostility, and rejection (The very adjective "mental" connotes the dualistic view that behavioral deviance is of the mind and not the body)—giving rise to the belief that the individual in question may be malingering or not truly disordered—yet this contention is increasingly challenged by integrated conceptions of brain and behavioral functioning (Cicchetti 2006) (p. 368).

Besterman-Dahan et al (2014) investigate cognitive, anthropological and structural components and models of stigma, and explain the need to identify "how various forms of power (social, economic, political) shape the distribution of stigma within a social

environment (Link and Phelan, 2006) (p, 110)" they warn: "we cannot overstate the agency of the individual seeking treatment, but rather must consider how stigma is embedded in the [system power relations] (p. 123)." Hooyer (2012) agrees: "The fifth component of stigma is exercise of power. Stigmatization cannot take place without the social power necessary to translate all these components into negative consequences" (p. 110) As long as the top-down power structure of the military and VAC continue to dominate the transition process, and exclude the voices of Veterans, or address them only in law courts, the stigma that shadows the transition of Veterans will be one of the negative consequences that Hooyer refers to.

The Negative Consequences of Stigma

"I have lost a lot, but mostly family, friends, colleagues, and neighbours have lost me." (Participant)

Participants have explained that stigma affects them across a multitude of dimensions. It isolates them and disconnects them from interpersonal resources such as their families, peers and mental health professionals. Although participants had information that might have been useful to fellow soldiers about to be deployed, the effects of stigma prevented the sharing of this knowledge.

Stigma has *kept participants away from the information they need* to make sense of their experiences:

> P: I was pretty angry, and couldn't fit; I just couldn't understand why.
>
> D: You couldn't fit, is that what you said?
>
> P: I don't, I don't… I didn't fit that's for sure. Civvy life is all well and good, you know, it's what we aspire to participate in at some stage of the game usually- most of us.

> D: At some stage of the game.
>
> P: At some stage…I was always conscious of what time in did to everybody- I mean my predecessors.

This participant has previously spoken about seeing the 'old soldiers' ignored, herded into the Legion and left alone to drink. Since his transition to civilian life, he has developed his own treatment regime, overcome family difficulties and been fundamental in connecting other individuals with the resources they need to navigate the systems of transition. The exchange below follows a conversation in which another participant refers to being 'captured' by the military mental health services (OSIS). 'Hooked in' refers to his words about asking for help and being defined as having a mental illness by the treatment system, when he had reservations about the accuracy of describing his experiences this way:

> D: And so for you- what would you have seen as the natural course if you hadn't gotten hooked?
>
> P: Caught up? I think I would have come home, as per normal, I think I would have had an adjustment period, it might have been a longer adjustment period than whatever is considered normal, because I don't know what's normal.

Stigma (and lack of information) is *isolating transitioning soldiers*, *keeping them away from connection and mentoring*. One participant stated: "…the fact that I'm having difficulties… you're reluctant to share too, right?" He explained that when he came back and encountered individuals who were waiting to be deployed, there was a tension between how much they wanted to know about his experiences and their discomfort with the information he shared. His dialogue expresses his frustration about this; he knew that his experiences had been profound, and could be profoundly helpful (lessons) to these

other soldiers, but he also understood that before he had been deployed, he would have had the same resistance to hearing.

> They all want to know… there's that desire to know- and then you know you can't tell them but if you start to tell them a little bit they're like: "Oh yeah that's great ok, so we got this to do today and we got…" … "You've got this to do today? That ain't important! What I've been just through, and the lessons I can tell you about what I've been through because you might be next- that's important! But it's all right- I'll just put that aside." So you'll go through that strangeness, in that people that you thought you were buds and friends, they can't understand what you went through, and that's unusual, and that might be my naivety, but you know if it was me on the other side of that coin: "Oh, I don't want to know about that stuff over there man- that's some bad juju!" You know what I mean?

This same participant explained about his transition experiences that: "The entire process leaves the participant feeling bewildered and forced down a path rather than being an active participant working towards a common goal." Later, we had the following exchange:

> D: Do you talk to anybody else in this way?
>
> P: No, because that's part of the problem-there's no opportunity for feedback…
>
> D: But I mean even- that's you and the service providers…
>
> P: I've tried to talk to SISIP.
>
> D: [Interrupting] No- but I mean even other people that used to be in the military- even about the system.
>
> P: Yeah, again, I'm going to try, I've got to try something different because just trying to go by on my own is not proving effective, and maybe shared experience- I'll at least have knowledge in the fact we can all commiserate in misery together- we're all unhappy kind of thing.

Stigma is *keeping individuals away from treatment*. The participant quotations below illustrate that the reticence to jeopardize a career (getting the punt), and the stigma about

being a soldier who needs help, exists for both younger and more experienced individuals.

> I know for those guys there was the implication that you can't go forward, because if you go forward with asking for help you're going to get the punt, but the ones that did want to go forward, the ones that said: "I need some help and I need to work this out," for a lot of then there wasn't help available to them or: "Hey man you're an old man, we don't spread poison around here, we don't carry driftwood, we burn it," kind of thing. So if they were pressured not to go, or if they realized there was no help- there was definitely that kind of sentiment I got from some of them (and some guys self-medicated)….

The same individual explains that when others knew he sought help in the form of connecting with the OSI Clinic, they began to ask questions of him. The participant also challenged the military anti-stigma policy; he knew what the consequences to asking for help would be for him, despite the rhetoric of the military: "come forward, you'll be good" versus the number of retentions (individuals who kept their military careers after identifying as needing help):

> …who else are you going to talk to but someone who's been there right? You don't talk to anybody that hasn't been there, you don't talk about that ever, and then when they start approaching you and they start asking you questions, and they're specific as to treatment: "How did you get in there?" "Why did you go in there?" and they kind of show you a little bit of the genie in the bottle and it's like: "Oh yeah- you could benefit from going over there." But they don't want to go because again- they're junior folks or folks that have responsibilities and there's a big fear, and anybody that says that there's not is full of crap, man! I've seen them standing in front of the mikes for the past two years: "Oh no if you have a problem come forward, you'll be good." Really? Really? Let's see the statistics on how many retentions you have.

Stigma: Situated and Multi-layered

"...you don't talk about that ever" (Participant)

Stigma is present as *societal, or public stigma* (civilians' thoughts about what Veterans are like); and as previously discussed these attitudes are often made explicit

through media portrayal, and are "especially rooted in television and film representations… (Hooyer, 2012, p. 111). Participants are very aware of this *anticipated stigma* and they modify their behaviour accordingly, as humans are evolutionarily programed to do in the face of perceived shame (Zinck, 2008). This shows up in the way participants define themselves to others:

> D: Yeah, so you're at a party and somebody says; "Oh, what do you do?" because people seem to like to know those details…what do you tell them?
>
> P: Tell them I'm a student
>
> D: Yeah?
>
> P: It's the truth- it's easier.

And:

> P: It has a stigma too right? You're reluctant to share; you're reluctant to tell people. I don't even want to tell people now: "Hey how's it going?" "Oh pretty good, you know- I finished my contract," you know what I mean? I don't tell folks I got released- prisoners get released! [Laughing]

The interactions of everyday life are affected:

> P: …there's been such a gap of doing nothing. I'm in school, but you're not actually- it's nothing… You know what I mean?
>
> D: Well I know it looks like nothing to a lot of people, I do know that.
>
> P: Yeah, like you're kind of *at home* [Laughing]…even my neighbour said like: "Jesus Christ, you're in the yard everyday!" You know- I have that benefit right now…so he works some weird hours until the ships are unloaded; but I'll be out there with the dog in the afternoon taking a break- you know it just drives him crazy, cause he's busting his balls, but whatever…
>
> D: So there's, there is 'that thing' about society expects people to get up, go someplace, come home, and that's what it looks like to be…
>
> P: Yeah, especially at my age too, cause I'm not old- or young.
>
> D: You're in the middle.

> P: Yeah I'm in the middle, so…
>
> D: So is that what you would call successful, or…?
>
> P: What's that?
>
> D: Well that… your neighbour's idea about you?
>
> P: Oh, no, I don't really care what he thinks, it's just kind of…it's true, I can see where people would be coming from, like: "Jesus Christ, this guy's out in his backyard everyday playing with his dog. [Laughs]

Participants often laughed when they described the effects of stigma in their interactions, they did not use the word shame. It is clear, however, that they are aware of societal stigma, they deal with anticipated stigma, and additionally, they bear the consequences of cultural stigma when they are excluded from the military. As explained previously, military culture fosters stigma because it both defines soldiers as hegemonic males (who belong to a military family), and enacts the Universality of Service Policy (that negates the covenant that defined them as part of the military family):

> [Service members hear] 'We can help!' from the mental health providers, while at the same time being told, 'If you're broke, we'll kick you to the curb,' from the rest of the military community… (Besterman-Dahan et al., 2014, p. 111)

Feeling kicked to the curb results in what Hooyer (2012, p. 111) explains as labeling, being associated with negative traits, and the separation of 'us' from 'them,' which creates a rationale for rejection and exclusion. Medical release can be thought of as the ultimate exclusion, and in a culture that does not encourage asking for help, expects individuals to complete a mission or support fellow soldiers no matter what, and to keep absolute control over emotional, psychological and physical responses, soldiers 'take on' societal and cultural stigma, as one participant illustrates:

> D: Can I just ask you what do you think it says about you that… you can't just pick up and be whatever you call normal after your experiences?
>
> P: Well, nothing positive, that much I can tell you.
>
> D: Really, what kind of a person can just, can just….
>
> P: I would say well-adjusted, someone who's got their shit together, someone who has the strength of character to at least hide what needs to be hidden, to control what needs to be controlled.

Mittal, Drummond, Blevins, Curran, Corrigan and Sullivan (2013) explain the process of how cultural stigma becomes internalized during Veterans' transitions:

> … research has found that active-duty soldiers and guardsmen are most concerned about being perceived as weak, their leaders regarding them less positively, and undermining peer confidence if they seek help (Hoge et al., 2004; Kimet al., 2010). This observation may relate to the military culture, which promotes invincibility among soldiers, and acknowledging mental illness is likely to be viewed as a sign of weakness and a potential threat to their careers. Once veterans move into a civilian life, they may perceive and internalize negative public views about PTSD and mental illness (p. 90)

As Mittal et al, and Vogt, Fox & DeLione (2014) explain, internalized negative views become self-stigma, and this in turn must be handled and controlled, which can result in negative self-assessment, depression and the use of substances and isolation to cope. A participant, mentioned, after he explained "I've gotten to know a lot more about wine in the past few years":

> P: No I think I'm in a safe place. I've always been very self-assertive, self-controlled very self-disciplined, or at least so I've thought. Let's face it, there's times in your life where there's going to be certain things that will invite an element of weakness. That's what I've discovered anyways.
>
> D: What do you call weakness if you don't mind my asking?
>
> P: Well if you can't control yourself…

As they transition and are medically released, soldiers become defined by the historically and socially constructed illness and Veteran narratives which are saturated with ideas about mental health problems, control or lack of control, victimhood (David, 2015) and malingering (Vogt et al, 2014; Caddick et al, 2015). When researching the two terms 'stigma and military' together, it is practically impossible to find information, both academic and general, that does not automatically couple those two terms with mental health, more specifically PTSD. This indicates the extent of how pervasive the attitudes, both in general society and in military culture are, that associate stigma with the invisible injuries of war.

For some soldiers, post-deployment experiences include intense emotional reactions to overwhelming and accumulated stress that has been held at bay by the need to be mission-ready for prolonged periods of time. Although these reactions will be further discussed in the Treatment Chapter (p. 197), they are important here, because they exist in the context of a special culture, and do not align with the ideals of that culture and are therefor a source of stigma (Fox & Pease, 2012). As Besterman-Dahan et al (2014), explain: "across cultures the meanings, practices, and outcomes of stigma differ" (p, 111). In the military, the stakes are especially high for transitioning soldiers; as previously discussed, the sub-culture of military mental health treatment, particularly the medical model of addressing transitional difficulties, also contributes to conflicted understandings and stigma.

One of these conflicts includes the understanding of readjustment after traumatic experiences. This process can include a period of recalibration of the physical arousal, animal defence and cognitive meaning-making systems that needed to be tuned up or

down, in order to survive. The combat-ready state that soldiers often exist in has been described as 'battlemind' by the American army (Nelson, 2013); one participant described it as "being lit up on the edge of aggression." Transitional difficulties involve not being able to physiologically down-regulate this heightened state according to the time frame dictated by the medical model (which is called PTSD), or using traditional culturally acceptable coping mechanisms such as alcohol (which is called having a 'co-morbid' condition) or isolating oneself to preserve feelings of safety for oneself and others (which is called avoidant behavior in the medical model). Experiencing anger and sadness about losses of relationships and engagement with life, a heightened reactivity to stimuli (similar to those that were once life threats), and feelings of not fitting in are described as symptoms of PTSD.

Participants have experienced some of these, however they do not always attribute their reactions to having a mental health issue, and they hold different understandings of moving through the process of readjustment according to their individual schedules, in manners which are less pathologizing than the medical model terms them to be. Their stories provide evidence of their capacity and ability to resist stereotypical descriptions that dominate the Veterans' narrative and that limit the understanding of outsiders about what Veterans actually are. In the story below one participant describes the advice he was given by other soldiers who were concerned about him. His words also highlight his resistance to the way that he sees difficulties like his handled in the military:

> …there was that: "Lets just go and we'll go have a chat and we'll have a good drink and get it out." Unfortunately though when you take frustrated people and you give them alcohol it's going to loosen their inhibitions, yeah- that kind of stuff eventually comes- it just seems to be the trifecta, eh? - this, this, this

> [*drinking, frustration, fighting motions*]; it's just dumb. Yeah, I didn't think that was a constructive use of my time, so I kind of stayed away from that.

The following excerpt, from a study on stigma in the military, offers advice to military mental health practitioners. It advocates for a strengths-based approach, which like the words of the participant above, challenges the pathological aspects of the Veterans' narrative and recognizes the potential for an expanded sense of self that can result from navigating a difficult experience:

> Recognize the potential for personal growth associated with combat exposure, rather than perceiving combat solely as a "bad" life experience. Ask service members what they have learned about life or themselves, what new skills they have acquired or mastered, or how they have become better people as a result of combat. Frame adversity as a necessary mechanism through which growth and development occur. (Bryan & Morrow, 2011, p. 21)

Anti-stigma Campaigns

Self-stigma is the aspect of stigma most often addressed in anti-stigma campaigns such as the CAF example; it is often described as a 'barrier' that has to be overcome by those who encounter it. This approach places the onus on individuals to act, and fails to adequately address the pervasive, powerful and deeply entrenched cultural attitudes which hold the larger context around individual stigma, and which, according to participants and also recent events such as post-deployment suicides (Everson, 2013) and the verification of pervasive misogyny in the military (Milewski, 2015; Deschamps, 2015), isn't changing. In fact, highly placed military leaders are appearing to address the problems while perpetuating them with their practices. This was recently the case when the former Chief of the Defence Staff, Thomas Lawson, publically described and excused the problem of sexual misconduct in the military as resulting from people being

"biologically wired in a certain way," (CBC News, 2015, para. 1). Subsequently, although the CAF acknowledged the Deschamps (2015) external review into sexualized conduct and misogyny in the military, Lawson instructed his staff not to implement several of the changes outlined in it (Cudmore, 2015).

Effectively addressing ways to combat stigma is more than just an academic exercise, because at one end of the spectrum of readjustment difficulties lies suicide, one of the most tragic consequences of stigma pertaining to Canadian soldiers' experiences of transition out of the military, and one that has become indelibly etched into the Veterans' narrative. During the Afghanistan War there were 138 combat deaths, and as of March 2014, the CAF reported 160 soldier suicides (Campion-Smith, 2014). The actual numbers are probably higher; Cudmore (2013) reports that these numbers do not include reservists (a highly vulnerable population), or female soldiers, and Mayer (2014) adds that neither the CAF nor VAC keeps statistics regarding Veteran suicides. An investigative report written by Globe and Mail journalists, who interviewed knowledgeable individuals such as former Veterans Ombudsman Pat Stogran, and accessed data about soldier and Veteran deaths through the Department of National Defence, and from obituaries which were corroborated as suicide by soldier's families, links the cause of these suicides to deployment and the lack of effective mental health efforts by the CAF for deployed troops (D'Aliesio, 2016). In his 2013 lecture as part of the Fallout: The Aftermath of War, lecture series at the Interdisciplinary Humanitarian Center, University of California, retired VA psychiatrist Jonathan Shea also links combat experiences to soldiers' suicides (Shay, 2013).

The CAF anti-stigma policy has been discussed in the Covenant and Culture Chapters (pp. 70, 115) where it was explained that when the practices that underpin stigma are entrenched historically and culturally, as they are in the military, a systemic versus an individual approach must be employed in order to effectively address the problem. If anti-stigma campaigns continue to do nothing more than describe, or worse, deny the problem, they result in 'blaming and shaming' of the individuals they are intended to help. Hooyer (2012) attributes this ineffective pattern to the military's alignment with the medical model and its hierarchical manner of sharing information and power:

> **…**predominant biomedical discourse of "self-stigma as the barrier" to care. … assume and favor the autonomy of the individual, as recent studies show. This limits its application in settings like the military or prison where self-sufficiency is limited and a rank and command power structure exists. This could be the reason behind why "anti-stigma campaigns are bullshit". The social-cognitive/cognitive-behavioral models focus on dyadic interactions between individuals without more fixed considerations of the social structural elements that influence or control those interactions…. However, using these stigma models without going beyond the individual to access the social structural elements exaggerates the agency of the soldiers, doctors and possibly even the commanders. In cultures and settings where autonomy is limited, it may be more useful to include broader analyses of the structural forces. (p. 123).

Deconstructing Stigma: The Difficult Conversations

Stigma is maintained by practices such as blaming, silence and shame; shame is fostered by secrecy, silence and judgement (Brown, 2010, 2012); it is a 'circular problem' that both fosters and is exacerbated by isolation. As noted above in the definitions and accompanying examples, stigma (and shame) disconnects, as opposed to connecting people to each other and to other healing resources. Womersley et al, (2011) explain the seriousness of this disconnection:

> The mystifying dualism of shame is that it is at once an isolating, intimately intrapsychic phenomenon seeking concealment and yet remains deeply embedded in a visual and public interpersonal space where the self is violently and unexpectedly exposed to the critical gaze of the Other. The source of shame can, therefore, never be completely in the self or in the Other but is a rupture of what Kaufman (1989, p. 22) calls the "interpersonal bridge" binding the two. Indeed, the experience of shame has been revealed to potentially hold the same properties as traumatic events involving intrusions, flashbacks, strong emotional avoidance, hyper arousal, fragmented states of mind, and dissociation (Matos & Pinto-Gouveia, 2010) (p. 876).

Tucker et al., (2013), support this understanding of the isolating and limiting effects of internalized stigma: "Common expressions of self-stigma include feelings of shame, limiting one's social interactions, and reluctance to seek employment and other rightful life opportunities" (p. 520). Additionally, Kranke, Floersch, Townsend, & Munson (2010) explain that "self-stigmas … predict shame (p. 496), and according to Corrigan and Miller (2004), shame is a "non-specific component of stigma" (p. 540).

In military transition studies, common themes have been PTSD, stigma, grief, and suicide (Cornish, Thys, Vogel & Wade, 2014; Zinzow, Britt, McFadden, Burnette & Gillespie, 2012; Fink, Gallaway & Millikan, 2014); for some people, these are difficult things to talk about. Participants have expressed various ideas about their willingness to enter into conversations about difficult topics during our conversations. One individual described that he was reluctant to make things worse for people he knew were in trouble, or: "rip off the Band-Aid." As mentioned above this is a circular problem: stigma fosters shame, and shame fosters isolation and is often a precursor to one of the most serious consequences of trauma: suicide (Herman, 2013, Shay, 2013). Although the participants did not use the word shame, two of them mentioned that they had or have thoughts about suicide:

D: So, you're coming up to being medically released?

> P: Yes Ma'am.
>
> D: What do you hope for you, after that? What do you want to happen?
>
> P: Not to commit suicide too ugly, with too much of a flare, I want to die naturally, sooner than later. That's what I want.

And later: "I find that I hate just about everything that life has both provided me, and living itself." Another individual mentioned to me in his intake interview that I did not have to handle him with kid gloves because although he now described his transition as successful he had been "down that road." These participants willingly and generously entered into conversations with me about difficult subjects; they know that although they are difficult, conversations about suicide need to happen; in fact suicide is what finally made the military turn its attention toward stigma.

Janina Fisher (2009) explains that suicidal ideation is usually about controlling overwhelming fear and pain, not about wanting to die. Martin (2009, p. 29), in a study involving suicide in the US Army, indicated that interpersonal distress, including: "themes of thwarted belongingness, rejection, and loneliness" were observed in 55% of the individuals whose deaths he considered. The 'first voice experience' of mental health advocate and therapist Will Hall, (2013) encourages us to look at suicide not as a symptom but as a form of communication:

> When we begin to listen we also discover something very surprising. Suicidal feelings are not the same as giving up on life. Suicidal feelings often express a powerful and overwhelming need for a different life. Suicidal feelings can mean, in a desperate and unyielding way, a demand for something new. Listen to someone who is suicidal and you often hear a need for change so important, so indispensable, that they would rather die than go on living without the change. And when the person feels powerless to make that change happen, they become suicidal… And I have learned to meet my suicidal feelings as messengers of

> change, an opportunity to search within myself for new directions in life. (Hall, 2013, para. 11)

Judith Herman (2007), eminent researcher and professor of psychiatry at Harvard University, has deceptively simple advice for therapists practicing with clients dealing with what she calls shame-states: "shame is discharged in restored eye contact and shared, good-humoured laughter." Hall and Herman are essentially talking about meaningful connection as the antidote to shame and therefor stigma. The importance of connection is one of the 'counter-themes,' or missing experiences in the process of transition according to participants. After the study, the individuals quoted above as hating living and everything that life has provided, sent me a reflection that included the following, very encouraging news:

> A therapy group had started in [*city name*] about the same time we'd last conversed. What a great thing it has been for me...I now realize that I am far from alone in this cursed condition.

Another manifestation of disconnection is post-traumatic stress, called Post Traumatic Stress Disorder in the medical model of treatment (American Psychiatric Association, 2013). As described below in the chapter about treatment (Chapter 6), classifying reactions to the overwhelming experiences of war as PTSD provides a 'clinical' home for them and is useful and necessary for mental health professionals and insurance providers (Fox & Pease, 2012); however, in times of transition, when these reactions meet with the Universality of Service Policy, they create the 'ultimate othering' or disconnection, of medical release. This points toward yet another paradox in the transition experience: accepting a PTSD diagnosis enables individuals who are dealing with adjustment difficulties and being medically released to gain access to benefits they need to support

themselves in their future lives, and inherent in this acceptance is the accompanying stigmatizing label of a mental health diagnosis and medical release. This scenario can set off the cascade described by Hooyer (2012) in his discussion of stigma and PTSD:

> For the soldier with PTSD, variations of stigma that occur "off" the body across various "domesticities" include: coward in the commander's office, liar in the physician's clinic, faker in his peer group of service colleagues (depending on what level of "proof" of suffering can be made public), and lastly, disposable warrior in the VA administration. Each domestic domain in which the post-traumatic stressed soldier is embedded creates a different stigmatizing experience. (p. 122)

Due to the pervasive effects and influences of stigma, a holistic, systemic and contextually relevant effort, which considers the fact that stigma is situated culturally and sustained by ideas and practices about gender and illness, must be employed to combat it. In the military, the historical and cultural underpinnings of stigma have been magnified by the alignment to the warrior/hero narrative. These origins, as they pertain to military transitions, are discussed next in order to ferret out the roots of this insidious problem. In keeping with a hermeneutical approach, this effort may reveal the extent to which stigma is entrenched in the transition system, help to understand how this happened, and illustrate a path away from the problem.

Tracing the Path from Stigma to Social Responsibility: Social and Historical Influences

Social and historical constructs have greatly influenced the understanding of soldiers' transitions from war. This understanding has evolved (or devolved) through a spectrum of different interpretations of the effects of war on warriors, ranging from 'whole society' wounds, to demonic possession, to accusations of moral weakness against soldiers, to diagnoses of mental illness Ben-Ezra, 2011; Marsella, 2010). In order to understand this

devolution, a retrospective analysis is useful, because the processes by which stigma have developed have cycled through soldiers' transition experiences since ancient times. Although the roots of stigma are anchored in the past, the 'shoots' re-emerge and are shaped by societal forces according to current paradigms. As illustrated above, themes of stigma, such as limited options for future employment, allegations of malingering and moral weakness, homelessness and isolation in the stories of today's Veterans reveal that these shoots are still alive, even in the face of the anti-stigma efforts of the CAF.

Ben-Ezra (2011) has taken a past-focussed approach in his article about post-traumatic stress where he explains the recycling of ideas and understandings about the concept. He advises a broad investigation of knowledge sources: "Most of the authors who exhibited a profound understanding of human behaviour in their writing were not physicians" (p. 231), and suggests that an 'unawareness hypothesis' explains how unscientific accounts are not valued in the modern medical and scientific model that circumscribes the understanding of post-traumatic stress (p. 237). He explains: "… the field of psychological trauma itself was subject to 'forgotten history' during the 20th century" (p. 237), with periods of episodic amnesia and moving away from community, where trauma becomes the province of the medical community. Ben-Ezra writes that an historical approach, clues us into the common denominators of psychological trauma throughout history, and provide us with hints that the core symptoms of psychological trauma are universal (p. 234). This is important in the discussion of stigma because if there are common denominators in the presentation of war related trauma, then there are also likely to be clues about where the stigma that clings to it came from, and perhaps about how to 'uncouple' these. Paramount in this search for clues is the inclusion of the Veterans'

views and capacity to exercise agency in their diagnoses, respectful treatment that includes continuing to be part of the military, acknowledgement and support for their families, and meaningful empowering training opportunities after their release.

Ancient cultures: community based healing and meaning-making models.

In ancient cultures, war-related trauma was seen as a wound to the individual *and* collective soul; it was treated as loss of connection to self, family and community. Societies had healing practices that helped individuals reintegrate with community after overwhelming experiences such as war (Jayatunge, 2012; Shay, 2013), and these were embodied, and grounded in community rituals that honoured the physical, emotional, spiritual, meaning making dimensions of both individuals and entire cultures; they also involved shared, public engagement with the loss and grief that are the aftermath of war, including mourning. Ben-Ezra explains that clues to these practices appear in the forms of classical art, drama and literature, some of which we still have access to in museums and ancient sites (Boardman, Griffin & Murray, 2001, p.51; Chong-Gossard, 2007). These holistic, community-wide models stand in contrast to the present level of public unawareness about the experiences of Canada's deployed soldiers, narrowly focused media depictions of Veterans and disempowering treatment scenarios that combine to form the societal remembrance and healing rituals of today. As one participant, previously quoted has been watching the way in which the military disseminates information to the public for most of his career, expresses his concerns about public disengagement:

> … being in a profession such as mine, I've been all through these shitholes if you will, and this was the first time that we became (unbenounced to the general public) were in a real serious shooting war, so coming back we learned a lot of lessons hard and tough, and the Canadian public wasn't prepared for that. They

> weren't prepared for all these people with limbs blown off, multiple amputees, bodies in boxes; the Canadian public was not at all aware of really what we'd gotten ourselves into…

Jayatunge (2012) employs the example of ancient Sri Lanka, citing evidence of combat and combat-related trauma dating back more than 2500 years. He refers to a Sinhalese text called the Mahavamsa from the 6th century AD, which illustrates the severe depression, guilt, anger, alienation and emotional numbing experienced communally, by both warriors and individuals in the general culture after war (Jayatunge 2010), and indicates that the number of ancient Sinhala words for trauma symptoms provides evidence of how prevalent societal trauma was. According to Jayatunge, "The religion and culture provide great resilience to cope with trauma" (2012, para. 3). Sri Lankan society was embedded in a religious framework of Vedic, Buddhist and Hindu faiths that understood trauma as a form of possession, and to deal with this, ancient Sri Lankan society used healing practices consisting of dancing rituals and psychodrama, to bring purification to the patient as well as his immediate family and the community. One of the complaints that participants have had about their transitions is that their families were not supported and sufficiently acknowledged or included in treatment; this will be discussed in the Families and Relationships Chapter (p. 255).

Interestingly, some of the specific rituals described by Jayatunge contain elements similar to those of modern PTSD treatments: the drumming, dancing and rhythmic rituals may have provided the elements of the modern trauma treatment EMDR (Eye Movement Desensitization and Reprocessing) therapy (Najavits, Kivlahan & Kosten, 2011; MacKinnon, 2012). The tenets of Hinduism and Buddhism reappear in the principles of modern therapies such as Albert Ellis' Rational Emotive Therapy (Weiten & McCann,

2007, p. 566), mindfulness interventions (Follett, Palm & Pearson, 2006; Baer, 2003), and psychiatrist and holocaust survivor Vicktor Frankl's existential ideas about trauma (Frankl, 2006, pp. 137-154). Interestingly, modern understandings of post-deployment difficulties are expanding in response to the lack of a 'place to put the bigger concerns and questions' that some Veterans are expressing and that once was part of society's understanding of a whole person. The present evidence-based paradigm is attempting to quantify such concerns and is labeling them as post-traumatic growth (PTG), (Tadeschi & McNally, 2011) and moral injury (MI), (Dombo, Gray & Early, 2013).

Accounts from the Middle Ages (500-1500 AD), (Ben-Ezra, 2011) cite descriptions of trauma including written examples such as Shakespeare's depictions of plague and famine. This literature is significant because it indicates that trauma continued to be a shared, societal experience, and that it cut across societal distinctions such as class lines, which as will be explained below, was not to remain the case.

Shame and blame: The Catholic Church and Victorians. After the Middle Ages, societal power was held by monarchs whose beliefs were highly influenced by the philosophy of the Catholic Church. According to this paradigm, mental problems of any kind were seen as moral failings, and individuals with invisible wounds were shamed, shunned, and labelled; their condition was attributed to the domination of evil, animalistic passion over religious virtue. During the 1600s and 1700s in Western society the 'insane' wandered the streets, or lived segregated from society in madhouses along with criminals. They were 'treated' with punishment and confined in chains and manacles; subjected to purging, bloodletting and blistering, and accused as witches and sorcerers (Foucault, 2011, pp.107-124). Such conditions and treatments seem unimaginable today, however

the problems of Veteran homelessness (Katz, 2013), institutionalized allegations of malingering (Pugliese, 2010), and the shunning practice of medical release with a psychiatric diagnosis for soldiers who do not assimilate their combat experiences into narrow pre-deployment belief systems (Decker, 2014, pp.144-145) remind us that we have not, as a society, removed ourselves from such practices entirely.

In the late 1700s, enlightened reformers such as Philippe Pinel in France and Samuel Tuke in England, who understood that the 'insane' were ill, not criminal, instituted a practice of moral management which involved housing patients in safe, clean asylums. Pinel was influenced by the egalitarian principles of the French Revolution and by ideas of social responsibility; Tuke was an English Quaker who adopted the title 'Retreat' to replace that of madhouse or asylum. Their moral therapy model emphasized self-control, moral and social responsibility, the use of modelling and rewards, and separated the ill from criminals. Although it is recognized as an improvement over the past, moral management has been criticized for using exclusion and blaming techniques as treatment methods, considering the individual to be the source of the problem, and understanding mental problems as moral failings. Additionally, Michel Foucault, in his work Madness and Civilization, points out that the moral therapy model set up a hierarchy of power between doctor and patient, based upon the doctor's superior scientific knowledge, observations and judgement of the patient. This power imbalance was later bolstered by the medical field's zealous adoption of the positivist paradigm, which elevates objective knowledge (scientific, clinical research) above subjective knowledge (experiential, client-generated) and it remains highly influential today (Barchilon, in Foucault, 1988, p., vii; Decker, 2014, p.67).

In the Victorian Era (1837- 1901), romantic, mythical terms such as soul-sickness, melancholia and hysteria described mental illness. Victorian ideas about morality (sexual restraint, prudence, elitism, duty), and strict social expectations about remaining in control of emotions, continued to influence the development of moral therapy. These ideas heavily influenced soldier's treatment during the American Civil War, where troops with psychological injuries were mustered out of the army with no support (Gabriel in Bentley, 2005), court martialed, executed, left to wander on battlefields and eventually disgorged into society to wander at large. Mental wounds continued to be constructed as moral failing, and treated by punishing methods such as branding, which were sometimes administered by physicians (Winchester, 2005, p.59; Talbot, 1996). Again, the plight of soldiers with invisible wounds during this time foreshadows the problems of Veteran homelessness and inadequate transition systems of today.

Hysteria. The pre-WWI (late 1800s) understanding of mental illness continued to be informed by the emerging positivist paradigm, and this resulted in a focus on cataloguing symptoms and describing observable phenomena. The early positivists attempted to understand mental conditions in a concrete manner in response to their frustrations with the intangible psychodynamic theories and romanticism of the Victorians, and significantly, they began to look outside of the individual's moral character for the causes to psychological problems. This focus away from moral failing was a step toward reducing the blame, and thus the shame surrounding mental illness.

At this time in European history, the most prominent psychological injury was hysteria, which was attributed only to women, and understood as a malfunction of the

nervous system due to an inherited predisposition; importantly, it was understood to be precipitated by an overwhelming event or shock (Mollerhoj, 2009). Charcot, a French physician, proved that the symptoms of his hysterical patients were psychological, brought on by a traumatic experience and expressed in observable physical symptoms. Charcot demonstrated that these symptoms could be both elicited and relieved by hypnosis, indicating that patients were in an altered state (called dissociation) during their reactions, and not intentionally 'faking' them. Additionally, he discussed the idea of the neurotic temperament, or biological determinism (associated with weakness and femininity), as a causative factor in hysteria; his discoveries foreshadowed the philosophy that would inform treatment of war related trauma in World War I. Although this awareness of dissociation as a feature of traumatic stress (van der Kolk, McFarlane & Weisaeth, 2007, p.50), along with the recognition of the importance of a precipitating overwhelming event, helped to widen the understanding of traumatic stress and focus attention away from a preoccupation with locating the cause in the individual, it continued to construct the problem as a failing specific to a group, originally women. This reinforces ideas of malingering and weakness as associated with femininity; these continue to influence stigma in the military today (Deschamps, 2015).

Soldiers with hysteria: an un-English disorder. Pre-war observations that nervous disorders such as hysteria were on the rise in all of Europe concerned clinicians and researchers, and made them wonder if this was a warning of societal degeneration. Debate began to emerge about whether some cultures (for example the 'Continentals,' as opposed to the English), were more emotional, or prone to hysteria and reactivity. This 'them versus us,' or othering, blaming thinking, is a stigmatizing tactic used by more

powerful members of society to discredit and silence the less powerful (Krumer-Nevo & Benjamin, 2010). Loughran (2008, p. 41) explains in her analysis of war trauma in the context of pre-WWI British society: "Here hysteria moved from individual to social and political pathology, and was constructed as a fundamentally un-English disorder."

Categorically, hysteria and neurasthenia were termed 'functional' diseases, a designation given to disorders for which no physical cause could be found. This ambiguous description reflected the current state of understanding, which also appeared in the uncertainty present in British society. Loughran (2008) explains that the 'soma versus psyche' dichotomy in the field of psychology mirrored societal polarizations about body and mind, female and male, nature and culture, lower and upper class, and ancient and modern definitions of disease, and that this cast a shadow over the construction of shell shock, the WWI label for war trauma. This 'shadow' was the stigma associated with the soma side of the dichotomy described by Loughran including body, female, nature, and notions that conferred ideas of weakness and faulty inheritance upon the lower classes. This stood in contrast with the other side of the dichotomy, which much more closely aligned with the values of the English public school system, which are the precursors of military values. These two ethics were set up in contrast to each other in society and this shaped the understanding of war trauma greatly. It continues to influence the thinking about the treatment of trauma, as today's medical model privileges interventions based upon soldier's faulty cognitions, (an approach considered to be rational and empirical) over somatic modalities, which despite the evidence provided by neuroimaging techniques, are still labelled as complimentary therapies and excluded from

'best practice' guidelines. This discussion will be taken up in the theme of Treatment (p. 194).

In pre-WWI British society, dominant and entrenched conservative values were being challenged, and this created friction, especially in areas such as the labour union movement (which conservatives constructed as a threat to their unilateral power) and issues of workmen's compensation, (which conservatives constructed as condoning malingering); the suffrage and women's rights movement, (which conservatives constructed as condoning emotional reactivity and a threat to the stranglehold of the patriarchy), and Irish Home Rule (which represented the possibility of yet another loss of control for British conservatives). Bogacz (1989) describes how pre-WWI decision makers in Britain were influenced by the combination of the conservative public school system, somatic theories of mental illness, condescending attitudes toward the general public, and racist, elitist attitudes. According to Loughran, pre-War British medical discourse with its ideas of morality and self-mastery were a "hangover from the Victorian era," (p. 26), she explains:

> Through the notion of the 'neurotic temperament' the pathologies of individual and environment were linked to discourses of nation and race… Hysteria and neurasthenia were therefore highly charged, politicized categories on the eve of the war. (pp. 28, 42)

Bogacz agrees:

> In Victorian and Edwardian England, the medical profession espoused the values associated with what Nathan G. Hale calls 'civilized' morality,' among the most important of which were character and will-power. 'Victorian' is almost synonymous with 'will-power… For educated Englishmen, the existence of will-power confirmed the 'special dignity of man and his moral nature'. (p. 230)

The physicians and military officers of the day were 'educated Englishmen,' they generated and maintained the dominant discourse, setting the standards that circumscribed the roles of professionals in medicine and in the military. These standards greatly influenced the stigmatization of psychological injuries in WWI. They are still evident in CAF culture today in the 'trappings of elitism,' which appear in the traditional structure and rituals of the military mess system; in distinctions between the ceremonial dress and practices between officers and enlisted members, in the beliefs about the need for control that extend beyond the battlefield, and in the culture of misogyny that, although denied, is unequivocally present (Deschamps, 2015; Levitz, 2015; Kapelos, 2015; Vongdouangchanh, 2015).

Shell Shock. WWI called elitist and class-based ideas into question as overwhelming conditions caused soldiers from all levels of society to exhibit symptoms like those described in hysteria, previously thought to exist only in women, attributed to lack of a strong moral character, over-emotionality and an origin in the lower classes. Military physicians and psychiatrists saw that brave and seasoned soldiers were succumbing to hysteria in record numbers; 10,000 Canadians were diagnosed with war neurosis (another term for shell shock), (Canadian War Museum, n.d.). The circumstances of these soldiers challenged the dominant discourse, which dictated that morally superior, civilized individuals could control reactions to the trauma of war with a 'stiff upper lip.'

As elitist and classist distinctions proved insufficient to explain who succumbed to psychological injuries, war physicians began to wonder if the cause of the problem was physical damage sustained to the brains of soldiers in close proximity to the massive

explosions that were common in the war. In 1915 British psychiatrist Charles Meyers coined the term shell shock to describe this damage (van der Kolk et al, 2007, p.48). When shell shock showed up in individuals who were not exposed to percussive explosions, it once again pointed to the fact that there were psychological causes to the mental injuries of war. The term shell shock remained in use during the world wars, along with the terms war neurosis, psychoneurosis of war, and neurasthenia.

As WWI progressed, the shadow of stigma re-emerged, as overwhelming levels of shell shock were associated with suspicions of malingering by some physicians. Van der Hart, van Dijke, van Son, and Steele, (2001) report that the "... official British military position was that shell shock and malingering were impossible to separate, therefore, both should be dealt with in army prisons" (p. 37). This stance was typified by clinicians such as the British psychiatrist Lewis Yelland, who said to a patient: "... remember you must behave as the hero I expect you to be...A man who has gone through so many battles should have better control of himself" (Herman, 1997, p. 21). Those who 'broke down' under the strain of battle carried heavy burdens of guilt and shame. In WWI Britain, courts martial for cowardice, desertion and other crimes convicted 3000 individuals, and 346 soldiers were executed (Bogacz, 1989).

Connection to self and others: The valiant efforts of a beautiful mind.

Eventually, a more progressive model of understanding combat stress emerged from the work of W.H.R. Rivers, an English neurologist and anthropologist, who in 1917, studied and treated his patients with compassion, understanding that their actions were the result of psychological self-preservation, and not cowardice. Rivers' ideas informed a brilliant explanation by Myers, of the way that a psyche caught between evolutionarily

honed animal defence responses to combat and entrained military values (Fox & Pease, 2012), can fragment in the face of this overwhelming situation. First described by Myers in 1940 (Nijenhuis, Van der Hart, & Steele, 2004), as he noticed that soldiers seemed to have two co-existing mental states, was the model of structural dissociation of the personality. The theory describes the unconscious process whereby a personality separates into states including one that is able to function in daily life (the apparently normal person, or ANP), and one (or more than one) that holds the 'problematic,' or trauma related behaviours (the emotional person or EP). In essence, structural dissociation is the mind's attempt to put the "unacceptable" (emotional) reactions to trauma into an alternate personality that the ANP is unaware of (Clark, Classen, Fourt & Shetty, 2015, pp. 74-76). Importantly, what made these symptoms unacceptable during WWI was the influence of societal and military constructions of a soldier and hero, because to a WWI soldier, the unacceptable was being seen as emotional and out of control.

The structural dissociation model is still in use today, and is now understood as a brilliant survival strategy developed by the human mind in a time of overwhelming circumstances (Ogden & Fisher, 2015, p. 36) in its attempt to 'endure the unendurable.' This theory was a large 'step away' from blaming individuals for their symptoms, and although this understanding informs trauma treatment today, it must be remembered that the stigmatizing circumstances that surrounded its generation continue to be influential.

Rivers contributed to one of the biggest leaps forward in trauma treatment; this was the realization and documentation that combat trauma occurred in soldiers of high moral character. He also noted that the sense of connection, attachment, and love of soldiers for

one another was stronger than their fear of returning to battle after injury; this idea would prove to be very informative in the future treatment of trauma in military settings. In modern times, the rise of the post-positivist paradigm has contributed immensely to the understanding of the neurobiological, cognitive and behavioral mechanisms of traumatic stress and injury, however for a time its exclusive emphasis on objectivity obscured the value of subjective knowledge such as the importance of connection between soldiers described by Rivers (Rivers in MacCurdy, 1918, p. 3). The discussion or connection will re-emerge below in the work of Kardiner.

Benefits and malingering; the origins of VAC's "deny, delay, die strategy".

After WWI, the issues of pension reform and malingering sidelined the importance of attending to connection in healing the trauma of war, dominating the attention of military doctors and casting doubt upon the veracity of soldiers with psychological problems. In 1925, psychiatrists began to doubt the wisdom of providing pensions to the injured, due to a prevailing belief that pensions reinforced disability. Research and concern about this emerged from both sides of the WWI conflict, and in Germany the term 'compensation neurosis' was created in response to the rash of claims by industrial accident victims seeking benefits (Kinzie & Goetz, 1996). Eventually, many doctors chose to place their commitment to the care of their patients first, and leave the legal matters to the courts, and the debate was silenced for a time, but continues to emerge in the Veterans' narrative today.

The fact that malingering has been continually associated with seeking benefits is a crucial one; this rhetoric is an example of a 'problem saturated narrative.' As previously mentioned, such narratives are often internalized by those to whom they are applied

(Berger, 2014), resulting in internalized stigma and socially reinforced negative stereotypes. In the NVC charter challenge (discussed in Ch. 6, Covenant) the Crown's stance and testimony rests upon this out-dated argument, placing the onus on Veterans to prove their disability, sometimes repeatedly (Brewster, 2015). This practice is also the foundation of The Veterans Review and Appeals Board (VRAB), the adversarial entity that Veterans Affairs Canada employs to review Veterans' claims for compensation. Participants pointed out VRAB as being particularly symbolic of the systemic stigmatization they deal with in their post-deployment lives; it will be discussed at the end of this chapter.

Importance of connection re-emerges: "She listens". Psychiatrist Abram Kardiner began to work with WWI Vets after studying psychoanalysis with Sigmund Freud. He was discouraged about the ineffectiveness of his methods, until a patient told him that it was his caring aspect that made the most impact; Kardiner appreciated the significance of this and also came to realize that it was the experience of his own traumatic past that allowed him to connect with the Vets. These understandings foreshadowed the relational, dyadically attuned therapeutic models that are emerging today as the most effective methods in trauma (discussed in the Treatment Chapter, p. 197). Eventually, while studying anthropology, Kardiner found 'a conceptual framework that recognized the impact of social reality and enabled him to understand psychological trauma' (Herman, 1997, p.23). He writes about connection in his work The Traumatic Neuroses of War (1941):

> … it is a deplorable fact that each investigator who undertakes to study these conditions considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before. (Kardiner, in Herman 1997, p. 24)

Kardiner's work was reinforced by his contemporaries, Roy Grinker and John Spiegel, psychoanalysists who had treated WWI soldiers and recognized the vital importance of protective factors such as "training, group cohesion, leadership, motivation and morale" for soldiers. Kardiner and his fellow military psychiatrists began to work together in groups with soldiers, and in WWII, used a treatment refined from the French model called Forward Psychiatry, which included brief intervention in the field to minimize separating soldiers from their comrades, and is still influential today (Jones & Wessely, 2003; Warner, Appenzeller, Mobbs, Parker, Warner & Hoge, 2011). The importance of connection, whether it is between soldiers, or soldiers and therapists, is illustrated in the words of one participant who is telling me about the most effective health professional he deals with:

> D: So… I'm just wondering if you could identify one… what it is that she does that supports you guys so well- she's now a civilian, she's making room, she understands…
>
> P: She listens.

Connection to society: Koreans Vets, Medak Pocket Vets, and Afghanistan Vets. The experiences of Canadian Veterans of the Korean War illustrate the importance of connection and the ways that societal acceptance and acknowledgement have a direct effect upon Veterans' future life experience. Research involving Korean War Veterans helped crystallize the Homecoming Reception Theory, which posits that acute stress can lead to PTSD when social and family structures do not help to assimilate the meaning of combat experiences (McCranie & Hyer, 2000). Jonathan Shay wrote that healing from trauma depends upon communalization of the trauma, or being able to safely tell the story to "someone who is listening and can be trusted to

retell it truthfully to others in the community" (Shay in Wilson, Mitchell & Ritchie, 2009, pp. 4-5). Canada's Korean War Vets did not have this opportunity, and in retrospect, their story indicates that they have paid a price in terms of their physical and psychological health because of this.

Compared to WWII vets and Vietnam vets, Korea Vets exhibit significantly poorer health outcomes such as psychosocial maladjustment, anxiety, depression, suicidality, and cirrhosis (Page & Miller, 2000). The Canadian Association for Suicide Prevention identifies men as a high-risk group for suicide, and specifically describes the post-WWII generation of men as a strong, stoic generation that dealt with their emotional pain by using alcohol instead of asking for help or disclosing distress, making them an especially higher risk sub-group (Suicide prevention, n.d.). The key to this emotional pain, according to Page and Miller is that the Korean Vets in their study felt less appreciated than WWII Vets, upon their return, and had higher levels of anger over society's lack of support and understanding of their war. Other research also suggests that groups of individuals who do not perceive relevant system and societal validation regarding their trauma, may be particularly unlikely to seek professional help for PTSD (Sayer, Friedemann-Sanchez, Spoont, Murdoch, Parker, Chiros, & Rosenheck, 2009).

The researchers above are describing disconnection, and the disconnection that bears particular significance for Korean Veterans is epitomized in the story of the Battle of Kap'yong. In 1953, to honour its NATO commitment, Canada sent 30,000 troops to Korea as part of the police action of the newly formed United Nations (Korean War, n.d.) and initially, Canadians were under American command. During this time their actions at the Battle of Kap'yong resulted in a rare and prestigious decoration being bestowed upon a particular

regiment, the Princess Patricia's Canadian Light Infantry (PPCLI), by the American Army. This honour is still a source of pride to the regiment:

> The Battle of Kapyong was an important episode in the Korean War. The soldiers of the 2nd Battalion of Princess Patricia's Canadian Light Infantry persevered in the face of great adversity to help prevent a potentially costly defeat for the South Korean and UN forces. Their heroic efforts did not go unnoticed with the Americans awarding them the United States Presidential Unit Citation—a very rare honour for a Canadian unit. (Veterans Affairs Canada, n.d., Canada Remembers the Battle of Kap'yong)

The recognition of Korean War soldiers by the Americans stands in contrast to the post-war experience of Canadian Korean War Veterans returned home to "an ambivalent and disinterested public," where few people outside their families knew much about where they had been and what they had done (Don Landry, personal communication April, 2013; CBC Archives, n.d.; Melady & Rockingham, 2011, pp.265-266). For Canadian Korean Vets, the lack of acknowledgement was worse: the Canadian government did not allow Korean Vets to wear the citation they were honoured with for the Battle of Kap'yong, because it was bestowed by a foreign nation, however, some soldiers wore it secretly on the inside of their collars (Don Landry, personal communication April 2013). For years Korean Vets had to advocate for benefits and recognition on their own behalf; it took the Canadian Government 39 years to issue their medals (CBC Archives, n.d.), and was marginalized as a 'conflict,' or called the Forgotten War or the unfinished war. Eventually Korean Veterans along with Korean Canadians raised their own funds for Canada's Korean War Memorial, which they built together in 1997. The following reminiscence from a newspaper article commemorating the Battle of Kap'yong illustrates the way in which the particularly marginalizing experiences of Canadian Korean War Veterans have informed the Veterans' narrative:

> A friend of my Dad's went through Kapyong and Dad said he was never the same after. He came through Italy and survived but when he came back from Korea he

> must of had PTS but suffered alone or with a few friends like Dad who in retrospect had PST of his own… He died in the late 60's alone and an alcoholic. When you hear about vets returning now and dying on the streets of Calgary, homeless and destitute, are we really a grateful nation or is it political lip service? (Boswell, 2012)

The Korean War Veterans were left to fend for themselves more than any previous Veterans, and they suffered the consequences although they may not have named their problems as stigma. As they grew older many of them fit the descriptors of high risk for mental problems due to their war-related post-traumatic stress and the lack of government and societal recognition of their experiences and contributions. Not until the Canadian peacekeeping mission in the former Yugoslavia, did a group of soldiers experience the lack of recognition and the marginalization familiar to Korean War Vets.

The Battle of the Medak Pocket, in Croatia, on September 1993, is spoken of in a similar manner as the Korean War Battle of Kap'yong, referred to as a Forgotten Battle or a lost chapter in Canada's war history. This battle was again fought by the PPCLI, and again it involved the deployment of Canadian soldiers as part of a United Nations force. Again the acknowledgement of the unique contributions of the Medak Pocket Battle soldiers by the Canadian government and public didn't happen, and the soldiers endured the consequences of this:

> …abandoned by their military, marriages fell apart, soldiers turned to drugs and alcohol, some became homeless …The Patricias, many of them part-time reservists, just got on a plane and dispersed across the country. There was no follow up, no official recognition that the battle had even happened. (Salter, 2013)

Veterans from this battle felt abandoned as the Korean War Veterans did, however what was different for them was that they were a more vocal group of Veterans, and eventually, there was an inquiry (the Sharpe Inquiry) concerning the entire peacekeeping mission, which

recognized the special circumstances of the soldiers of the Medak Pocket. The head of the inquiry, retired Colonel Joe Sharp, explained:

> Many were self-medicating, were alcoholics, and (the Canadian Forces) threw the book at them, dishonourable discharges and everything," says Sharpe. "There was absolutely no attempt to understand them. (Salter, 2013)

According to Col. Rakesh Jetly, Canadian military's lead psychiatrist, the situation had created:

> The perfect storm (was) a society that doesn't quite understand mental health, a military that was the same way, and health services being cut like crazy," he says. "It was extremely difficult for someone to raise their hand and say 'I'm having trouble.' (Salter, 2013)

Eventually, partly due to the Sharpe Inquiry, the Veterans' struggle pointed out the stigma surrounding the lack of honour and recognition and the effects of these upon mental health, as it hadn't done in the post-Korea era. Retrospectively, Sharpe credits the inquiry with creating a "cultural shift in the Canadian Forces." Nine years after the battle, in 2002, Canada awarded the soldiers of the Medak Pocket Battle a special unit citation (Salter, 2013); recall that the Korean Veterans own efforts for this recognition took almost forty years. Caution is necessary in interpreting this reduced recognition time period as a sign of hope in the struggle against marginalization, isolation, lack of recognition that leaves Veterans to struggle alone with their mental health problems in a culture that stigmatizes help seeking. Retired Master Warrant Officer Barry Westholm (Cobb, 2014) points out that the problem still exists; he is quoted below in response to a member of parliament who publicly stated that the problem with self-stigma is not in the transition systems but in soldiers' minds:

> Your recent statements regarding injured and ill soldiers having to confront issues that are 'in their minds' and supporting the new, and stark… catchphrase 'self-stigma'… "So you're aware, many of my former peers in the Canadian Armed Forces refer to the sidewalk leading to the Warrior Support Centre (where mental injuries are treated) as 'the Walk of Shame' — this is the true stigma that faces our injured veterans.

Westholm once again underscores the fact that the cultural shift in the Canadian Armed Forces, and in the highest levels of Canadian society, has still not reached a level where it effectively mediates the stigma of having a service-related psychological injury that has been exacerbated by disconnection.

Recently (January, 2016) a participant who ended his lifelong career as a member of the reserves sent me the following update about the ways in which his service and experiences were unrecognized:

> Three [*members of his group*] including myself, did not receive a 'Depart With Dignity' ceremony...'Depart with Dignity' program…involves having [*his unit*] members assemble at the head quarter's flag poles for a flag raising in the members honor on release. The event is officially photographed with the member's family present, followed by congratulations from all assembled, including the Commander, and a formal portrait sitting …again with family. The events' documentation is gifted to the member via a co-worker a few days later. …and this is even more inexplicable, I was not given the opportunity to have my portrait taken with my family...My family had arranged that day off for this very occasion…
>
> Nor were we in receipt of our 'Certificate of Service'. … The official document framed and presented on an appointed day set by the section's Officer in Charge. Only one certificate is allowed per member's service period. The actual dates of service are highlighted making the certificate most valuable to the releasing member.
>
> … and neither did we receive 'Letters of Congratulations' from the Prime Minister's Office, the Premiere's Office nor a 'Mayoral letter…The main letter, again highlighting years served, is from the sitting Prime Minister, signed and also framed. A second letter is often included on release from the sitting Premier, echoing the PM's comment in his own words. A third letter, albeit not obligatory, is from the local community's sitting Mayor.
>
> Apparently as I was an 'A' Class Reservist on release, I was automatically unqualified to be given a retirement gift… an unnecessary slap that made the bitterness of my release … So why am I telling you this now... simply because the time we spoke, the hope was within me that I, being release as an injured… member, would be a proud recipient of what was certainly due.

This individual explains of what this lack of acknowledgement meant to him:

> … unfortunately like others, the taste of this at the end of my lifetime service is not only bitter, but deeply saddening. More saddening to all of this is that the Armed Forces have

> veiled themselves in the image and a very public policy of 'People First' and 'We Take Care of Our Wounded'. … I will be able to tell my family in years to come that I was 'In', but cannot show them not a single document, framed or otherwise stating, 'A Job Well Done'… *A Medical Release is still an 'Honorable Discharge'*. [emphasis added]

Lessons from Vietnam: Manipulations of the Veterans' narrative. The Vietnam War (1955-1975) was the first televised war; information about it was constantly available to the public, and as the war went on it was evident that there were disparities between the publically stated policies of the US administration and their actions. The 'moral superiority' of the government's anti-communist agenda began to be questioned as the American public, including troops in Vietnam, saw the epic scale of the destruction being committed in their name. American society was in upheaval with student-led anti-war demonstrations at home and soldiers in Vietnam seeing through the illusion of the quick and righteous victory the government had led them to expect (Lembcke, 1998a). The synergistic effects of these elements was significant to the social and historical construction of stigma concerning Veterans, because it resulted in an intentional 'rewrite' of the Veterans' narrative in a way that conflated it with victimhood.

Soldiers in Vietnam had questions that reflected the concerns of American citizens at home, as the following quote from an article by Vietnam Veterans Against the War (VVAW) illustrates:

> In order to save Vietnam we had to destroy it. Civilian casualties from U.S. actions ran from 100,000 in 1965 up to 300,000 in 1968, just from bombing and artillery. In addition, millions upon millions of gallons of herbicides were sprayed over 6 million acres of land. We bombed hospitals to save orphans, we sprayed Agent Orange and destroyed the land in order to save crops, and we burned hamlets to save villages and turned Vietnam into a huge whorehouse in order to save Vietnam from Communism. (Romo, Zastrow, & Miller, 2002, para. 14).

Soldiers began to contribute to the anti-war movement with their own activities, such as protests and public revelations of their deeds (Romo et al). Lembcke (1998b), a Vietnam Veteran and sociologist writes: "With the exception of German Veterans after World War I … there had never been a generation of Veterans who had turned so completely against the regime that had sent it to war" (p. 106). In this social and political climate where large numbers of soldiers and Veterans aligned with protesters against the government, the Nixon administration attempted to fragment the anti-war movement by discrediting Veterans, as Lembcke explains in the following excerpt:

> I proceed by locating the origins of PTSD at the intersection of political and media events. It was the Nixon Administration's need to discredit the anti-war movement generally and anti-war veterans in particular that provided the context in which the news media began constructing the image of the dysfunctional veteran. (Lembcke, 1998a, p. 38)

The rationale for this was that Americans could reconcile themselves with the more palatable 'victim image' of guilty soldiers than that of soldiers who had been ordered to commit atrocities in the name of their country, who were angry about that, and who were committed to doing something about it. Lembcke contends that influential Vietnam War era mental health professionals such as Chaim Shatan and Robert Lifton were quoted in the media strategically, at a time when their valid concerns about their patients would put a spin on the public's opinion that conveyed the pathological image of Veterans that the Nixon administration wanted to portray. Vets were thus "blanketed in the discourse of disability" (p. 40), and portrayed "within a mental health framework" (p. 41) (Lembcke, 1998b).

Lembcke explains that media emphasis on images of "out of control" Vets, and accounts of soldiers coming home to empty airports and hostile anti-war protesters, when

that was far from the experience of most Veterans and protesters, has proven influential in the shaping of the Veteran narrative. Lembcke's views are contended and continue to spark debate even in recent times (Botti, 2008), however they illustrate that the Veteran narrative is subject to influence by powerful institutions through their use of media. Although media formats are vastly different now than they were during the war in Vietnam, mainstream and social media remains a tool for all stakeholders concerned with the effects of Veterans' transitions.

A more positive Vietnam War era contribution to the Veterans' narrative was the 'rap group,' which Veterans developed outside of the Veteran's Administration framework as they invited certain psychiatrists to work with them in groups where the power of camaraderie was acknowledged. Judith Herman, (1997, p. 27) stresses that this was significant, because for the first time, so-called 'victims' were raising awareness and creating the conditions that they needed to help themselves heal from war experiences in the way that was most effective for them. Vietnam Vets' advocacy work eventually resulted in the establishment of a new order in the US Veteran's Administration, a "self-help, peer-counseling model of care."

Although contended by Lembcke, Robert Lifton's research remains influential as it foreshadows the concept of post-traumatic growth, illustrates what he learned about the capacity of Veterans, and challenges the discourse describing them as victims:

> They were patriotic. And they had a kind of macho feeling that war was a kind of testing ground for manhood…. an encounter with death could threaten one's entire belief system and then one had to struggle with what one learned, what images came from that encounter, reorder them, put them back into some kind of structure that one could use, which is a whole restructuring process of the self… we could see them undergoing changes, and they were changes about their views of the war and war-making and about macho and maleness, and about their ideas about life itself. (Conversation with Robert Jay Lifton, 1999)

These challenges to the construction of Veterans as victims were of great importance, however they have not resulted in the level of change that is necessary. A study participant, who today is an active and committed Veterans' advocate speaks about how he was influenced by the way he saw Veterans treated as he grew up in the aftermath of the Vietnam War:

> P: I saw what happened to these guys when they spent their whole life in the military, 30 years, 35, 40, and I realized that had to … I didn't want to be that.
>
> D: Can you just say a little bit more about "that" what that was?
>
> P: Feeling like a victim I think.
>
> D: So there's a mentality about… yeah?
>
> P: You know… well, there's nothing worse; doesn't matter who you are right? I don't think anyone likes anyone else feeling sorry for you, you know? And I know why, the guys and myself and all of my compatriots when we were growing up in the military- that's how we felt for the, the guys that were fucked up, one way or the other; doesn't matter.
>
> D: So you felt like that toward these people, the people that had done the 30 years?
>
> P: Yeah. And I just didn't want to be like 'that'

Recently, David (2015) explains that what he refers to as "top-down reframing of the war Veterans' memories," which casts Veterans as victims in order to keep them disempowered, fragmented, and asking for little compensation, is happening today in post-conflict Serbia:

> Thus, it seems that the grants are given away as a payoff for relegating the veterans to the margins of society and keeping them silent. Socially excluded, the war veterans were brought into a position where they preferred to reshape their memories in order to obtain only the very minimum needed in terms of rights and benefits, to survive. Thus they settled for being labelled as victims and for keeping their private memories away from the public eye. (p. 115)

Aside from challenging the victim label, Vietnam Veterans' advocacy work spurred a groundswell of research into their post-war lives. Although this was mostly positive for Veterans of the past, who needed to fight to have their psychological wounds recognized as valid in order to receive the support and benefits that they deserved and were being denied, it also entailed accepting a stigmatizing and pathologizing mental health diagnosis. It is clear that when prominent politicians accuse Veterans of self-stigma to excuse the culture of shame around seeking help as MP Cheryl Gallant did (Cobb, Feb.3, 2014), that our own, and other governments, continue to manipulate the Veterans' narrative for their own purposes, according to their political or financial agendas.

A recent example of the way in which the 'tool' of media has been wielded to manage information is provided by the CAF webpage on suicide and suicide prevention. In addition to paying serious attention to the problem of stigma only when the results of an inquiry are published (Deschamps, 2015; Canada, MPCC, 2015), the CAF has in essence deflected responsibility for an open, clear dialogue about suicide by blaming intensive media coverage in the military for the phenomenon of 'contagion.' (National Defence, Suicide and suicide prevention in the Canadian Armed Forces, n.d.). Although there is research to support the allegation that irresponsible press coverage can encourage contagion around suicides, the CAF has dedicated effort to managing information and damage control instead of paying attention to the more serious issue of suicide in a systemic and responsible manner. Perhaps this is not surprising, as according to Healy (2008), the current Prime Minister, Stephen Harper: "treats the national press corps like a

special interest group that has to be managed, controlled, and contained." (Healy & Trew, 2015, p. 40)

The CAF information page on suicide (National Defence, n.d.), calls stigma a barrier to care, and amid short descriptions of its efforts and programs, links to hotlines and chaplaincy services is a section on media coverage. In this section a World Health Organization report is cited in a very selective manner by Bohanna (2013), emphasizing the contagion aspect of the report without acknowledging that the same article (which is based on research in youth, less than 24 years old, thereby missing the exacerbating effects of military culture) explains that responsible media coverage can be influential in reducing contagion and suicides. In a Canadian Psychiatric Association policy paper also cited on the CAF site (Nepon, Fotti, Katz & Sareen, 2009), the issue of guidelines for media reporting of suicide is stressed. What is not reported on the CAF site is the finding from the same paper, that after responsible reporting of suicide, the rates of copycat and actual suicides go down. The findings of these studies are a call to action, not a call to blame the media for speaking out about an issue that the CAF has attempted to obscure (D'Aliesio, 2015; Campion Smith, 2014). Additionally, the CAF webpage on suicide prevention in the Canadian Armed Forces makes no mention of the crucial influence of military culture on soldier and Veteran suicides.

Resistance: A co-constructed Veterans' narrative. Dawes contributes an analysis of how the separation between a population and its military is managed according to a political agenda using narrative means, much like an advertising campaign. In the context of his studies of war criminals in the Sino-Japanese War (1937-1945), he warns of "cultural misunderstandings and ethical compromises," that can

happen if, as a society: “We let ourselves believe a leader can create our meanings for us, and we delight in surrendering the terrible weight of our individual agency” (Dawes, 2013, p. 60). A level of surrender to authority is a feature of military culture, however in a democracy, the military is meant to exist in the context of a society where citizens, including soldiers and Veterans, remain aware and informed about political agendas enacted on their behalf. This responsibility may not be seen by citizens as imperative when a thorough understanding of the issues is unsettling, and complicated by conflicting narratives. When information about war is managed by tactics, such as one that Dawes describes as (pp. 22, 74) “sanitizing language,” where “worklike, playful, healthful” slogans and jingles constitute “prepackaged language as a safeguard against thought,” it becomes easier for us to remain comfortably complacent about wars. Names of American military operations, for example, Operation Enduring Freedom and Operation Iraqi Freedom, during which ‘surgical strikes’, are employed by the military, as if they were healers, can divert the attention of the public from what is actually happening in faraway lands when coverage of the wars is limited to short sound bites.

During the war in Afghanistan, Canadian operations tended to be named in a less obviously misleading manner, invoking warrior images from ancient Greek mythology (Operations Archer, Achilles and Athena), or benign images named in the local language: Operation Bawaar (Pashtun for assurance). Innovations in computerized weaponry have also been described in a way that can deflect the critical glance, as Moon (2009, p. 75) explains attacks are referred to as “precision targeting” which supports the practice of “risk- transfer militarism,” that “limits risk to Western troops, policies and societies.” These deliberate, contrived language conventions, combined with pared down selective

press coverage and home-front media stories featuring angry Veterans taking the government to court or committing suicide, have been 'layered onto' the Veteran narrative.

In the absence of the Veterans' voice, stigmatizing remnants from the past, bolstered by inaccurate stories from popular culture, combine with an incomplete understanding of war and transition experiences to construct the public mindset. As in the Vietnam War, a Veterans' narrative that is easiest for society to live with is the result of this process in which the 'real' story is difficult to contend with; this leaves soldiers and Veterans 'holding' their lived experiences without the support of a resonant public. Tyler Boudreau, an Iraqi War Veteran who eventually resigned his commission in the Marines, warns of the consequences of this for Veterans in transition:

> How well understood combat stress has been in any given time or place would be, I suspect, proportional to how resistant that society was to knowing about it… (Boudreau, 2008, p. 212)

What do you think all this rage is about?

"I didn't want to go out like that actually… so I can maybe at least try and look like I'm normal… But I'm not- not by a long shot." (Participant)

In modern warfare, deployed troops often fight an invisible enemy, where terrorists are indistinguishable from the civilians that soldiers have been mandated to protect. Boudreau (2008) describes the confusion that results as soldiers, involved in situations where children and families can also be 'terrorists,' come to understand that they are not perceived as the liberating heroes that they believed themselves to be. He describes the hate that emerged in him as a result of seeing comrades injured and killed, and how it can transfer into a desire for revenge. He explains that these factors, combined with the need to make tactical decisions in split seconds, result in mistakes involving the deaths of

civilians. The military construes these mistakes as collateral damage, however Boudreau explains it differently: "What do you think all this rage is about? ...Where do you think the stress comes from? ...It comes from trauma… It comes from witnessing and participating in, extreme violence." (p. 211)

In spite of efforts to keep the contextual, lived experiences of war out of public awareness and in spite of public implicit agreement with this, the problems of transitioning Veterans continue to point at the problem, and even in the face of fewer deaths of soldiers in combat, the incidence of PTSD and post-deployment suicide is not decreasing (Jordan, 2011; Campion-Smith, 2014), indicating that psychological injuries persist after deployment and into the transition period. The following words from a participant are far from a complete description of all that he is, for instance they do not include his capacity as a father, husband, friend and artist, however they are words he chose to include in his documentation upon leaving the military after medical release:

> I experience a sense of guilt all the time due to some awful tragedies I experienced in Afghanistan… Emotionally totally destructive, except for the feeling of guilt and scars of depression left behind… Unfortunately too, I have little in the way of care, and a surplus of hate and intolerance.

Bessel van der Kolk (van der Kolk & Najavits, 2013) adds his perspective as a researcher and clinician who has spent his long career attempting to treat and explain the ramifications of traumatic experiences for Veterans and others:

> We can send people to Iraq but that will mean that there will be more suicides after the war than there were combat deaths." This is evidence of the fact that as a society, we know how to prepare individuals to go to war, but we have not learned how to receive them home. (p. 521)

Challenging the victim discourse with their actions, questioning the suitability of their diagnoses, being highly effective advocates for change and for each other, and critically

analyzing transition systems are some of the ways that participants have stood up against stigma in all of its forms. These stories of Veterans who are wise individuals with highly developed self-referencing capacity, exist alongside the fact that some of them live with psychological problems resulting from experiences of war, and that they sometimes benefit from medical intervention. When these two, once paradoxical concepts can co-exist openly in a soldier's narrative, there is no need to employ the mechanisms of secrecy and shame, which perpetuate stigma. If the narratives of 'Veteran with Lived Experience of Deployment' and 'Critical Thinking Veteran' combine in the awareness of the public, and are reflected in the polices which inform the transition system, the resulting systemic change will do more to combat stigma than any anti-stigma campaign has ever been able to.

The Veterans Review and Appeals Board (VRAB)

"*…its like two civvies sitting around a desk"* (Participant)

In February 2015, I attended a VAC Ombudsman's Town Hall Meeting, called to address Veterans issues. Previous to the meeting there were many conversations among the Veterans present as they shared their experiences with each other, the conversations I heard left me with the impression that these individuals were very well informed. Many of them had documentation with them, indicating that they were prepared to address specific concerns.

Ombudsman Guy Parent began his presentation by quoting statistics about the contribution VAC was making to the wellbeing of Veterans, and acknowledging that they needed to do better, he repeated the departmental mantras indicating that the Ombudsman's office strives for a 'simple, open, and generous' model of service and that

they are a 'Veteran-centric,' and 'evidence-based organization.' Caseworkers from the Ombudsman's office were at the meeting, and Veterans were encouraged to open files with them, and avail themselves of the opportunity to have their grievances heard and followed up on. Veterans' comments about this information expressed their frustration with what they called the bullshit they were hearing from the Ombudsman, who they felt was rendered ineffective because he would soon be leaving his position.

Another response to the Ombudsman was a delivered by a First Nations Veteran from the audience who reminded the Ombudsman that: "The stories of the people who are here tonight are evidence," and that this understanding, which emerged from an Aboriginal model of First Voices Evidence based upon stories, memories and experiential knowledge, is now acceptable in legal proceedings, and most importantly, that this model gives the Veteran the benefit of the doubt. This comment was significant for two reasons: firstly, as the Veterans present at the meeting were indicating, they have never been given the benefit of the doubt in the process of addressing their grievances, and they were insulted by this, and secondly, the comment challenged the definition of 'evidence' as being solely quantifiable data produced by objective means. The words of the Town Hall participant above are reminiscent of those of author David Webb, an advocate for the inclusive and respectful use of First Voices Evidence:

> The only remedy for ignorant prejudice against a population… has always been face to face encounters with those discriminated against. If you allow us into your conversations we will let you know when you say… silly, and sometimes offensive, things… We need to be part of these conversations in sufficient numbers to support each other and so that it doesn't require great bravery to speak up. (Webb, 2013, p. 4)

Previous to the Ombudsman's meeting, participants had explained to me that the Veterans Review and Appeals Board (VRAB), which is the Veterans' final recourse in disputes with Veterans Affairs Canada (VAC) was a particularly stigmatizing experience:

> D: The way you end up in front of one of those [VRABs]… is that a bunch of other things have failed?
>
> P: Yeah, knowledge is why you end up there- it's a lack of knowledge- you either filled it out wrong, it's not complete, you don't have enough information, you wrote it wrong, your doctor wrote it wrong- it's something. Cause they don't give you as you'll see- I've said over and over- the benefit of the doubt. You're denied until proven approved- that's how most Veterans feel.

This participant was explaining the overly complicated process that Veterans must engage in to continually provide evidence about their already documented injuries, and to prove to VAC that they are service-related, even when they occurred during military deployments and on exercises that these individuals would never have been present at without military sanction. Veterans understanding of the VRAB process is that it is a system that was designed to expose malingerers. Veterans at the Town Hall Meeting echoed these sentiments; one speaker at the Town Hall meeting expressed his opinion succinctly, describing mindset of the board as: "March the guilty bastard in," he questioned the impartiality of VAC appointed lawyers and "uninformed adjudicators" who "all walk in together." Veterans explained that not enough VRAB employees have medical backgrounds and complained about them being "unqualified, overpaid board members." The Ombudsman pointed out that now positions are not appointed, but competitive, however the Vets present didn't think this made any difference, because from their perspective the positions are still attractive to unqualified people who don't understand military culture. An article describing the history of Canada's Veterans'

pension scheme for Veterans (Morton, 1987), including the predecessor of VRAB illuminates some of the tenets upon which it was founded:

> By 1917 Todd had established a system to save Canada from its own 'pension evil.' If parliament gave Canadian soldiers the highest pension rates in the world, Todd made generosity cheap. Barely 5 per cent of pensioners ever qualified as 100 percent disabled; the great majority were rated under 5 percent. In every pension decision the board was sovereign. Pensions, Todd agreed should let veterans' live decently but they were not a substitute for a pensioner's own efforts: 'no man, because he has fought, has a right to be supported in effortless idleness.' Everyone must understand that armless, legless men can become self-supporting…Neither Todd not other veterans' policy makers consulted their clientele…Denying 'neurasthenics' a pension was a part of the cure... Macphail's own conviction that 'shell-shock' could be dismissed as 'a manifestation of childishness and femininity' was widely shared… An ex-German prisoner of war told of being ordered to get medical evidence from his former German captors. (p. 205)

Veterans have suggestions about changes to the process that would help it to reflect a greater degree of cultural sensitivity, and a truly simple, open and generous model of service; these include conducting audits after help is given, and as one participant explains:

> P: Actually the Review and Appeals board… they should have Veterans sitting on that and not…
>
> D: That's when you have a problem and you need to address it?
>
> P: Basically you've been denied something so you're appealing it from VAC; it could be anything… there's a million things you can go and do, but its like somebody who sat on the board of 'whatever' in Calgary something, it's ridiculous –they don't have a clue…you're in there talking and it's like all the military acronyms, "What does that mean?" oh, it's just ridiculous.
>
> D: Did you have that experience?
>
> P: Yeah, and then they hand you some legal officer from VAC and she doesn't know what's going on, you only meet with her once for like 10 minutes it's not …

> D: And that's where the buck stops isn't it? So there's a lot a stake when you get to that point.
>
> P: Yeah, and there's guys that have gone back to the Review and Appeal Board countless times, and it's just the same complaint; if you talk to other Veterans it's the same they need a Veteran, at least one Veteran-
>
> D: At least one Veteran.

Veterans at the Town Hall meeting explained that the appeal process is adversarial and intimidating; it keeps them away from treatment and is highly stigmatizing and retraumatizing for them and also for their families, and disrespectful of their culture. As one individual told the Ombudsman: "I bottled it up for years, left the military…don't want to go back there and deal with VRAB." A study participant explained his similar view:

> You're denied. Cause I just put in a claim for hearing and they – she was like: "Well why has it taken so long for you to put it in?" and I was like "Because I don't want to end up in front of the Review and Appeals Board, so I've waited eight years." I've failed countless [hearing] tests and logged them all … now I've got to wait for the right doctor …

Veterans at the meeting felt that the appeals process is a huge waste of money, and that if any aspect of the transition process needs to undergo a cost/benefit analysis, perhaps to align with the outlook of the Harper Government…VRAB does. The comments of the Vets at the meeting, in addition to the participants' stories, made it clear to me that VRAB was a particularly important symbol of the stigma that Veterans are subject to, and a consideration of the historical process that it is founded upon reinforces this view and illuminates its origins.

In September, 2015, upon following up with a study participant who spoke to the Ombudsman's caseworkers on the night of the Town Hall Meeting in February 2015, I

received the following information:

> I watched Guy's interaction with the vets and his answers to my questions were the pat politician type, "improvements are coming, contact us for more information" given his tenure was up, his little cross country tour seemed nothing more than a junket. I know a lot of the vets asked specific questions about programs and they got little information.
>
> I subsequently followed up with his office and an aide. I did receive a reply that they appreciated my feedback and would return my call. They never did.

Conclusion: The Need for Sufficient, Respectful Support

Larger contextual analyses are useful in the investigation of stigma because they reveal the extent of the problem, locate it outside of individuals and reveal that transitioning individuals are located between two cultural narratives, 'military' and 'Veteran,' each of which layer on their own sets of values and constructions. Ultimately, the Universality of Service Policy of medical release removes individuals from their place in military culture to civilian culture without sufficient, respectful support. As they become defined by a Veterans' narrative, which has been shaped by themes of pathologizing diagnoses, malingering and blame, they are subject to a replay of past debates that has not been incorporated into effective transition systems that honor the gravity of the covenant they have undertaken with Canadian citizens. Unfortunately, the long history of stigma has deeply informed the construction of the Veteran narrative and although sometimes unconscious, it remains influential today in both facets of society which 'bookend' transition: military and civilian.

Chapter 9: Treatment

Treatment Of…?

"*…the last year I sailed and I came to the realization that I couldn't do it anymore. I was broken: 100% broken… and I couldn't function, I couldn't do anything, I couldn't stand to be awake."* (Participant)

"…sometimes to go in to my hobby room and to do anything is: "Put me in front of a firing squad." (Participant)

"I'm just very pissed off." (Participant)

"Being motivated to get my day underway at home is a huge effort in its own. I no longer volunteer for community related activities, where at one time I did not hesitate in a wide variety of community and church events and functions." (Participant)

"I am completely paranoid of my personal and my family's security. Double and triple checking of doors and windows being locked is a regular function."(Participant*)*

"I now wash my hands up to two dozen times daily, because I always feel dirty and germ infested. I take all sorts of precautions to mitigate this." (Participant*)*

"Visions of horrific events are evident with little to no external prompting. Sometimes it's a smell, a whisk of a breeze, a certain temperature, taste or sound that can trigger an onslaught of past difficult events" (Participant)

Sorry, what? Oh! Hearing aids! [Laughing] (Participant)

Participants oriented me toward the Veterans' narrative and their stories explained that treatment, like all of the other themes, cannot be understood alone, but must be explored contextually because it exists within military culture and interacts with the other aspects of the transition system. Veterans fight for their benefits or forego treatment due to the difficulty of navigating VAC protocols, paperwork, and policies; they stand up to the CAF 'culture of carry on' and experience isolation due to the stigma around post-traumatic stress. As I listened to their stories, I realized that one way of understanding

treatment was to look at the many ways in which connections in their lives have been severed. Some stories were about physical injuries and described disrupted connections to formerly healthy bodies; others were what soldiers call operational, occurring as they were removed from their jobs and eventually the military structure; some occurred intrapersonally, as identities shifted from soldier to Veteran, and experiences of separation from comrades and disharmony in personal relationships illuminated disruptions of relational connection.

Participants talk about their struggles after medical release differently; for some the loss of connection to a former sense of vitality and the joy of living is fundamental:

> You know what I miss? I miss living… you just do it one moment like that after another after another after another, and I remember- that is what I was like- and I loved it! Again it didn't matter what I was doing- I could be jumping out of a fucking airplane, I could be sitting on top of a mountain, I could be blowing something up, I didn't give a shit- I just loved this moment- you know? You were never so alive… So, I don't know, that is the one thing that I miss more than anything else- is living. And I stopped living back in 2005.

> Yeah, and that is true- I know it first hand that when things are gone, or joy is gone- it hurts, and it hurts down inside. To be very frank with you many evenings, when I'm by myself, I cry over those losses; I can't get them back, I just don't have the capacity anymore- it's like the PTSD and the illnesses that are associated with it have muted those areas of your life that you found pleasure and joy in- they're just gone. They may not be gone forever, but they're gone from the way that you enjoyed them or practiced them in the past.

Physical injuries exemplify a loss of connection to once healthy bodies and are often accompanied by constant pain. In the case of one participant, an injury has caused hearing loss and extreme sensitivity to sounds; the accompanying disconnection from his former socially active self and his identity as a strong, fit soldier has increased his sense of isolation. The words of this individual illustrate how physical and psychological

injuries are intertwined with identity (me of all people! -indicating a radical shift in his self concept), and also an understanding of how they affect relationships:

> Horrible. It's horrible. It is horrible. At home I avoid the grocery stores for a variety of reasons and the noise is one of them. The wheels on those carts- they drive me crazy- you don't know it until you become aware of it.
>
> …my hearing loss- the tinnitus that's associated with it and the hyperacusis that's associated with it- all noise trauma that I experienced in Afghanistan. That's something I never expected, I never thought that I would have to be careful of what I'm listening to, what I'm watching on TV- fearing the noise. Other than the PTSD kind of overlapping a bit, I am careful where I go for how long I go, where it is that I go…
>
> … this is a bit of bragging I suppose, but the annual PT test, well I always excelled and have taken great pride in that. Well now, I'm medically excused from that- 'cause I've got a knee that's shot, a hip that's full of bursitis, I'm losing my hearing, this eye's getting operated on, actually next Monday- again. These parts; I want to get going but I'm leaving broken parts behind here there and there. I never imagined that I would be medically released, I just never thought- me of all people- not that there's anything wrong with it- please don't misunderstand me.

Another participant describes the way that he experienced a loss of confidence in his mental acuity; this is a disconnection not only from his former sense of self, but also from his capacity to ensure the safety of others, which was once the basis of his identity as a soldier. Referring to his service before being medically released, this individual was previously quoted as saying: "We were the ones who never, ever, ever didn't do our jobs!" He understands that the consequences of this loss for others, as well as for him professionally, is particularly significant in the military context where he formerly excelled:

> I just can't think, which is why I had to quit, and being given up among other things was-it just took too much effort to think, and it was killing me…I just didn't have the capacity! It's just –I would normally- I could figure this shit out in my head- I could calculate everything in my head- I thought in 3-D, and I just can't do that anymore- it's just not there, I can't multitask. In my old world, that's

> not a good thing, right- that's what gets you killed; worse than that it gets other people killed.
>
> Things just don't make sense. So anyway I don't…I'll figure out what I am someday maybe.

Individuals' closest relationships are affected by the consequences of transition after medical release; a sense of isolation and a belief that difficulties should be borne alone, affect their desire and ability to share interpersonally. As discussed in the Stigma Chapter (p. 143), the self-sufficient ethic has been reinforced in the military environment. Participants explain:

> I got away from [*a confidante and friend*] a few years ago and then I called her about a year or so ago- there was just a break in time, just garbage going on and … it's one of those scenarios where: "Oh, maybe I should call [*my friend*]," you know, you get motivated to walk over and pick up the phone and then you're de-motivated you put the phone back down. I just I can't explain that, I just don't understand that.
>
> So eventually? Yeah, I've got to engage someone… and sadly I have not and that's a shortcoming of my own, but I just kind of thought- same thing why I'm reluctant, or I would be reluctant to share within a personal relationship. To me it's just that, you know: "We don't need to talk about that."

Who participants once planned to be, and how the consequences of their service have changed that, affects their connection with the future goals they set for themselves. Their sense of 'possible selves' that they *know* are congruent with their skills, accomplishments and life stages are not always supported in the limited offerings of transition systems:

> … a lot of our folks- they naturally transition- one or two of them had actually picked up positions in [*professional occupations that are a logical extension of this individual's experience*]... So I thought that was a good transition model in that I had a background, I had a base skill set and it could be expanded upon given time and it would produce a decent job, a rewarding job-something I felt fit and I would no longer be a burden to the insurance company- they could be free of their obligation- I would have a lovely piece of paper that I could hang on the wall, but more so, a satisfactory 'new life' that I would find satisfying and rewarding. Again however given the limitations of the insurance provider, that couldn't

> happen so I quickly reassessed, wasn't sure what it would be- their answer to me was: "We can send you to Fort Mac: heavy equipment course, it's twenty-two grand.

Their place in a unique culture where a sense of transience ("posted in, posted out"), and loss has been so pervasive has made it difficult to maintain deep friendships, as one participant explained: "I know plenty of acquaintances, but precious few that I can name." These two features can combine in a way that makes connection, or the loss of connection, even more difficult during transitions, when individuals struggle with what one participant called "ripping off the Band-Aid," which is his way of being sensitive about the experiences of other soldiers. The participant below was explaining how he feels that difficulty in his communication with a close friend:

> … we call each other now and again; I don't like thinking of this very much. He lost his best friend over there; he was killed in front of him. He was de-fusing a mine, he was an engineer…

Another participant explains the loss of connection to the military structure and way of life eloquently, evoking a sense of how absolute the uncertainty of what's out ahead feels for him as he navigates the process of transition:

> When I was in uniform it was easy; that was all defined for me-I knew everything, right? I knew where I fit in regards to everybody else, what I did and what I do. And now in retirement… there's nothing- there just isn't anything- you're finished. So…that's probably the hardest, is trying to redefine ourselves and figure out where we are, where we're going to. I suppose we know where we are, we know where we've been, but there's the big wide unknown…

A dotted line connection: The need for a multidimensional treatment model

Post-traumatic stress disorder is the primary lens through which post-deployment problems are understood in the military; this is in accordance with the medical model, which dictates rigid adherence to evidence-based practices (EBPs). This symptom-based

understanding reduces the more relational options available to Veterans as treatments. The experience of connection has been largely discounted in the medical model and relegated to the categories of therapeutic alliance and cultural competence, which are often not given the weight of 'technique' in a treatment modality, because as will be explained, connection is not easily assessed, standardized and manualized. This difficulty is seen as a problem in a system where treatment has been delivered according to the values of the neoliberalist paradigm of the government that was in power for most of the war in Afghanistan. It is also a problem for participants who, although they have experienced improvements in some of the psychological problems that led them to treatment, explain that this is 'not enough.' Participants relate that they are left with the problems that arise from the disconnections that are not addressed by the medical model; they feel separated from their own sense of capacity and hope for fulfilling future employment, and are defined by a disempowering illness narrative. The domains of physical and psychological; career and identity; and relationships and families are all 'contexts of being' in which the effects of post-traumatic stress are evident. Treatment that integrates all of these domains addresses the whole self, however the present treatment system does not do this. The narrow treatment approach in use today is unbalanced in favour of a small number of approved therapies, and most treatment research persists in an attempt to describe the spiritual, psychological, and interpersonal disconnections along with the psychological problems of transition in terms of a paradigm which is too small: post-traumatic stress disorder (PTSD).

Individuals in this study describe their psychological difficulties according to more contextual understandings; their explanations paint a richer picture, which provides clues

about how these disconnections can be healed. For Veterans, the concept of treatment is complicated and the stakes are high. In my attempt to begin the discussion about treatment, I rely upon the words of one participant who understands the complexity of transitional difficulties. He describes this complexity as a 'dotted-line connection,' and talks about the need for the transition system to support connection with competent health care providers and a broader, holistic approach to his problems:

> P: …there's something else that's bothering me- or something else that I'm just- we're just not fully grasping. That's really not all that… I don't think that's [*referring to treatment models*] as important as it is getting in to see someone. And hopefully the person you get in to see has got a wide range of experience to know, or understand how to deal with you, right? To deal with you himself or at least recognize that he should be moving you on to somebody else who can. And, because VAC- this is the only way VAC can help the individual- is by giving the stamp, this is what we're going to call it, and this is a real broad definition: you gotta somehow fit in between these borders, and as long as you fit between those borders we can treat you.
>
> D: And what does the stamp have to say to have the broadest range of options open to you?
>
> P: Well it depends on whether you're…there's the physical and then there's the psychological.
>
> D: Right, they're not really separate are they?
>
> P: There's a dotted-line connection, so any one thing that's affected compounds everything else.

In the discussion of treatment I was tempted to focus exclusively upon a critique of the present protocols, but that is not what participants did. They spoke about connection, about a broader approach than they were offered, and also about their individual needs and having the agency to choose what they require as their post-deployment lives changed. They have all had some experience of the present military treatment protocols, and they have informed opinions based upon these experiences. They also recognize that,

just as when they were in the military, they need to understand and navigate a system during and after medical release, and once again, they explained this system to me.

In my attempt to write about treatment I will begin with the fundamental importance of connection because this is indicated by the participants, and then follow the advice of Jardine (1992) who advises learners to give up the need to be right and 'suspend position thinking' long enough to enter into the ongoing conversation about what they are studying. In the Stigma Chapter (p. 143), it was explained that the problem (soldier's heart, neurasthenia, shell shock, post-traumatic stress) had been repeatedly addressed throughout history, and that it simply re-emerged with a new label after each cycle or war. Jardine (1992) explains that we study not simply to confirm the reoccurrence of a problem, (he calls that 'counting'), but because the phenomenon isn't only located in the past, but also the present and the future. He advises that a 'good' interpretation is not definitive and final, but keeps open the possibility and the responsibility of returning, "…for the very next instance might demand of us that we understand anew" (p. 57).

In keeping with this search for the best possible understanding at the moment, one that resonates with soldiers and is attuned to possibilities for positive change, treatment of transition problems will be discussed within the following guidelines:

1) From the perspective of how transition difficulties relate to the concept of connection
2) With respect for the need for a new more connected understanding and treatment options that participants have expressed
3) By considering the evidence that the present paradigm is insufficient

4) By exploring what keeps the present model in place past its usefulness, and who this serves
5) By exploring our understanding of assessment: the process we use to know whether someone is either not well or well again

Throughout the discussion, perspectives of the participants and senior researchers will be woven together. In this way, attention to the importance of connection may reveal how the medical model can be enhanced so that the idea of treatment becomes broad enough to heal connections across all of the dimensions in which Veterans have explained that they have been wounded.

Disorder of Disconnection

The latest neuroscience research has provided irrefutable proof of the importance of connection and interpersonal attunement on the human brain. Dan Siegel, a professor of Clinical Psychiatry at UCLA, who has developed a multidisciplinary approach to healing trauma called Interpersonal Neurobiology (IPNB), explains: "Human connections shape neural connections and each contributes to the mind" (Siegel, 2012, p.3). Neural connections form the networks that are pathways for information in the brain, and Siegel's research affirms the primacy of strong interpersonal relationships in the construction of a resilient mind, and also in healing. A healthy mind is understood as having the capacity to integrate a wide range of experiences, information and emotions (Ogden & Fisher, 2015, p. 227; Siegel, 2012). At an even more basic level, physiological studies investigating the role of the hormone oxytocin, (the 'hormone of connection' that facilitates pair bonds), in the healing of post-traumatic injuries, explain how treatment is literally 'intimately' tied in with connection (Buisman-Pijlman, Sumracki, Gordon, Hull,

Carter, & Tops, 2014). It is important to connect this cutting-edge research back to the lived experience of Veterans, and Bruce Moncur, an Afghanistan Veteran and Veterans' advocate, does this as he explains that when he sustained a serious and nearly fatal head injury while deployed, connection to loved ones was foremost in his mind:

> I started sending messages, like telepathic messages, "I love you…praying that somehow, some way, these messages were going to get home" to Windsor Ont., to his aunt, who had raised him, and to his brother"… (Adams & Day, 2015, p. 30)

The 'new' knowledge about connection emerged from the most relational of fields: attachment research in child-caregiver relationships. Interest in vulnerability to psychological problems illuminated the fundamental importance of a secure attachment relationship, and explained how this is protective against post-traumatic stress (Schore, 2003). This in turn, led to research concerning the ways that attachment relationships can be repaired with emotional attunement, and to the fascinating concept of neuroplasticity, or how the brain changes itself throughout an individual's lifespan, in response to learning.

Siegel's work on Interpersonal Neurobiology (IPNB), mentioned above, provides a framework that unites biological and relational perspectives, and holds immense potential in the field of healing trauma. It has shown how *the brain responds to attuned connection*, on a physical level, by strengthening neural networks between the areas of the brain that 'hold' an individual in traumatic neuroprocessing and those that can 'file' the trauma as a past event and 'integrate' it into a new concept of self. *This is the essence of how to heal post-traumatic stress*.

Participants have acknowledged the primacy of connection explicitly in their explanations of how important it is to be connected to family, and also by explaining that their connections to health care professionals are more important than the specific modalities they use. Some participants have also demonstrated it implicitly in their choices to maintain connection with other Veterans through their advocacy work, and in their decisions to privilege their family connections over their opportunities for career advancement.

Neuroplasticity research describes a way for clinicians to understand the *experience-dependent* ability of the brain to initiate the repair of the disconnected neural networks that are the result of post-traumatic stress. Siegel (2012, p.117) explains that the experiences in question are those non-verbal and verbal exchanges that promote emotional engagement, and a sense of 'feeling felt' that result in overcoming isolation. In 'research language' this concept sounds one way:

> Meta-analyses of effective therapeutic ingredients tend to contraindicate the helpfulness of the specific-treatments for-specific-problems approach, finding more positive therapeutic effects in the common factors of psychotherapy (e.g., the quality of the relationship... (Quinn, 2008, p. 462)

A participant explains it this way:

> I went and saw this fellow- he's a specialist of course. I might have seen him twice before I said: "enough's enough." …this guy is apparently the best at what he does and I said, "I sure hope so!" because he doesn't have much else going for him, personality or [*his affected manner*]… and all I could think of was "god almighty how the fuck do you get anything done with anybody?" …I mean character is more important to me than what you know.

Another clue involving connection appears in the way that the overwhelmed mind can learn to disconnect, or 'split off' information that it cannot presently integrate as way of protecting itself. Unintegrated information exists in the form of what the medical model

terms intrusive symptoms (memories, dreams and flashbacks). In combination, Veterans and the latest research about connection are showing us that post-traumatic stress or PTSD may be more aptly understood as a "disorder of connection," than as the anxiety, dissociative or cognitive processing disorder it has been understood as (Clark et al, 2015, pp. 12-13).

If transition problems are understood in terms of connection, it opens up the possibility that the issues mentioned by participants above will find a home in expanded treatment models, and once again multidimensional, contextual research supports this. Research that connects the transition experiences of Veterans to the context of developmental life stages can result in treatment and opportunities that are reflective of their own goals and are more individually relevant and respectful (Daniel & Goldston 2012). Research recognizing the importance of connecting to families and partners in therapy (Ray & Vanstone, 2009; Jordan, 2011; Williamson, 2012) affirms what participants have mentioned about their own experiences and also addresses intergenerational transmission of trauma (Dekel & Goldblatt, 2008; Lambert, Holzer & Hasbun, 2014). The development of more effective therapeutic peer-support models addresses the needs for cultural relevancy and interpersonal support that some participants have explained are important to them (Westwood, McLean, Cave, Borgen & Slakov, 2010; Perlman, Cohen, Altiere, Brennan, Brown, Mainka & Diroff, 2010).

The concept of connection provides a framework that is broad enough to explore the need for treatment to be much more interdisciplinary and less pathologizing than it is presently, and also to critique and appreciate recent promising research that spans all of the contexts of being for Veterans. In the quote below, Bessel van der Kolk, a psychiatrist

renowned for his long career in the field of trauma treatment and research reflects on how the two understandings (medical model and connection model) of trauma can come together:

> ... I think this field has opened up two areas. One is the area of trauma and survival and suffering, but the other one is also people are studying the nature of human connections and the connection between us, also from a scientific point of view….As much as trauma has opened up things, I think the other very important arm of scientific discovery is how the human connection is being looked at scientifically now and what really happens when two people see each other, when two people respond to each other, when people mirror each other, when two bodies move together in dancing and smiling and talking…There's a whole new field of interpersonal neurobiology that is studying how we are connected with each other and how a lack of connection… has devastating consequences on the development of mind and brain. (van der Kolk, 2014b)

Bruce Alexander, a senior Canadian clinician and eminent scholar in the field of substance use, describes connection as 'psychosocial integration' which he equates to "belonging, wholeness, social cohesion, and culture, which makes human life bearable and even joyful at its peaks," evoking the descriptions above, of participants who explain the loss of this joy. Alexander writes that psychosocial integration "fosters a sense of identity, oneness with nature, connection with the divine," and advocates a global approach to re-establishing connection instead of one that locates the problem within individuals:

> … the historical view does not focus on single individuals. Rather, it focuses on the societal causes ... the global view provides a societal framework within which the struggles of addicted individuals in general can be more deeply understood and it fits very well with the individual life stories that I have encountered in a lifetime of work…. (Alexander, 2015, speech)

This is an understanding that is not only less pathologizing than the medical model, but also encourages responsibility on the part of society, for what happens to our deployed soldiers, as opposed to leaving these individuals feeling wrong or not normal.

Veterans in the study used the terms "fucked up, changed, different…a conflict," to describe their problems. A participant who was helping me define the parameters of this study explained that after a long career including multiple deployments, "… we all have 'it' …" he indicated that for soldiers, post-traumatic stress is a problem, an enigma:

> I've never seen an operational guy ever the same after, no matter how long I've known him. The one thing that's consistent is that they're all changed, they're all different from when they started out- we all are. And you know, when you get to the end, you've got to look at what you were, where you are, and where you're going, and what's my definition of normal?

This participant locates the problem in the past: "where they started out…what you were," in the present: "where you are," and in the future: "where you're going." This indicates that the scope of treatment needs to encompass all of these temporal elements and must be available to individuals as they need it in the future, which can be problematic in the present system. As explained previously, the problem is embedded in a cultural context that dictates to soldiers how they must handle it in a disconnected manner:

> P: …as long as you can keep it separated- locked up- you'll be ok.
>
> D: Locked up?
>
> P: It has to stay locked up, cause the second those locks are damaged or broken it seeps back into your consciousness and tears you apart…
>
> Later:
>
> P: "I got too much crap banging around in my head and I need to get it out.
>
> D: Yeah, well getting it out and keeping it locked down seem like opposites….
>
> P: Bit of a conflict isn't it?

Daniel and Goldston (2012) explain the serious nature of one of the ramifications of disconnection:

> …lack of connectedness to others has been defined in multiple ways, but generally refers to lack of social support, poor integration into a social network, or perceptions of social isolation…We consider lack of connectedness to others to include actual social support and/or perceived social support (i.e., one's subjective sense of connection to others). A recent review by King and Merchant (2008) highlighted the role of connectedness, social isolation, or social integration and risk for suicide or suicidal behaviors. In Joiner's (2005) interpersonal theory of suicide, thwarted belongingness, a concept similar to lack of connectedness to others, has been posited to be one of two factors that can precipitate suicidal behaviors in individuals who have acquired the capability of engaging in self-harm. (p. 289)

A Bit of a Conflict: Connection and the Medical Model

Recalling the importance of language in constructing reality (Dawes, 2013, pp. 22, 34; Caddick et al, 2015; Kleinman, 2007, p.12) highlights the need to pay attention to how we name the problem. Although the Canadian military advocates the use of the less-stigmatizing term Operational Stress Injuries (OSIs) instead of PTSD, the term PTSD is much more widely used in practice; this divide between theory and practice had been discussed in Chapter 8, Stigma. Tyler Boudreau, an American Veteran who is advocating for a different definition and label for the problem challenges the label PTSD. He objects to the use of the term 'disorder' (Boudreau, 2008, p.1), explaining: "I do not consider the psychological struggle of returning Veterans a "disorder" and so I will only refer to this *injury* as "combat stress" or "post-traumatic stress."

The context in which the medical model is embedded is the very question asked by the Veteran above: 'what's normal?' If the problem is located within an individual who can be objectively assessed in relation to an artificial standard that is stripped of connection to

past, future, self-concept, family and society, then the problem can be described as the medical model understands it.

The Gold Standard

With respect to treatment, the military relies heavily upon three methods: cognitive behavioral exposure based therapies (CBT), (Najavits, Kivlahan & Kosten, 2011; Hoyt & Candy, 2011), pharmacotherapy (drug therapy), and a technique called Eye Movement Desensitization and Reprocessing (EMDR), all of which are highly validated with randomized controlled trail (RCT) research (Steenkamp & Litz, 2013). Because of the way that post-deployment experiences have become labeled as a psychiatric disorder: "glued together by the practices, technologies and narratives with which it is diagnosed, studied, treated and represented" (Summerfield, 2001, p. 97), it is necessary to understand the rationale of the medical model. This exploration will be brief, because the plethora of information about the medical treatment of post-traumatic stress is more than adequately covered in scientific treatment literature. At one point in the research process for this thesis, (2014-2015), an Internet search of peer reviewed publications (using the Published International Literature on Traumatic Stress Database (PILOTS), with the criteria "randomized controlled trials PTSD" yielded more than two thousand studies conducted over the last twenty years, with a trend toward increasing numbers. Summerfield, as long ago as 2001, reported that 16,000 PTSD articles had been indexed in the PILOTS database.

Medical model research is organized around the American Psychiatric Association (APA, 2013), post-traumatic stress disorder diagnosis, included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which was revised in 2013, resulting in

the DSM-V. Diagnostic criteria for PTSD include: 1) a history of exposure to a traumatic event that meets specific stipulations, and symptoms from each of four symptom clusters: 2) intrusion, 3) avoidance, 4) negative alterations in cognitions and mood, and 5) alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition. The model also refers to 'co-morbid conditions', which are other psychological disorders highly associated with PTSD such as Major Depression Disorder (MDD) and Substance Use Disorder (SUD) (van Minnen, Zoellner, Harned & Mills, 2015; Irwin, Konnert, Wong, & O'Neill, 2014) and associated conditions and behaviors such as domestic violence (DV), (Williamson, 2012; Ray & Vanstone, 2009), dissociation (DSM-5 Diagnostic Criteria for PTSD, n.d.) and suicide (Kimbrel, Johnson, Clancy, Hertzberg, Collie, Van Voorhees & Beckham, 2014).

One research method above all others bolsters the medical model: the hugely expensive randomized controlled trial (RCT), which is designed with the goal of eliminating subjectivity in scientific experiments. The elevation of this research method above all others has led to a rigid adherence to evidence based treatments (EBTs), and to 'best practice guidelines' generated by these RCT studies, which extends to the adoption of manualized treatments designed to be delivered consistently, objectively and according to a standardized protocol, often referred to as the gold standard of therapy. The gold standard retinue of treatments is described below.

CBT and Exposure Therapy. These treatments focus upon two principles: unlearning (extinguishing) responses that have become coupled with stimuli reminiscent

of traumatic experiences, and changing thought patterns (challenging 'faulty' cognitions) about present meaning-making strategies concerning past events. In these methods, patients are "exposed to their own individualized fear stimuli repetitively, until fear responses are consistently diminished." (National Center for Post-traumatic Stress Disorder, 2004, p. 38). Edna Foa, one of the foremost clinical researchers in this method explains:

> Exposure therapy is among the best-supported treatments for PTSD (Foa et al., 2000). It is designed to help veterans effectively confront their trauma-related emotions and painful memories, and can be distinguished from simple discussion of traumatic experience in that it emphasizes repeated verbalization of traumatic memories … (Lawhorne-Scott & Philpott, 2010, p. 97).

Foa mentions that these are 'first line' therapies, and participants have explained that they have been treated with these methods at OSI clinics. Paradoxically, the method involves repeated and detailed confrontation of the experiences that individual's mental, emotional and physical systems are organized around trying to keep out of conscious awareness because they are too painful and threatening to be integrated (Boone, Steele & van der Hart, 2011, p. 9). Cognitive therapies in post-traumatic stress are designed to target guilt, shame, anger and depression (Gros, Strachan, Worsham, Foa, & Acierno, 2014), which presupposes that individuals have these emotions, or that the emotions are inappropriate to the situations in which individuals have found themselves. Participants have related some of the situations they are being asked to integrate into a pre-deployment understanding of self:

> …some of the stuff I struggled with- when we'd go to scenes, and it was total chaos and there were wee ones that had been hurt: "Hey man, they're not a participant, you can't do that! You can do it to me, you can do it to my buddies but you can't do it to them," I struggled with that…

> "I had one bullet whiz by my ear- it was so close I could even tell where it was made. It went right by me and struck a civilian woman right straight in the chest- she was killed instantly right in front of me; two kids."

Boudreau (2008, p. 211), as previously cited, asks his readers to consider the appropriateness of labeling post-deployment struggles as a disorder. He challenges the construction of anger as a faulty cognition: "What do you think all this rage is about? ...Where do you think the stress comes from? ...It comes from trauma… It comes from witnessing and participating in, extreme violence."

What cognitive and exposure therapies are not designed to support, is the experience of grief and the long-term integration of overwhelming experiences that are often the consequences of combat. A participant who has experienced CBT exposure-based therapy is left with questions:

> D: …exposure therapy, just: is it useful?
>
> P: Ah, well I guess I'd have to say yes. Yeah, in my case it did what it was designed to do, but it's not enough- it doesn't address the only issue that I have, so… and again I'm one of those people, I'm not sure that I have PTSD or not to tell you the truth. But depending upon whose definition you're listening to on any given day, yeah I guess it could get into that, but… sometimes I just don't think that quite captured what's going on- but who am I? So!

Quinn's interpretation of the effects of combat explain that it can be related to self concept:

> Because of the extreme nature of the combat trauma, the veteran's defences, by which threat to conscious awareness is avoided, are brought to task and fail to protect the pre-trauma understandings of oneself and the world. If psychological defences cannot keep the combat trauma at bay, the veteran fully perceives into awareness the hell subjectively observed on the battlefield. As a result, "the self-structure is broken by this experience of the incongruence [the death and dismemberment of war] in awareness. (Quinn, 2008, p. 469)

The participant above indicates that the therapy reduced his symptoms as it was designed to do. He also remains with the question: "who am I?" This can be understood to mean 'who am I compared to the therapist,' which indicates a question about power imbalance in the therapeutic relationship, or perhaps, as Fisher explains below, the participant's self concept has been changed, as this participant has previously indicated happens to deployed soldiers, and the therapy is not expansive enough to help him integrate this change.

Fisher, (2009; Ogden and Fisher, 2015; & personal communication, Trauma Training Workshop, 8-9 June, 2015), teaches therapists that talking about what happened (i.e., accessing narrative memory) does not process or integrate memories; it does establish a context for the symptoms, validate the suffering, and increase self-compassion, however, because narrative re-telling activates implicit memories (held in the forms of emotions, body sensations, autonomic arousal), it risks autonomic dysregulation and re-traumatization. She practices alternatives to the CBT methods (which attempt to process traumatic memories by employing an exclusive focus upon the entire or most disturbing sections of the narrative), and also challenges the construction of individuals' coping mechanisms as disorders. She employs interventions that process and transform the experience of trauma somatically, and promote a sense of mastery, often including a renewed sense of safety and presence that is enduring and reduces the need for coping with substance use and suicidal ideas. The work of Fisher and her colleagues, which is based upon a method called Sensorimotor Psychotherapy, explains the way that addressing traumatic reactions and patterns that are stored somatically and facilitated in the limbic brain, can support a new sense of meaning for the future:

> In Sensorimotor Psychotherapy, the meaning-making that takes place without awareness, beneath the words, through the body is a primary interest. Since they are implicit, such meanings cannot be consciously reflected upon or revised… (Ogden & Fisher, 2015, p.607)

Another participant describes that his experience with CBT exposure based therapy did not engage him in his own process of healing, especially with respect to the future:

> P: So I just stopped asking those questions and I stopped- I just figured- go through the motions, right? "Ok, we're going to relive this one again? Oh all right, yeah, sure- so yeah, I could smell the dust, yeah, I could hear the burning….
>
> D: Seemed to be the expected behavior?
>
> P: Yeah, I don't know… that makes me, we kind of shirked our responsibilities I guess, but we didn't think- I didn't think I was getting all the answers.
>
> D: What do you mean shirked your responsibilities?
>
> P: Well…I became less of an active participant, I just: "Ok you want me to live with? [re-live?]- I will just give you the narrative, but in some ways maybe that was therapeutic because I was just, at a certain point you got dissociated, you got disconnected from the narrative and you're just yeah and then, yeah and then….

As participants have explained, there is an element of 'checking the boxes' in the protocols adopted by the transition system service providers. For this participant, it will be clear, upon looking at his medical record, that he was provided with therapy. What will not be recorded are the effects of not having the answers to the questions he was left with after his experiences, when he stopped asking all those (existential) questions and simply went through the motions.

Pharmacotherapy. Pharmacotherapy is the name that doctors use for prescribed psychoactive substances and also narcotic pain medications. In a foundational text on evidence-based practices, doctors are informed that pharmacotherapy should not be a stand-alone treatment or treatment of choice, but should be coordinated with client's own treatment goals and used to augment psychotherapy, *in the context of an ongoing*

relationship between the health care provider writing the prescriptions, and the patient. The authors caution that knowledge of drug interactions, especially non-prescription drugs and narcotic pain medications with psychoactive medications, is crucial, and that although pharmaceuticals are effective in reducing symptoms of PTSD and co-morbid conditions, they are constantly changing due to new research, and physicians need to be current with such research (Opler, Grennan & Ford, 2009, pp. 329-350). Although a relational approach in a co-constructed therapeutic endeavor is indicated by this advice, it was not the experience of participants, who understand the paradox between needing to "get by" and the cost of this treatment option in the context of the military:

> P: I now face taking six + prescribed drugs every day just to get by and to be able to get some sleep now and again. This 'meds crutch' has taking away my freedom, to reliance on pills. It has compromised my self-confidence and made me feel at times mentally and emotionally helpless.
>
> P: So that's when they started pumping me with drugs, and when they started pumping me with drugs it meant the end of my career.

Over time, one of the participants above has learned to advocate for his own treatment choices, and although he had no option to choose not to be medically released, his self-education has resulted in a more relational experience in treatment. Today, although he doesn't feel completely happy about taking medications, he is more empowered in the decision, which is collaborative and based upon agreeing with his psychiatrist that prescribed medications are sometimes part of his health care regimen:

> P: …the reason I see a psychiatrist is because they felt I needed to take some mind- altering drugs.
>
> D: What are your ideas about that?
>
> P: Well, I wasn't- I'm still not too keen on it, but things have been getting a little too extreme for me over the last two months, so I think it was necessary.

Another participant describes that when he initially elected to go to an OSI Clinic, pharmacotherapy was high on the list of available options:

> P: …they have to identify you and they will bring you into their regime. For better or worse their regime involves pharmacological assistance. Everyone's experience again- there are benefits to drugs and there are side effects to drugs, everyone reacts different and I'm sure they all have things. My experience was that the clinical psychologists were …
>
> D: You look like you're writing.
>
> P: They were- not quick, they were eager to offer pharmacological assistance should it be required, and from what I understand from my experience, and from others- they offered a lot of pharmacological assistance. Was that helpful? I don't know, everyone's case is different.

The words above are an understatement of the participant's knowledge of CAF medical practices involving pharmacotherapy, both during and post-deployment. Skidmore & Roy (2011) write about the aspects of military culture that promote the use of alcohol to deal with the symptoms of PTSD, including sleep disturbances, and numbing; they acknowledge that it helps manage symptoms without resorting to outside help, reduces stress, and often starts soon after discharge. Soldiers advise each other to handle their problems with alcohol, a culturally accepted practice in the military, especially for older individuals (Bryan & Morrow, 2011) and an option for anyone who is not willing to lose their career and its attendant economic and social security and status by asking for help. The participant above explains that he was given the following advice after telling other soldiers that he had been to an OSI Clinic:

> Oh no man- you tell them you're not happy- you tell them you're done! There's no help- there's nobody to talk to- you go downtown with the boys, you have a few beers, you get into a punch-up and then you work it out...those guys were well aware that should they come forward they were done.

This individual's story involves resisting the stigma around help seeking and also the culturally sanctioned practice of self-medication. The resistance of this participant is remarkable, because he experienced pressure from both the treatment providers and fellow soldiers about limited options to deal with his difficulties in the 'culture of carry on.'

Eye Movement Desensitization and Reprocessing (EMDR). Although Eye Movement Desensitization and Reprocessing (EMDR) is a validated therapy, according to RCT outcome research, the quality of this research is being questioned (Korn, 2009). Debate continues about how it actually works, and much effort has been expended in the effort to isolate the effective components. The most prominent theories involve the way that especially visual memories are stored in working memory, and how they can be reprocessed with less emotional charge, or 'desensitized,' thus it addresses the memory and the associated emotion (Engelhard, van den Hout, Dek, Giele, van der Wielen, Reijnen, & van Roij, 2011; Engelhard, van Uijen, & van den Hout, 2010). EMDR is also relatively brief, which makes it attractive treatment in a system that adheres to neoliberalist values. In complicated post-traumatic reactions, more sessions, which are longer in duration, are necessary, and due to the intensity of the material being processed, there is a need to integrate material that arises during 'approved for coverage' fifty-minute sessions and a need to support clients between sessions. These are important considerations, as they would be with any treatment that involves the processing of traumatic material, and they need to influence the choices of treatment providers toward comprehensive, multidimensional methods.

Research about the efficacy of EMDR illuminates that the effective element in its success may be that it provides what could also be ensured by a very basic practice: deep, restorative sleep. Research into the prevention and healing of intrusive memories after trauma indicates that the presence of nightmares and the absence of the integrative REM sleep cycle have predictive effects on the onset, severity, and duration of PTSD (Van Liempt, Van Zuiden, Westenberg, Super, & Vermetten, 2013; Pigeon, Campbell, Possemato, & Ouimette, 2013; Harb, Thompson, Ross, & Cook, 2012). The integration of experiences during the rapid eye movement (REM) stage of sleep is a natural occurrence in individuals with healthy sleep patterns. Military psychiatrist Jonathan Shay (2013 podcast) has explained that the consideration of sleep disturbances as important in recovery from combat trauma is such a simple idea that it is being overlooked. Shay repeats his mantra: "Peers, peers, peers, sleep, sleep, sleep, heal combat trauma." Bessel van der Kolk (2013) agrees that sleep is a very important way in which we restore ourselves, and that process of restoration occurs during REM sleep; he emphasizes that REM sleep is dream sleep, and disturbance of this stage is probably an important factor in why traumatic memories do not get integrated.

Three out of four participants in the present study have mentioned their difficulties with sleep, including nightmares. Other sleep researchers challenge the gold standard approach as too narrow, on the basis of their findings that sleep disturbance is a core feature of posttraumatic stress disorder, which has always been considered secondary to PTSD, and therefor has not been considered as an area for effective intervention (Margolies, Rybarczyk, Vrana, Leszczyszyn, & Lynch, 2013; Jordan, 2011). Dow (2015), describes his success in working individually and in groups with Veterans using a process

that he calls dream revision, which he claims can reduce or eliminate the need for pharmaceutical intervention. He attributes the success of his methods to both the technique and the influence of the peer-based group model, once again pointing to the effectiveness of connection for healing.

The above examples challenge the gold standard therapies (CBT. Pharmacotherapy, and EMDR) with Veterans' and veteran researchers' ideas, and illustrate the capacity of both to inform other ways of thinking about healing the effects of post-traumatic experiences. These views question the foundations and breadth of the gold standard therapies, which rest upon ideas that transition problems are based upon faulty cognitions, instead of a natural reaction to what individuals have witnessed and a difficulty with integrating such experiences into post-deployment Canadian mainstream culture. The participant below explained that current treatment protocols were not sufficiently addressing the 'bigger' questions he had about his transition experience:

> P: I think we would all kind of eventually- not all folks- certain folks are going to be reactive, that's just the way people are and I get that – in my case I was a little too, except when you get caught up in that, and you might not be… the flow of information that you're willing to give out is maybe going to be metered- but they want you to kind of- "Hey lets get in there and talk…
>
> D: They being?
>
> P: Clinicians, social workers…I get the whole CBT thing where they're trying to numb you out. For me I didn't have so much an issue with the intrusive thoughts and stuff – yeah that happens, but it was more with how to deal with- you know, the things that had happened since then type of thing, or how my views have changed or how to accept how my views had changed or the lack of concentration- things like that. I mean, I never got an answer about that, and I kept trying to get an answer cause I thought if I'm in this program and who I was is gone and who I could have been is gone, and now I'm yours, "Well then give me some goddamn answers, help me out here- give me a clue!"

> D: If you're that kind of a person and you're in a…some kind of a treatment situation where those issues aren't being addressed what do you do? What was the reaction?
>
> P: You know it's sad but after a while, I just kind of figured I wasn't going to get the answers, or god love them for their best intentions- they didn't have the answers to give me. It's not that they had them and they were keeping them a big secret or anything, it's just that they probably didn't know, and I'll accept that because I didn't know, and if I didn't know and they don't know, well then, we'll just kind of find a way to make peace with this and it might just be one of those questions… Maybe you know if I end up, up there, if there is an 'up there', I can ask him!

Another participant described a particularly discouraging experience with a highly recommended mental health professional who quickly passed him on to an associate. At the end of his unflattering description of this encounter he summed up his feelings about this treatment experience:

> Don't ask me to tell you about my day, because we'd be here for two days while I'm trying to explain to you one day- just don't do that! We don't like repeating ourselves, talking about that…

These words reflect the way in which a lack of knowledge about the context in which Veterans with deployment histories enter therapy influences the effective implementation of even the most evidence based methods. For one participant, the natural, existential concerns he had in response to a life upheaval were not addressed in therapy. Another was offended by the lack of consideration and understanding that was reflected in the therapist's superficial approach. Without expanded understandings of culturally sanctioned attempts to keep going and assuage pain, genuine reactions to trauma and loss, mechanisms and strategies to maximize the ability to cope, keep jobs, and exist in a culture that privileges endurance and stoicism in extreme circumstances, therapists can construct Veterans' attempts to carry on as symptoms. Participants are explaining that

they need treatment that is respectful of their individual needs, multidimensional, relational, contextual and less re-traumatizing.

How Did it Get This Way?

Jardine's (1992) comment about part of any phenomenon being located in the past as well as the present and future, indicates the need to look back in order to understand how the problem came to be. Although it is beyond the scope of this study to include a comprehensive exploration of the progress of post-traumatic stress research since its inclusion in the DSM in 1980, it is important to understand the medical approach in order to appreciate Veterans' experiences and then deconstruct the model. With this approach, and the Veterans' viewpoints, it will be possible to understand who the EBP, medical model serves and who it marginalizes (Kleinman, 2007, p.20).

PTSD: the dominant discourse. In 1980, PTSD was incorporated into the DSM-III: van der Kolk (van der Kolk & Najavits, 2013) describes that, at the time, the disorder as an amalgam of rape trauma syndrome, Vietnam Veterans Syndrome, battered woman syndrome and abused child syndrome. As described earlier, the inclusion of PTSD as a psychological disorder can been seen as a double edged sword; Woolf (2013) and Lembeke (1998a) explain that it reinforces a victim construct, however van der Kolk (van der Kolk & Najavits, 2013) adds that it began as a framework used by drug researchers to communicate with each other, and indicates that the inclusion of PTSD in the DSM gave it legitimacy in the specialization of psychological disorders. In a society that would be increasingly dominated by an insurance-based, medical model of health care, this enabled individuals who were dealing with PTSD to gain access to the health, financial and social benefits they needed, and this remains true today, as assessment and diagnosis according

to the DSM are the first steps in the process of opening a claim with VAC, which is necessary to begin treatment.

Randomized controlled trials. In treatment research since the 1980s the influence of the post-positivist paradigm has dictated that the method of communicating research findings be objective and outcomes-based. Studies generating this type of knowledge are published as highly technical articles in peer-reviewed scientific journals where they are available to those with academic standing and professional-level knowledge of the randomized controlled trial (RCT) methodology and symptom-focused terminology used in such writing. This research is highly influential in the design of treatment protocols approved as EBPs. Psychiatrist and tour de force in the PTSD research community Bessel Van der Kolk (van der Kolk & Najavits, 2013), who was instrumental in having post-traumatic stress recognized in 1980 as a mental disorder, now reflects upon this in an interview about his observations during a life-long career as a researcher and clinician:

> Treatments in which patient's PTSD scores drop from 65 to 45 are not effective treatments. They may have shifted people just a little bit; they are possibly a little less miserable, but given how much suffering there is and how much money is being spent, that's not enough. That blasé recommendation may be fine if your principal concern is to keep your research lab going, but if your job is to heal your patients from their traumatic injuries, buying additional treatment manuals may not be the best way to restore them to a joyful and productive life…Most treatment outcome researchers seem to become wedded to their particular method, which they study over and over again, in slightly different populations, under slightly different conditions, usually with the same equivocal results…..The question is: Are our patients really getting better or do they just meet the statistical cutoff for improvement? (pp. 520, 521)

This reflection by van der Kolk indicates that in the treatment and research field concerning post-traumatic stress, the overvaluing of EBPs and RCT research has created an imbalance, and this is creating the gaps that the participants above describe in their

experiences of treatment. There is an encouraging addition to the counter-narrative regarding EBPs in the new Canadian Journal of Military and Veteran Mental Health:

> Considering these data, it may be important to note that evidence based often means only that a protocol has been through the peer review process, replications have occurred, and statistically significant changes have occurred, whether or not they are clinically meaningful. (Gray & Bourke, 2015, p. 18)

As mentioned, by the 1990s, the DSM construct of PTSD became the only epistemology; the United States' National Institute for Health (NIH) and National Institute for Mental Health (NIMH), for scientific research, amassed copious amounts of numerical data about the minutiae of PTSD. This focus sidelined the contexts in which post-traumatic stress was generated which were not included in the criteria for diagnosis until 2000, when the importance of an overwhelming event was recognized (Clark et al, 2015, p.12). Bowman & Chu (2000) highlight the problem of how reductive the approach that does not consider context became:

> Along with the welcome advances of the biologic aspects of psychiatric illness has come a theoretical stance that emphasizes biochemical and genetic causes for mental illness to the exclusion of much consideration of external events in shaping symptoms. This viewpoint, carried to its ultimate logical conclusion, is that every twisted thought or emotion can be traced to a twisted molecule. (p. 5)

Babette Rothschild, an eminent PTSD researcher and therapist, also takes a critical approach to outcome research, agreeing that it is usually undertaken to advance a therapy model, and often is not conducted on a truly random and representative sample (Rothschild, 2012). Janina Fisher, trainer, researcher and clinician in the field of trauma, expands upon the flaws in RCTs by stressing the importance of realistic exclusion criteria in RCT research design. She indicates the futility of subscribing to the definition of a disorder that includes symptoms of dissociation, re-experiencing and co-morbid

conditions such as substance use, intimate partner violence, and suicide, and then designing experimental studies that screen out the very individuals who would benefit most from the research by including conditions such as depression, psychosis and alcohol or substance use, suicidality and dissociation as exclusion criteria, while simultaneously indicating that these very conditions are the hallmarks of the problem they are attempting to study. This illustrates that the RCT experimental approach is often too reductionist to be meaningful in such a contextual problem as post-traumatic stress. Fisher explains that the common exposure-type CBT treatment studies have such a high drop-out rate (because so few people can tolerate the retraumatizing worst-case narrative creation aspects), that they cannot be considered as having been conducted on a sample that truly is representative of PTSD, but on asymptomatic individuals who have a wide 'window of tolerance,' (Fisher & Ogden, 2015, p. 48), which is not typical of individuals who fit the diagnosis of PTSD. One Canadian military mental health study investigating treatment outcomes and including prolonged exposure reported a 70% drop out rate (St Cyr, Roth, Richardson, McIntyre-Smith & Cameron, 2011). Additionally, Fisher and Rothschild question the level of sustained positive change reflected by studies that do not include long-term follow up (Fisher, 2015: Personal communication: Working with addicted survivors of trauma; Substance use, eating disorders, sexual addiction and compulsive self-harm, June 8-9 Charlottetown, PE).

Resistance: First Voice Evidence

All of the participants have a mental health diagnosis as part of the reason for their medical release, three of them have named it as PTSD, some of them question this diagnosis, or the usefulness of the diagnosis, in describing the complexity of the issues they work with in therapy and daily life. The words of participants and other Veterans explain the ways in which they are challenging the pathologizing aspects of being diagnosed with a mental health disorder. They do this with their own interpretations of their transition difficulties and their ideas about what treatment and healing means to them. It is significant that these words are currently being echoed in the clinical research and treatment community by 'veteran researchers' who have developed and now advocate for, more connected, multidimensional approaches to treatment, because it illustrates that these two communities (Veterans and researchers), who are currently described by disparate narratives of 'ill' and 'healer' could work together in a manner that respects the capacity of both at the crucial, decision making level of post-deployment treatment of transition problems.

Dr. David Webb is an individual whose experience spans the categories of patient and researcher. He is a survivor of numerous suicide attempts, and writes about the way that as a researcher he values the importance of first-voice evidence and as a therapist he is committed to inclusive and multidimensional modalities. In his 2013 essay, The Politics of Suicide he explains how 'default to the objective' thinking has affected treatment by marginalizing lived experience knowledge:

> Another medical public relations exercise has been the touting of "evidence based medicine", which has colonised just about every aspect of life so that we now talk

> about evidence based strategies, policies, programs and practices. It seems a sensible, common sense idea that the decisions we take and the activities we perform are based on the best evidence available. But the criteria for what constitutes valid evidence within the medical field are not necessarily the criteria that should be applied to other fields. For instance, the "gold standard" of medical evidence is the fully randomised, double-blind control trial (often abbreviated to RCT), which is appropriate for, say, testing new drugs, But RCTs are not only often impossible but also totally meaningless for researching many other questions. They are particularly useless for enquiring into the invisible, unmeasurable, dark depths of subjective experience. RCTs can be an excellent research method when working with observable, measurable, third-person (objective) data, but are simply irrelevant when working with first-person (subjective), experiential data. Despite this, and many other occasions when the medical criteria for the validity of evidence is inappropriate, it is the medical "hierarchy of quality of evidence" that is assumed and applied. (p. 6)

When held too rigidly and defended as unassailable, a paradigm can exist past its usefulness, absorbing resources, and causing those highly invested in it to marginalize more effective approaches. As entrenched models remain unquestioned, especially in a climate of neoliberalist dominated thinking in government service delivery and research, it becomes easier to deny the usefulness of less easily measured approaches. Valuing experience-based, Veteran-generated, first voice data, and the considered opinions of elder and committed Veterans' advocates and researchers, is a more multifaceted, interconnected way to approach the problem of how best to treat post-traumatic experiences with Veterans. First voices approaches will not easily translate to numerical form or fit on a spreadsheet, they demand a messier engagement that generates creative solutions to a serious, intractable and contextual problem in a more empowering manner for those involved with the questions, than the present paradigm does.

A participant explains the need for a wider, contextual approach:

> P: I don't know, there's a lot of people out there that because they study and they are able to have the capacity of loading people into slots… that's good if that's all you have to deal with. I get that idea, I get that approach, I understand it: you

> know, you've got a broken bone? Well, stick the person in the broken bone bin- they'll get it fixed and off you go. But what if they've got ten other things that are broken, and for you to fix that will double the effects of everything else that anyone else is feeling or dealing with. How do you do that? Do you continue- or do you figure out another approach- or at least ask the question?
>
> D: Nobody's asking the question.
>
> P: Most people don't even ask the question.

Paradigm change: Power and Influence

According to the current paradigm the medical model, with it's attendant RCTs approved by the APA, and codified in the DSM-V, we understand post-deployment psychological problems as an illness, a disorder, and it follows that individuals with a disorder are sick and in need of order. When a powerful organization such as the APA constructs PTSD as a disorder, it influences the rest of society; PTSD becomes 'ordered' in society in such a way that there are healers and patients, and these are different from each other in terms of power and influence. As a culture we are continuing to address post-traumatic problems according to ideas that were critiqued by Foucault in the 1950s, as medically managed, manualized approaches that are easy to measure continue to bolster more outcome research. Henry Mintzberg, a Canadian professor of management who has studied and written about neoliberalist management practices and their effects on a global scale, recognizes this problem and provides the following insight from his book Rebalancing Society:

> A senior British civil servant, when asked why there had been such a profusion of measuring in his ministry, replied: "What else are we to do when we don't understand what's going on?" Did he try connecting and communicating, even using judgment? (Does anybody remember judgment?). (Mintzberg, 2015, p. 87)

Summerfield (2001), in an essay on the usefulness of the construct of post-traumatic stress disorder indicates: "…the story of post-traumatic stress disorder is a telling example of the role of society and politics in the process of invention rather than discovery" (p. 95). He adds: "Distress or suffering is not psychopathology," explaining that: "… the misery and horror of war is reduced to a technical issue tailored to Western approaches to mental health…" and concludes that: "There is a veritable trauma industry comprising experts, lawyers, claimants and other interested parties; it is a kind of social movement trading on the authority of medical pronouncements" (p. 96).

Summerfield's predictions have come to fruition, and the latest 'interested parties' are private service providers. Veterans' needs are now commodities, and the government organizations entrusted with their care are providing advertising space in which to market goods and services in their publications, in return for corporate sponsorship, which is a clear indication of their alignment with a business model of care.

Kleinman (2007) advises researchers who are interested in systemic change to "analyze the elephant" (p. 6) and notice who sets the standards in a situation, and also who bears the consequences of these standards (p. 7). The official conference program of the VAC and CAF sponsored Canadian Institute for Military and Veteran Health Research (CIMVHR, 2013), which holds much power and influence over the treatment and understanding of post-traumatic stress, includes ads for private addiction and mental health services, residential treatment facilities, and physiotherapy services and devices in its sponsorship section (which is multi-tiered according to the level of sponsorship, much like an airline loyalty program). The problem with this approach is that it will exacerbate the uncoupling of the problem from its context, because research (especially RCT

research) is expensive and when is financially supported by service providers who have a financial interest in being included in narrow 'best practice' guidelines, there is a danger that studies will exclude context that detracts from the reliance upon their methods or services. Veterans describe this context as essential in the understanding of their problems, and they want it to be considered in the design of treatments.

Berger (2014), writing about personality disorders, also addresses the power imbalance inherent in the medical model, especially concerning the classification of mental health disorders. She employs the example of personality disorders, which she posits could be understood more inclusively, as alternate constructions of what is understood to be normal, just as post-traumatic stress could. Berger critiques the DSM for considering differing constructions of self as "typologies of deficit." She explains the ramifications of this:

> When a clinician, armed with this model and definition, makes a diagnosis of BPD, for instance, the power to classify derived from this knowledge can influence how individuals view themselves in relation to societal standards. In Foucault's (1982) sense, the client may therefore internalize the problem discourse and come to understand themselves as deficient and that deficiency as a fundamental quality. (Berger, B., 2014, para 5)

Turf-wars over funding (Richardson, Frueh & Acierno, 2010) influence, and lack of clarity about the construct of post-traumatic stress, unbalanced treatment approaches and the commodification of Veterans' needs and services, are detrimental to Veterans wellbeing because they reinforce a faulty paradigm, based upon internalized typologies of deficit, and absorb resources that could be focused upon relational research and practice. Additionally, this situation leaves no room for the input of Veterans whose knowledge and capacity is discounted despite the fact that is the most contextually relevant and

experientially generated first voice evidence. A final effect of the imbalance of power and influence is that it contributes to the Veterans' narrative in a way allows our society to sidestep responsibility for what has happened to our Veterans, and continues to marginalize those who speak out, as victims and troublemakers.

The evolution of transition research and practice supports a rationale for connecting the immense body of trauma research to holistic, culturally informed treatment methods; this evolution is apparent in the thinking of both astute military Veterans and 'veteran researchers,' who are the elders of the trauma research community.' These people are emphasizing the value of treatment methods anchored by practices of re-connection. The fact that these methods are commonly excluded from approved treatment protocols reveals a lack of connection and integration in the research community, which mirrors the dissociative symptoms of PTSD. This 'symptom,' exists alongside power struggles and an unbalanced approach in the research community, providing evidence of how shaky the present paradigm is. One of the participants explained this disconnection as a result of his own experiences in treatment; he has concluded:

> P: Now the problem with this is, is this PTSD thing, OSI, all these other names that researchers, clinicians, specialists from *whatever* field, and really, it doesn't matter, but there are just *so many* of them out there, and it's like anything else- the more bodies you have out there, the more conflict there is, because the more egos get involved, research- well even if you exclude that their research will lead them to believe that they're following the right path. But if it conflicts with anybody else's path or if there is a conflict with anybody else's path, there always has to be, one of them has to be right. Well, you know, you both could be wrong, actually.
>
> D: Or right, partially, like you said, but it can turn into a turf war.
>
> P: Oh yeah: "No I've been studying this longer than you have, so your stuff is shit," and they spend more time trying to disprove somebody else's work than trying to prove their own.

Congruent with the comments of this participant are the views of Yemada and Marsella, who warn about the way that, in the past the personal agenda and philosophy of one individual can have a considerate influence on research and ultimately treatment:

> Biological approaches would gain further support in psychiatry in the United States with the development of tranquilizers and anti-depressant medications in the 1960s and 1970s, and with the leadership of Gerald Klerman, professor of psychiatry at Harvard University, and former director of the National Institute of Mental Health during this period. But it is noteworthy that Klerman's success in moving psychiatry toward a 'medical model' of mental disorders reflects the very role of disciplinary 'cultures' in shaping thought and practice via leader-based conceptual biases and preferences. This thought does not deny the fact that sound scientific research contributed to changes, but rather that 'power' in shaping thought and practice does often stem from individual biases. (Marsella & Yemada, 2011, p. 104)

These 'disciplinary cultures' that shape thoughts have great influence in terms of how therapists are trained to work with their clients, and what treatments are approved; this reflects the power imbalance that exists in the field of trauma treatment. At the end of his long career Marsella has concluded:

> Eventually, I came to see that therapy/healing efforts around the world use a variety of different healing principles. All of them are powerful sources of solving problems and across a lifetime, many different ones might be applied depending on the circumstances. In brief, no single principle is the best, and no single therapy is the only therapy to be used. (Marsella, 2010, p. 24)

The Cost of Resistance

We might have been a bit of a problem… (Participant)

It's obvious that the present paradigm is shaky; unfortunately, it is Veterans who are suffering the consequences of lack of cultural awareness, individualized assessment and consequent treatment and narrow approaches. The following quote reflects a participant's experiences with the differences in cultural awareness between mental health care providers at the Operational Stress Injury Clinic (OSI) where he was seen. His comments

indicate that he was aware of the different levels of understanding in therapists entrusted with his diagnosis and consequent medical release.

> …it's a weird hybrid because there are military folks in there, and there are civilian folks in there… I'm trying to think of the best way to phrase this. We might have been a bit of a problem for them because up until 2006… the cases that they may have had probably were a lot milder, and so they weren't quite ready for the flood that came after… I don't know- you know- they hold up the cookie cutter and they say you fit the cookie cutter, now you become my patient and I get paid. Oh really! There's a bit of job security there- whatever! That could be throwing something up against the wall to see what sticks! I did find that some of the guys that went through that dealt with military guys: "Yeah whatever that's the way she goes, see you!"
>
> D: So these were other mental health professionals?
>
> P: Yes- military mental health professionals- my experiences, and the persons that went through at my time frame, from my unit, had similar experience, but we all seemed to think that there was again- two hoppers, or two categories: if you saw a military mental health professional, they were very reluctant to diagnose you with a condition- or they did not have the experience to diagnose you with a condition, or-they thought that your view was a normal view for a person that experienced what you experienced, or those type of experiences, and that you'll get over it, and if you don't: "We're always here, come back and see us"- and away you go. The civilians that were employed in OSI [*clinic*] were aghast and shocked at some experiences that we had.
>
> D: Was that helpful?
>
> P: Yes and no in that they wanted to help, so that was helpful. No, in that a lot of us might have been misidentified perhaps?

Taking Responsibility: Veteran Generated Treatment

> *"…when I kind of made peace with it, and if anybody was going to ask me about it, that was going to be the thing: "Hey man, I did my part, so you've got your pound of flesh, whatever. I need a wee bit of help to get me by, I'm going to go get that wee bit of help."* (Participant, explaining his process of deciding to seek treatment)

The participant's reference to "pound of flesh," yielded a particularly appropriate definition, in light of his quote: "A payment, penalty, etc., which is strictly due but *which it is ruthless or inhuman to demand.*" (Shorter Oxford English Dictionary, 2007, p. 2306).

We build our individual networks. Another short participant quote*:* "We build our individual networks," affords an opportunity to see how this individual encompassed his ideas about the way that he sees effective treatment for Veterans. "We build," indicates the sense of agency that this participant has come to recognize within himself as he learned to navigate through his transition:

> I tend to accept all responsibility for everything that happens to me, so I don't care whether it's a doctor or not- it's me that will let the doctor do whatever they're doing. I'm not going to give him control over my life; I just refuse to do it.

The need for a collaborative, network approach in the treatment process is evident in the use of the word "we," and the details about who to collaborate with are not specific. This participant previously used the term 'handler,' which is significant because it indicates that for him, treatment providers are not only those that work in the medical model:

> D: So what's a handler, what does a handler do?
>
> P: Well a handler can be anybody from, me I suppose, to a professional, or anywhere in between. A handler is someone who just, helps handle an individual while they're having a problem, really. But not everybody responds to the same thing, not everybody needs the same thing.

Again the participant refers to his sense of agency and indicates that Veterans know they do not all need to be treated the same:

> D: That seem really clear to you, really clear to you- that there has to be more flexibility would you say, or individualization, or…? And who's the person…who knows best what each person needs?
>
> P: There's only one – it's the individual; it's proven thousands of times a day.

This participant has partially described his own multidimensional treatment regime:

> …massage, I've used acupuncture, I've used a chiropractor, physiotherapist- and that's an ongoing, on-off thing- well actually all these things are. Psychologist, psychiatrist… sauna, wax treatments- you sink your hand in paraffin wax to immerse the joints? I use that, there's all sorts of equipment that I've used; I've got this thing where I stretch my neck out from the ceiling, stretch out my whole spine. There's tens machines- I've got multiple different types- so I can- basically any part of my body that's affected, I can apply the electric current, that's for the chronic pain, primarily. There's all the medications that I take- and I take a whack of them- so, everything from the narcotics to vitamins. Then there's things like, beyond physiotherapy there's the physical activities that need to occur: working out, gym, things like that.

This is the participant who previously described his dissatisfaction with the two experiences of disconnection he encountered with the specialists in post-traumatic stress. Alexander understands the problem of disconnection as dislocation, and his lifelong study of addiction informs his conviction that a contextual, connected approach is essential:

> The basis of natural recovery without treatment is no mystery, since so many cases have been studied. As the historical view of addiction would predict, natural recovery occurs when people establish stronger relations with the community, or find a strong sense of meaning in a new life or religion … reducing their dislocation… The most spectacular demonstration of this is the natural recovery of heroin-addicted U.S. soldiers returning after the Vietnam. The great majority of them recovered without treatment… Medical and psychological treatments that focus on addictive thinking and behaviour with little or no concern for the underlying problems of fragmentation and dislocation have failed to do much good. Focussing on addiction without dealing with dislocation is a lot like trying to treat the symptoms of diabetes without controlling a patient's sugar intake. (Alexander, 2010, pp. 160-161, 290)

Edward Tick is a therapist who has been honoured for his ground-breaking work in the spiritual, holistic, and community-based healing of veterans and post-traumatic stress. He describes PTSD as a way of speaking, and has generated a comprehensive list entitled 'What PTSD asks us to do for our veterans.' It includes the following: generate an

immediate response; create gathering places; spiritual cleansing; meaningful ritual observed by all of society; treatment that addressed more than psychological issues; and invite vets into schools to connect with young people about the realities of war. He explains that as a society, we need to: "create safe havens that are not only shelters for homeless or addicted vets, but are houses of initiation where vets receive not just job and sobriety training but education, therapy, and rehumanization processes" (Tick, 2014, pp158-160). Tick's approach asks society to take responsibility for the wounds that Vets come home with.

Marsella (2010), a senior researcher in the field of culturally responsible treatment of mental health problems, has derived a formula for addressing post-traumatic injury, which he calls the 'complex healing calculus.' He indicates that it is a multidisciplinary, and individualized approach, which "draws[s] linkages across different levels (macro–micro–psycho–social–biopsychosocial) of human existence," that is imperative:

> … we may need to attend to the many complex variables that can influence the outcome of treatment for trauma and PTSD; we cannot assume that there is uniformity in the disorder, the client, therapist, or the therapy techniques. The reflexive response among therapists to apply their preferred therapies (e.g., cognitive-behavioral therapy) without consideration of the many other variables that determine outcome may well account for continuing problems we face in healing trauma and PTSD (e.g., Marsella, 2005). A complex healing calculus must be considered, and this is especially important across cultural boundaries when a score of intervening factors can impact outcome. (p. 23)

Marsella explains that his multidimensional "healing calculus" is comprised of many elements (See Appendix F), and advises a contextual approach to research and treatment:

> Although arguments can be made in favor of the progress that has occurred, problems in diagnosis, therapy, and prevention continue to exist. These problems can be found in both conventional psychiatric assumptions and models of care, and in the pursuit of ethnocultural determinants… it is necessary to adopt a multicultural and multidisciplinary approach… Marsella (2010, p. 24)

Families and relationships. One of the most important resources that participants have identified is relationship, especially family, and for some, a partner has been described as the reason they are still alive. The Families and Relationships Chapter follows this Treatment Chapter, and the theme will be explored in greater detail there, however the words of Perry (2009), explains that on a very basic level, preserving and protecting human relationships is sound post-traumatic stress treatment:

> For the vast majority of the last 200,000 years, humans have lived in hunter-gatherer clans in the natural world. The size of our living groups was small—40 to 60 people. These multigenerational, multifamily groups were the main source of safety from the dangers of the world. Our survival depended upon the ability to communicate, bond, share, and receive from other members of our family and clan. Without others, the individual could not survive in the natural world. Then, and today, the presence of familiar people projecting the social-emotional cues of acceptance, compassion, caring, and safety calms the stress response of the individual: ‘‘You are one of us, you are welcome, you are safe.’’ This powerful positive effect of healthy relational interactions on the individual—mediated by the relational and stress-response neural systems—is at the core of relationally based protective mechanisms that help us survive and thrive following trauma and loss. (p. 246)

Spirituality and joy. Larry Decker is a former clinical coordinator at a Los Angeles VA center whose research and writing has centered around the spiritual and existential aspects of combat experiences for soldiers as they transition. He explains that, as evidenced by the quote from the participant above who was not having his questions answered in therapy, some individuals need to fit their experiences into a framework that is more expansive than the one addressed by the gold standard offerings:

> But those acts that raised the soldiers on the battlefield are not conducive to adjustment to civilian life. As trauma therapists, we ask the veterans to return to their “shallow” lives and give up the meaningfulness of war in exchange for the mundane world of materialism. In addition, we may ask them to refute the meaning of war … (Decker, 2007, p. 33)

Decker's words explain that war changes individuals in profound ways, and these changes need to be integrated into their post-deployment, post-military concepts of self. In the newest trauma treatments, integration of traumatic experiences is the third step of treatment (Ogden & Fisher, 2015, p. 243). Sensorimotor psychotherapists and researchers Pat Ogden and Janina Fisher define integration, and we notice that once again experiencing the joy in life that participants are missing emerges as a goal:

> Our goals at this stage of therapy include taking up the tasks of growth and development, overcoming limiting beliefs and how they "live" in the body, navigating painful emotions, participating fully in work and relationships (especially intimate ones), and increasing joy and pleasure in life. (Ogden & Fisher, p. 249).

Once again, experienced clinicians indicate the need for a multidimensional approach to treatment. Additionally, Ogden and Fisher note the importance of "tasks of growth and development."

Life-stage congruent approaches to treatment. Daniel and Goldston (2012) have studied the effects of social support for individuals who use self-harming behaviors. They add their voices to the argument for treatment that is aligned with the life tasks and goals of the developmental stage that an individual is in:

> The context or precipitants of hopelessness and lack of connectedness varies across the lifespan. Each developmental phase across the lifespan presents challenges that may, in turn, prompt changes in one's view of self, others, and future. Indeed, patterns of suicidal behavior across the lifespan have been previously suggested to correspond to the primary developmental tasks and transitions associated with a given age period (Shiner et al., 2009). (p. 289)

The developmental context is acknowledged in research about returning Veterans (Bryan & Morrow, 2011) and is also important to participants, for instance one participant recognized that because he is a father of young adults, it was especially difficult for him

to see young soldiers in dangerous situations while deployed: “there wasn’t going to be a thing happen to her… and I was old enough to be all of their Dads.” Other mature participants have expressed the effects of being in the job market as older adults and being offered ‘vocational rehabilitation opportunities’ more appropriate to twenty-five year olds, while on the other hand, hearing “we appreciate your service, decorate you for your sacrifice and have promoted you in acknowledgement of your expertize.” Such incongruities affect the resolution of post-deployment experiences and their integration into the self-concept of a soldier turned Veteran, especially when the choice to become a Veteran was not part of the plan for how an individual was to end his career.

Participants have also expressed concern about being able to provide for their families in the long-term, with the limited financial resources that result from being medically released. Participant’s stories reflect how they recognize that, due to being medically released, their experiences in transition are often incongruent with the experiences of other individuals in their situations and life stages who are not lacking financial and career-related and relational resources needed to fulfill family responsibilities, and who are not retraining in middle-age. Daniel and Goldston (2012) explain the psychological ramifications of this:

> For many individuals, energies during the middle adult years are devoted primarily to two sets of commitments—those related to success or development of competence in the vocational area, and those related to successful negotiation of relationships with partner and family…. These tasks may be a primary source of social integration or connection during the middle adult years … and help provide a purpose for living. In addition, the middle adult years are often a period of reflection—a period to examine where one has been, and how one's trajectories or accomplishments measure up against prior expectations…. This reflection may result in a reevaluation of priorities, goals, and prior expectations… For many individuals, the period of the middle adult years is characterized by stability and well-being… (p. 291)

The incongruities reflected in the participants' situations *are* the contexts that affect their treatment. These contexts need to be considered and understood by therapists working with medically released Veterans, in terms of therapeutic processes, methods, and goals but most importantly in therapeutic relationships. Participants have explained that they need treatment that is multidimensional, connected to a trusted network that is respectful of their culture, their agency and the importance of their relationships. They value committed and caring helpers who collaborate with them to meet their individual needs and who know how to navigate the complicated transition system with them.

Relational, connected approaches that understand post-traumatic effects as more than cognitive distortions in one individual, are exceedingly promising treatments. They exist, not only in the areas of body-based treatment methods, but also in family-focused practices (Westwood et al., 2010), and practices that address spirituality and ritual (Decker, 2007; Brave Heart, 1998). These models are culturally sensitive; they combine the understanding generated by RCT research with a holistic outlook, acknowledging the needs of individuals to heal together in groups and families (Bussey & Bula Wise, 2008; Decker, 2007; Miller, 2002, Shay, 2009). Increasingly, therapies now regularly incorporate mindfulness (Foster & Kelly, 2012; Amaro, Magno-Gatmaytan, Meléndez, Cortés, Arevalo, & Margolin, 2010; van der Kolk & Najavits, 2013) due to the realization that mindful practices help to literally reconnect the trauma dominated survival-based parts of the brain with the 'future and relationship focused' cortical areas. Bessel van der Kolk explains:

> What we see is that the parts of the brain that tell people to see clearly and to observe things clearly really get interfered with by trauma and the imprint of trauma is in areas to the brain that really have no access to cognition. So it's in an

> area called the periaqueductal gray, which has something to do with the sort of total safety of the body. The amygdala, of course, which is sort of a smoke detector, alarm bell system of the brain that's where the trauma lands, and trauma makes that part of the brain hypersensitive or renders it totally insensitive…. Broca's area, which is sort of the part of your brain that helps you to say reasonable things and to understand things and articulate them, shuts down…We can talk till we're blue in the face, but if our primitive part of our brain perceives something in a particular way, it's almost impossible to talk ourselves out of it which, of course, makes sort of verbal psychotherapy also extremely difficult because that part of the brain is so very hard to access…I think we are really beginning to seriously understand how human beings can learn how to… observe and not react. (van der Kolk, 2014, audio file)

Although the lived experience of individuals with post-traumatic stress has been largely ignored in research until now, this is changing as context-specific treatment that includes the input of soldiers is being proven to be effective (Westwood, McLean, Cave, Borgen & Slakov, 2008; Bryan & Morrow, 2011).

The problem is that the system is out of balance, weighted heavily toward the medical model and away from interventions and therapies that are difficult to measure. There is however, as with any living system, evidence of a tendency toward balance (homeostasis); the most promising and latest research on attachment, relational therapies and neuroplasticity, provides an example of this and once again affirms the importance of connection in the treatment of PTSD.

Success in Treatment: Assessment

Initial assessment in post-traumatic stress usually answers the questions ‘what’s wrong?’ and ‘wrong’ means not meeting some definition of what ‘normal’ is. Participants have used absolute terms to express how far from a standard of normal they sometimes have felt: “100% broken”, “I am completely paranoid”, “I always feel dirty and germ infested.” These words indicate that at times, their experiences were seriously

painful and disruptive to their lives. The struggles of post-deployment soldiers must never be sidelined or minimized by an academic discussion, however, as with the other themes, the influences of the dominant systems and their attendant policies and constructions need to be considered in order to reveal how they add to the problem, and consequently, how this can be changed according to the Veterans' ideas.

In the Culture Chapter (p. 115), the influence of military expectations upon soldiers' identities and treatment-seeking behavior was discussed. These factors also contribute to what is seen as normal in this culture: as Marsella and Yemada, (2011) explain: "Culture determines standards of normality, deviance and health." Cultural determinants of health in the military are co-constructed by the medical model and military culture. This influences working systems, including training of professionals, diagnosis, treatment protocols and assessment models.

The medical model describes best practices for assessment as the use of a combination of standard protocols involving clinical interviews and checklists such as the broad PTSD Check List (PCL), and the Clinician Administered PTSD Scale (CAPS), which are designed to be administered by qualified mental health professionals. In addition to these, behavioral observations and physiological measurements of reactivity are included in order to: diagnose according to the 'seventeen cardinal symptoms' of PTSD specified in the DSM; monitor progress in treatment (clinically meaningful change); identify comorbid and associated conditions, and to facilitate "Comp and Pen" (compensation and pension) decisions about levels of disability and dysfunction. Although the measures are designed in part to quantify subjective experiences, the results can be interpreted

according to either lenient or stringent scoring scenarios where cutoff scores are chosen with respect to what the results will be used for (Keane, 2015).

The model of assessment for post-traumatic stress in the military is designed to be used in an objective manner, however it is largely based upon self-report measures, and includes a degree of latitude for interpretation by the mental health professionals who score the measures. Additionally, not all mental health professionals who work with military clients have the same capacities to understand and contextualize the experiences that Veterans speak about during assessment and treatment, and this is influential as one participant previously explained:

> Yes- military mental health professionals- my experiences, and the persons that went through at my time frame, from my unit, had similar experience, but we all seemed to think that there was again- two hoppers, or two categories: if you saw a military mental health professional, they were very reluctant to diagnose you with a condition- or they did not have the experience to diagnose you with a condition, or-they thought that your view was a normal view for a person that experienced what you experienced, or those type of experiences, and that you'll get over it, and if you don't: "We're always here, come back and see us"- and away you go. The civilians that were employed in OSIS were aghast and shocked at some experiences that we had.

As described in the Covenant Chapter (p. 70), because of the CAF policy of Universality of Service, soldiers understand that to answer assessment questions in a way that identifies a need for help puts their career in jeopardy. The approved assessment protocol explained in the previous paragraph was summarized from a training video on assessment on the USVA National Center for PTSD DSM-V section on validated measures for professionals; it clearly indicates that the scoring methods are subjective and influenced by whether they are intended for diagnosis or compensation. This raises the possibility that they could be interpreted in light of the historical 'suspicion of malingering' that pervades the history of post-traumatic stress, especially when

influenced by neoliberalist cultural values, which emphasize measuring in terms of fiscal restraint. Soldiers are aware of these factors, and once again, in the assessment stage of medical release, they are at the bottom of the power structure that makes decisions about their futures. The ramifications of assessment for transitioning soldiers are serious; they understand this, perhaps more than some of the health professionals that are assessing them do, as one participant explained:

> A lot of us had to explain a lot of our experiences, and that some of it we accepted as normal, some of it we were like: "Wow that's not normal." Then there's the whole value-shift: what was normal in Canada and what was normal in theater, and how people process that…

"*How people process that*"…. this is an essential element of treatment! It is this quality that determines the course of wellness and integration, even more than the trauma, or how we agree to describe it. The *sense* that an individual is making of his or her experiences is where we look for clues to successful integration of overwhelming experiences; for this reason it is the third (concluding) step of trauma-informed treatment (Dass-Brailsford, 2007, pp. 58-60). The participant quoted above has named the ultimate assessment tool: the Veteran.

Resistance: Healing and Strength

The following excerpts from participants' stories are combined with commentary from some of the foundational and leading therapists and researchers in the field of trauma treatment. They illustrate that participants are experiencing healing on a number of levels, some of which match DSM criteria for PTSD, and some of which are part of an expanded version of healing, one that addresses issues beyond the limited definition of the 'disordered' medical model view.

One participant alludes to his experiences during the Bosnian War:

> P: - there's a lot of things that the Serbs did; logic that was normal to them, but way beyond our mode of comprehension
>
> D: That was the genocide part right?
>
> P: Horrible. Yeah and we'll just never understand that- we won't.

This participant also served in Somalia and Afghanistan, where he had additional horrifying experiences that would undoubtedly satisfy the DSM description of overwhelming events. In his discussions about what draws him forward toward the open-minded stance that he exhibits in the quote above, he explains that the sense of connectedness with people who he might not even know, helps "neutralize" the effects of his witnessing what he did:

> I think those people that travel- I think travelling is a good way to neutralize those biases and those hatreds, cause you get to see and appreciate, or let's hope you get to appreciate- what other cultures, how they've gotten to where they are, whether through geography or politics or warfare, and I think the more we travel or the more we have our minds open to other people on the planet- and the planet's pretty small, then your understanding or your level of hatred just diminishes- that's what I think…that's strange for somebody to say that I suppose …is in uniform- but at the same time we live in a country that has such an outward look on the world because we're such a mixed culture of people, we are all connected. You just have to go anywhere in downtown Toronto and its like a hundred different cultures and cultural corners in the city that let you know that: "Wow, the world is terribly small.

The understanding described by the participant above reflects the treatment goals of Acceptance and Commitment Therapy (ACT), a mindfulness and cognitive-based therapeutic method that is challenging the stranglehold of Prolonged Exposure Therapy on treatment (Thompson, Luoma & LeJune, 2013). The goals of ACT are to improve entrenched thinking about past events and beliefs about self, increase experiences of being in the present, and guide goals and behavior with commitment to personal values.

In order to accomplish these goals, ACT theory draws from Buddhist principles of compassionate self-awareness and mindful attention on the present moment, an integration of approaches which is being described in current research as highly effective (Reber, Boden, Mitragotri, Alvarez, Gross, & Bonn-Miller, 2013).

Steele, van der Hart and Nijenhuis (2005), describe another treatment goal in terms that address the dissociative aspects of post-traumatic stress, in another example of the importance of connection, in this case temporal connection:

> Another related, but higher level integrative mental action is realization, i.e., the degree to which individuals become consciously aware of the implications and meaning of their personal experiences. Realization implies the degree to which closure of an experience is achieved (Janet, 1935; Van der Hart et al., 1993). It consists of two mental actions that are constantly maturing our view of ourselves, others, and the world: personification (Janet, 1903) and presentification (Janet, 1928a). Personification involves integrating the synthesis of an experience with an explicit, personal sense of ownership: "That happened to me, and I think and feel thus and so about it." Presentification is the mental action of being firmly grounded in the present and integrating one's personified past, present, and future. It manifests in acting in the present in the most adaptive, mindful manner. (p. 23)

One participant, in response to questions about how he copes with the difficulties posed by the transition system explained that he has reached an understanding of his experiences that meets the description of mentalization:

> Yeah I think about it on occasion, yes it comes back and bugs me, yes I just beat it back down and say: You know what? It happened, it's not happening, it happened, it's not who I am.

Fisher (2009) teaches that when this type of integration can happen, then trauma is processed. She explains, just as the participant above does, that trauma is not a forgetting or extinguishing or even an unlearning, but a reorganization of the individual's relationship to it, a "renegotiated sense of identity."

Steel et al (2005) expand upon this and indicate that this understanding has much to contribute to trauma therapy: "This last stage is much more process-oriented and will occur over a period of time. It is often a crucial missing link in the treatment of traumatic memories, as some therapists view the "retrieval" of memory as the end of the process, whereas in reality, it is merely the beginning of a difficult and longer course." The same participant expresses the idea in his own words:

> As you move on that curve you see yourself in different lights. You initially see yourself as broken, starting to heal, and hopefully at the end of it coming out stronger from that experience.

Steele et al (2005) write that advances in therapeutic work with clients involve an awareness of the ideas and meanings that client and therapist 'project' onto each other: "transference and countertransference responses must be meticulously managed" because "Such information will also be of relational value, as the patient begins to experience the therapist as someone who offers helpful information rather than as a withholding authority figure." Ogden and Fisher (2015, p. 49), add that when we can manage our own projections we have mature, authentic interactions that are a sign of increased capacity to integrate traumatic material. A participant recounts how he withdrew his preconceived ideas about what therapists are like, and that this has contributed to his ability to participate in an effective therapeutic alliance with his therapist:

> Well we talk about just regular every day things for 10-15 minutes and then we get down to feelings, attitudes, perceptions, emotions.
>
> D: Talking about them?
>
> P: Yes.
>
> D: And that's helpful?

> P: Yes it is actually- I was very sceptical at first, and very guarded and tried throwing them off by… with this stupid attitude of being like an alpha male. It's really, I don't know.
>
> D: Umhum, and at some point you decided you…?
>
> P: I'm a grownup now- literally, and I recognized that these people had a sincere hope that I would…chitchat with them long enough for them to make a difference.

Fisher's (2015, webinar) explanation of the philosophy of Sensorimotor Psychotherapy to student therapists outlines the need to respect individual's agency, the multidimensional nature of traumatic injuries, and the intent not to retraumatize that are the hallmarks of respectful therapy:

> …it helps to keep in mind that the "answer" in trauma treatment is not remembering what happened but the ability to be "here" instead of "there:" to be conscious and present in the here-and-now, to tolerate the ups and downs and the highs and lows of normal life, and to heal the injuries caused by the trauma—the injuries to innocence, to trust, to the heart, to faith—the injuries to the body and the injuries to the heart and soul. Remembering the past is helpful only to the extent that it helps to heal rather than re-open the wounds, and therefore remembering can only be helpful when the patient has learned to choose how, when, and where to remember and when she can remember rather than re-live the trauma.

Once again the words of a Veteran participant about the eventual course of post-traumatic stress echo those of a veteran researcher and therapist:

> So, yeah it's weird, but you just don't feel like you fit in, but eventually, I think after a time, if you got back to work and you just get into the routine, I think most people will figure it out that 'here' is not 'there'; and you can relax and you can start to let go, and you can start to feel that: "Ok, whatever happened, happened, I'll just chalk it up to experience and I'll carry it with me, it's part of now who I am," I got that, but it doesn't have to be 'who' I am.

Participants' examples of healing are encouraging, however the reality for soldiers is that once they are assessed and diagnosed with a mental health disorder, they lose their

careers and their status as members of the CAF. Despite the courageous and remarkable healing and capacity that they describe, they will never lose the diagnosis or regain their careers.

Common Ground

Boudreau (2008) advises counsellors and others who want to help, to be ready to listen to Veterans' stories that may make them uncomfortable and require that they face unsettling questions:

> … they can stand in silence acknowledging the veteran and what he's done, but they'll never be able to help him until they acknowledge why he did it. He's saying, "I want you to get to a place where you can believe, really believe, that the troops *are* more important to you than the mission, that the people in your world *are* more important to you than this fucking war and all that it provides you. War did this. Now why do we have to have war? (p. 213)

Boudreau is describing a situation in which he would feel connection (you are one of us, you are welcome, you are safe, (Perry, 2009, p. 246)), and attunement, ("she knows who we are, she knows what we are" (participant) in the context of a society that takes responsibility for its decisions, when soldiers are sent to fight wars and when they come home. He is also extending a challenge to therapists to work in ways that require them to step into a sense of vulnerability along with their clients and challenge the status quo of standardized, manualized programs. The new way is much more human, involving the dissolution of barriers between client and therapist, requiring the courage of the Veteran in sharing a story that s/he would like to be able to forget, and the attuned presence of the therapist in hearing it without what Boudreau calls "branding" it inappropriate because it is difficult to hear.

Boudreau (2008) explains that after his own transitional experiences, he learned the name of the quality that makes a difference in treatment and also, he learned that Veterans know how create this quality together:

> I have listened to WWII, Korean, and Vietnam vets. I've listened to Gulf War vets. I've listened to Iraq and Afghanistan vets, too. And in all the stories from all those vets, I couldn't help but notice one conspicuous trait that ran faithfully through them all. It was empathy. (p. 214)

Schore and Schore (2008) explain how this works from an attachment perspective in treatment:

> Implicit right brain-to-right brain intersubjective transactions lie at the core of the therapeutic relationship. They mediate what Sander (1992) calls 'moments of meeting' between patient and therapist. Regulation theory thus describes how implicit systems of the therapist interact with implicit systems of the patient; psychotherapy is not the ''talking'' but the 'communicating' cure. (p. 14)

This level of respectful communication and connection is not apparent in the narrow treatment systems offered to transitioning Veterans presently, it is impeded by the entrenched power imbalances between client and therapist, and rendered impossible by the ramifications of asking for help in the military. The present system is too narrow and based upon a mindset which does not foster the level of trust and collaboration necessary between clients and their therapists, for the reconnection of returning soldiers, as van der Kolk (van der Kolk & Najavits, 2013) explains:

> When you think about it, our diagnostic system is based on a strange paradigm, something like: "I'm healthy and you have a disorder and I'm going to apply this evidence-based treatment to you and after that you will be just as healthy as I am-disorder free." In reality of course, we fundamentally live in the same boat. (p. 522)

Shay (2009) names the missing element in the present model: "…recovery happens only in community. That is, the community of other veterans in the program, is an essential ingredient of the healing work… to a combat vet this is other vets- they heal

each other." Boudreau (2008, p. 208) speaks of how he re-connected with a sense of community upon his return from Iraq after he heard some Vietnam veterans speak at a school:

> I listened to them talk about the fear… about the indescribable concussion of the impacting explosives, about the helplessness, about the guilt, about the anger, and I knew at that moment that I was not alone after all, that we were truly connected...We can save each other's lives... The aftermath is our common ground.

Conclusion

Working with Veterans who have been disconnected from their identities, resources and relationships, and then further disconnected by the systems that have released them, requires knowledge of how these systems have added to their injuries, the empathy to engage with them, the understanding that they have great healing capacity, and that this capacity needs to be acknowledged at the policy-making level by including them in decisions about how they are reconnected. The work of feminist therapists addresses the pathologizing of post-traumatic reactions and respectfully acknowledges behavior associated with post-traumatic stress, as an intentional and intelligent survival strategy used to manage distress signals that indicate that there is something needing to be addressed (symptoms). These models recognize the shame inherent in relationships with large power differentials where 'failures of care' result in adaptions that are considered by other treatment models as co-morbidities. This understanding constructs attempts to "down-regulate" chronically hyper-aroused animal defence systems as options for coping when there are no others (Fisher, 2015). This work is compassionate, challenging the use of intrusive methods that are not multidimensional enough to support the changes that occur in individuals who have experienced overwhelming loss and horror. These changes

are not necessarily pathological; they have the potential to foster personal and spiritual growth, but they happen in the context of a transition system that has no provisions for this expanded self-concept and only provides in a narrow manner for a pathologizing understanding of this sense of a changed self.

Chapter 10: Families and Relationships

This chapter will consider 'military families,' which are embedded in the context of the military as family. The paradox of the ideal of the 'military as a family' and the policy that dictates that members will be medically released when they are injured has been discussed in the Covenant Chapter of this study. Family and partner relationships are the relationships that participants have identified as most precious, and as their biggest resource in times of trouble, which is highly significant in the consideration of Veterans' transitions. Siegel (2012, pp. 33-35) recognizes the effects of relationships on ultimate psychological wellbeing and encourages us to see relationships and the brain together, as the underpinning of a healthy, resilient mental life. Siegel is describing what is possible when partner and family relationships (attachment relationships), are strong, responsive and supportive, and this aligns with participants' wishes to reconnect with the "fundamental source' of the joy of living: relationships.

Equally as important as stories valuing family and partner relationships are stories about how they are being put at risk. Some of these have appeared in the discussions of other themes, for instance in the Covenant Chapter (p. 70), and the Stigma Chapter (p. 143); others will be recounted below. In this section we will explore aspects of military culture that particularly affect attachment relationships, including ethics such as 'mission first,' and 'secrecy, stoicism and denial.' We will also explore the military's empty rhetoric about the importance of families, and how that isn't translated into comprehensive support. The pervasive effects of stigma on post-deployment problems have been discussed previously, and will again be focused upon in this section as they

affect military families. We will explore the case that too often, the responsibility for 'keeping things together,' has rested with soldiers' partners, and also look at the problems that occur when treatment focuses exclusively upon the soldier and excludes his or her children and partner.

The consideration of family and partners dictates an understanding of the effects of the attachment relationships that participants mentioned. All participants who spoke about partners were referring to women and so we look at the discourse of the military wife in order to understand how participants' stories of relationship confirm and challenge this pervasive archetype. Participants have spoken about the influences of their own parents on their transitions and about their own effects on their children, and this concern will be taken up in the discussion of intergenerational trauma, the pervasive effect of unresolved trauma that lives on in future generations.

Through out the discussion, as in previous themes, the work of veteran researchers about the importance of attachment relationships in connected, relational approaches (those that include family members and acknowledge the importance of secure attachment for resilience and healing) to post-deployment adjustments and the effects of being medically released will be considered alongside the words of military Veterans and soldiers.

Strong, Resilient and Innovative: Military Culture and Family Life

The military values of service, dedication to duty, and camaraderie, can call forth great resilience on the part of all family members, as the military family community comes together in a variety of ways to provide a safety net for each other in times of

need. Conversely, the values of secrecy, stoicism, and denial can isolate families from support networks and from each other. Family life in the military is centered around the need to maintain some kind of schedule and structure while a parent is occupied with a mission, and to navigate the repeated 'hellos and goodbyes' and the worry inherent in the deployments and the frequent moves that are part of military life. One participant explains this and credits his wife with qualities that enabled his family to manage his long absences:

> …during the whole time I was away training. I left home in summer 2007, I came home at Christmas 2008, I mean I was home a couple of times through that period…
>
> D: That's a long haul alone with the kids.
>
> P: With all the extra training you have to do and mission specific training you have to do, and then the deployment factor itself... well first of all she is a very strong, resilient and innovative person, but what if she hadn't been?

The 'middle-class family life-style,' which is what Veterans are asking for in the Equitas challenge described earlier in the Covenant Chapter (p. 70), include an active, happy family with children who have experiences of secure attachment that allow them to develop their potential, a stable home, connection with extended family, and a sense of community in a benevolent society. For military families, this ideal is a challenge to maintain during peacetime, but during and after deployments such as the soldiers in this study have participated in, the added stress to 'keep it all together' both inside and outside the family home, can be extremely difficult. The participant above raises a valid question: "…what if she hadn't been" strong, resilient and innovative?

Post-deployment and transitional military families may experience further stress due to the interaction of the culture and the stigma around post-traumatic stress and its

associated problems. Hall (2011, p. 13) describes this as the shadow side of being in a military family and characterizes it as "living in the Fortress." When a returned soldier remains in 'battlemind' (Sayers, 2011), using the reactions and skills that kept him or her alive while deployed, (previously, a participant has described it as "being on the edge of aggression"), such a climate can occur in a family. If this happens, and a partner and parent can't talk about what has happened during deployment, only talks to his or her peers, feels the need to maintain control above all, and cannot seek help due to the effects of stigma, a family's secure attachments are put at risk (Ray & Vanstone, 2009; Basham, 2008). Partners seeing the effects of post-traumatic stress on their loved one may feel responsible for managing the atmosphere of the home to accommodate the high or low emotional arousal and reactivity of a soldier who has been changed by deployment experiences in ways that are profoundly unsettling for the whole family. Children may feel responsible for a parent's distress, or, depending upon their age, have other reactions as they watch their parents navigate the physical and mental health and vocational problems of transition. Overshadowing all of these issues, is the understanding that all family members live with: asking for help and talking about the fact that something may be wrong is antithetic to the culture of 'contain and control' and dangerous for the career of the soldier upon whom their wellbeing may depend (Lincoln & Sweeten, 2011; Hall, 2011; Williamson, 2012).

Couple relationships may need to be 'renegotiated' as family dynamics change in response to transitions after deployment (Basham, 2011, Sayers, 2011). Changes in roles, necessary during deployment, need to be re-evaluated and integrated into a new family structure upon a soldier's return and transition, which can put relationships under great

stress and in danger of breakdown (Shaw & Hector, 2010). The deployment of military family members has been shown to reduce the social networks of the entire family, and contribute to isolation from extended family and community (Howell, 2011, Westwood et al, 2010; Shaw & Hector 2010) creating conditions which increase the possibility of interpersonal violence (IPV) or domestic violence and abuse (DVA) (Kwan-Lafond, Harrison, & Albanese, 2012). This also raises the possibility that children will witness violence in the home, and may result in the transmission of intergenerational trauma (IGT), (Smith-Osborne, Wilder & Reep, 2013; Campbell, Brown & Okwara, 2011).

All of these problems exist within the context of the present transition system, where, when Veterans reach out for assistance and information, often after keeping things together for as long as they are able, they can find their attempts for connection and aid met by an automated voice messaging system which refers them to a website, that directs them to download and submit forms electronically. Such 'human absent' treatment adds insult to injury during transitions, and the effects of coping by containment and control, compartmentalizing and isolation, combined with the anger, anxiety and sadness that are natural reactions to war, are often witnessed by or focused upon the people who *are* present with the soldier: their families.

Medical release versus attachment relationships. Medical release from the military has the elements of an attachment injury; soldiers experience it as a betrayal of trust within a close relationship, and a rupture between them and the source of a 'secure place' in the world, as a participant explained:

> P: …that leads to a whole dynamic among your peers and/or your superiors. …and unfortunately… I equate it to the breakup of a significant other, you might have the best intentions, but eventually there's going to be a wee bit of hurt

> feelings on both sides. It's unfortunate… folks I had known and soldiered with for twenty-odd years, all of a sudden had a different view of me.
>
> D: And you could feel it.
>
> P: Oh absolutely, and I'd say, "Listen boys, I've been at the table man, I've touted the line, I've expounded the rhetoric, I know the game, right? Hey man, it's still me … but I digress. That happens in any…

The military has created the expectation of a secure relationship and continuing safety and care for its troops, and the present transition system has created failures of this care. The elemental steps in building and maintaining a secure attachment: attunement, disruption and repair (Prenn, 2011), mirror the steps of a positive transition from military life to civilian life, and because of this, attachment theory is an appropriate framework from which to understand the disconnection and reconnection of both soldiers and their families during transition (Basham, 2011). Additionally, Chafetz (2015, p. 2) explains that attachment theory provides new and expanded ways of understanding adult trauma-based problems, which can't be understood by neurobiology alone, but must be illuminated by an individual's experiences in the context of their relationships.

According to attachment theory, a secure attachment relationship is created and strengthened as disruptions in care and attention are continually repaired. In childhood, this process re-establishes the security and sense of trust necessary for an individual to explore and learn new ways of 'doing and being' in the world (Ogden, Minton & Paine, 2006, p. 114), which, remarkably are the goals of a successful transition such as this study is concerned with. During transition, the disruptions of normal military life (repeated moves and separations) can be exacerbated by more critical post-traumatic stress and 'relational' injuries including higher than normal rates of divorce, suicide and

interpersonal violence (Jordan, 2011). As mentioned in the Treatment Chapter (p. 197), according to the medical model used in the military, these problems are treated in isolation from each other and often from military culture, and they are addressed with cognitive methods instead of relational methods (Sayers, 2011; Basham, 2008; Westwood et al, 2010).

Kathryn Basham is a social work professor and senior researcher whose work relates to the effects of deployment and combat stress on the re-integration of service members, Veterans and their families (Smith College, n.d.), has spent her career investigating the effectiveness of trauma therapy for military families, and now advocates for a treatment approach grounded in a combination of neurobiology, attachment, and trauma theories. Dr. Basham explains the rationale for such a synthesis in the treatment of military families experiencing difficult transitions:

> Recent theorists have suggested this relational process can be conceptualized as a ‘‘circle of security’’ (Marvin, Cooper, Hoffman, & Powell, 2002), in which a child moves from secure base to exploration and then back to a safe haven following a rupture. Contemporary theory and research recognize the interconnections between attachment (i.e., careseeking or proximity seeking), caregiving (i.e., offering a safe haven), and exploration for adults as well (Feeney & Collins, 2004; George & Solomon, 1999). Similar to children, an adult's attachment system is activated in times of stress or novelty, and adults turn to their attachment figures to alleviate this distress and regulate their affect (Hazan, Gur-Yaish, & Campa, 2004). Typically, a partner or close friend serves as the preferred attachment figure for adults… Based on research about adult attachments, secure adult relationships are characterized by the capacity to relate to others in a mutual reciprocal manner, to provide coherent narratives about relationships, and to sustain continuity of connections (Basham & Miehls, 2004; Hesse, 1999). (Basham, 2008, p. 84)

Dr. Basham's philosophy aligns with what participants have explained; that their attachment relationships are the most important sources of strength and healing they have

available. Participants' answers to my questions about their own support systems confirm this:

> P: My family, my best friend, certainly my psychiatrist and my therapist- my family probably more than everything. It's not like they're overtly in the support mode: "Aw Dad, here let me get you that, your knee must be bad today" or "Dad, I'll speak a little louder cause you lost your hearing overseas," it's not that overt but they've always been there. They always will be.
>
> D: Well, you talked about your 29-year marriage, first of all.
>
> P: Right- with the same person.

Another participant:

> P: Well … one of the reasons why I love my wife so much. If there's anybody ever could knock the winds out of my sail it's her; she'll never let you put yourself on a pedestal and think you're better than anybody else, let me tell you. God love her, she's a good … woman, and I have to admit she's put up with a lot.
>
> D: Yeah- she was the first person you mentioned around you.
>
> P: Well I actually owe my life to her- literally. I can easily say that hand on heart.

Once again, Veterans and veteran researchers are in agreement about the importance of family as a crucial resource with respect to transition problems, and once again the military and the transition system is 'out of synch' with this thinking. In the Covenant Chapter (p. 70) it was explained that the CAF is not honouring its end of the agreement with soldiers, instead, the military's investment in soldiers and their families is restricted to maintaining the fighting force without consideration of the consequences of this beyond an individual's usefulness to the military. Hall provides an example of this paradox, in which the part of the soldiers and their families is understood, and the commitment of the military to families is exemplified in its empty rhetoric:

> Unlike most civilian occupations, with certainly a few exceptions such as the police and firefighters, the military is a world set apart from the civilian world

> because of its constant preparation for disaster. This constant preparation for disaster …places a great deal of pressure and stress on the military family. "Military readiness is like a three-legged stool. The first leg is training, the second equipment. The third leg is the family. If any of these three legs snaps, the stool tips over and America is unprepared to defend herself… (Hall, 2011, p. 13)

A Family-Friendly Climate

Coulthard, (2011) in a CAF report on The Impact of Deployment on the Well-Being of Military Children, uses language that interprets family problems as an objective phenomenon, only "indirectly linked" to the organizational interests of the military:

> Overall, it is clear that the issues and well-being of military children have indirect linkages to the organizational outcomes of the military. As such, it is therefore important that the military seek to foster a positive and family-friendly climate in the organization and provide support to military families in order to help them successfully adapt and meet the demands of military life. It is clearly in the best interests of the military institution to actively seek to promote and foster positive separation adjustments among the children of deployed military parents. (Coulthard, 2011, p. 2)

Consideration of a family-friendly climate is in service of organizational outcomes; it is to be attained by the 'positive separation adjustments', a term that attachment theorists may consider to be an oxymoron unless these are accompanied by more effective 'repairs' than has been the experience of military families.

The practical, emotional and psychological implications of this were pointed out at the Veterans Affairs Ombudsman's meeting (described previously in the Stigma Chapter (p. 143) recently by military spouses who waited to speak until after the Veterans had been heard. All of the partners were women; they sat together in a group, at the back of the meeting and presented an organized list of points that they wished to bring to the attention of the Ombudsman. In some cases, they addressed the flaws in the system, just as the study participants did, and these concerns ranged across all of the study themes.

The partners explained that Vets who had divorced needed to give permission for their families to have medical support and that some Vets are not able to make helpful decisions about this, which results in families going without care. They also voiced concerns that private-sector outpatient treatment in the new for-profit trauma centers (e.g. Trauma Healing Centers) for which VAC will pay, was being delivered by individuals with "no qualifications." Other concerns addressed the lack of support for spouses who often needed to leave a paying job to be caregiver for an injured partner. They stressed that there is no respite for caregivers, indicating: "When it's crisis to crisis, there needs to be somewhere for him to go," and explaining that their partners were told at a nearby OSI treatment facility: "If you're not going to kill yourself you have to go home."

This dismissive attitude about families is duplicated in a recent American study about multiple deployments, which referred to 'family and occupational problems' together as "homefront stressors," which could put soldiers at greater risk for PTSD (Interian, Kline, Glynn & Losonczy, 2014, p. 90).

In addition to the limited focus of research about the health of families in the Canadian military, its scarcity indicates that the wellbeing of military families hasn't been a priority, in fact Kwan-Lafond et al (2012, p. 165) indicate that in military organizations "violence against women is minimized and legitimized." According to a 2009 CAF study on families there needs to be more quantitative (focusing upon counting) research in order to determine the *prevalence* of familial violence as compared to that in civilian society, as opposed to the *problem*:

> [*due to*] …little scientific research …focused on Canadian Forces (CF) members and their personal relationships, and only limited quantitative research … on the incidence and prevalence of family/relationship violence. It is unclear… the extent to which this is an issue in the CF and whether the military exhibits higher

> or lower rates of violence in comparison to the general population. (Sudom, 2009, p. 3)

Williamson indicates the same lack of knowledge about this important issue in the British military, despite high levels of concern about domestic violence and abuse (DVA) from practitioners working with military families, including police, educators, children's services, health and military welfare services. In Canada, a large-scale VAC research endeavour, designed to 'fill gaps in the understanding of military to civilian transitions', the Life After Service Study (Veterans Affairs Canada Research Directorate, …2011), is essentially a one hundred and three-page survey document, which mentions families only as an item in a questionnaire (married or not? pp. 25, 71) that asks about demographic characteristics of respondents. Families and family problems are not included among the 40 items considered as determinants of health (their Appendix 1) in this study, which is described as a resource for Canadian and other militaries. Divorce, which literally breaks families apart, and is more common in military couples than civilian, according to Canadian researchers Ray and Vanstone, (2010), received a very small mention and was discussed only with regard to the inability of the study design to determine the *directionality* of its influence on transition, that is, whether this "potential confounder" of the data (p. 72) was as a result of the transition, (positive) or whether the transition was unfavourably influenced by divorce (negative).

There is, however, research that shows that intact family systems are highly supportive for men of similar age to some the participants, who experience problems associated with post-traumatic stress:

> Relationship breakdown is more likely to lead men…to suicide. Men rely more on their partners for emotional support and suffer this loss more acutely… Men are

> more likely to be separated from their children and this plays a role in some men's suicides. (Samaritans, 2012, p. 2)

For some Veterans, the loss of the family home becomes a serious problem, and is often part of the downward spiral that occurs as the result of divorce or restricted income after release from the military. This problem has been considered to be grave enough, that it was addressed in an American Psychiatric Association (APA) publication dedicated to advancing standards of service and promoting research and education in the field of mental health; as illustrated below, an integrated approach, which involves families, is advised:

> Together, outcomes such as homelessness and suicide and other forms of premature death among veterans…Recognizing the problem, VA has implemented a campaign to end homelessness among veterans that includes a number of important programs. In one such program…. a housing first strategy… that prioritizes access to permanent housing … to address the needs of veterans and families at imminent risk of homelessness... (Katz, 2013, p. 1)

Attachment systems versus survival systems. Although families may not be a priority for the military, they are for Veterans; the importance of connection to family has proven to be the 'final straw' that gives individuals a reason to finally overcome the barriers to seeking care:

> Much of the time, withdrawal from family members and close friends becomes the catalyst for a person who is experiencing PTSD to seek assistance. In other words, the person will subjectively know that something has changed at a core level, but he or she may go for years without seeking help. (Quinn, 2008, p. 468)

The barriers mentioned above exist in the culture of the military and also in the minds of individuals experiencing post-traumatic stress. Such individuals may be bound by an 'unending mission to survive,' constantly triggered by danger signals that are not always recognized by those around them who have not been to war. This thinking is survival-based and unconscious, facilitated by the most rapid processing the human brain is

capable of, and expressed in defences and behaviors associated with strategies such as anger, avoidance and withdrawal or emotional numbing (Ogden & Fisher, 2015, p. 180). These cognitive and behavioral patterns are the antithesis of the affiliative thinking and nurturing behavior that forms and maintains strong, secure attachment relationships (Basham, 2011). Sometimes these patterns lead returning soldiers to believe that they are dangerous to be around, that daily life is dangerous, or that only their comrades can understand them, all of which can result in withdrawal from family members and to lack of treatment.

When families are unsupported in this time of profound change, it can lead to the further fragmentation of relationships characterized by intimacy and caregiving: partner and parent relationships. More promisingly, when survival and attachment systems meet in a family situation, and families are supported, there can be great potential for healing the disconnection resulting from post-traumatic stress. Basham (2008, p. 87) explains that although: "Combat exposure is one of the greatest stressors a person can experience in life," in a treatment model with military couples which prioritizes the need to build a safe and secure, attuned family situation in which "nobody comes second," the effects of trauma, can eventually be integrated into a stronger relationship. Judith Siegel (2013) explains that when couples who have experienced IPV and intend to remain in relationship are not seen conjointly in treatment, they often deny the problem, fearing the breakup of their family. This is a valid fear, because historically, Siegel explains, men's treatment for domestic violence has consisted of CBT group psycho-education programs, while women's treatment has been focused upon parenting education, resilience, anxiety and depression, often conducted in women's programs focused on safety. Siegel

advocates for family and couple-centered approaches that increase emotional attunement, mentalization and grounding skills in an effort to reduce the climate of tension and increase feelings of safety and trust for all family members. Because research shows that the attachment style of the caregivers (Siegel, D., 2013, personal communication, An Interpersonal Neurobiology perspective on trauma, child development and wellbeing, Charlottetown, PE, July 2-3), especially the primary caregiver, predicts the attachment style of children, a safe, secure home is paramount for all families. With consideration of the special circumstances of military families, a secure base, combined with renewed understandings of partnering and parenting, can ease post-transition reconnections within families and eventually to community. Basham explains that this constitutes the repair phase of the attachment cycle:

> This process helps them restore more equanimity in their internal working models of attachment. As couples progress and heal, partners often describe experiences of an increasing sense of inner security and safety along with an increased sense of security within the relationship.

The Military Wife Narrative

> *" I owe her a great deal, not just because of that of course, that seems to be I guess a little bonus- she's suffered through a lot.*
>
> *D: Has she been supported?*
>
> *P: She used to have some- which was her family, but then the last of her family moved away and when that happened things went down hill really fast…But we were able to recover from that, and stronger it would seem…"*

The narrative of the military wife is characterized by the motto of the Military Family Resource Centers (MFRCs): "The strength behind the uniform." A recent campaign to honour a female who exemplifies this ideal explains that she should have positively supported the military or a military member*;* the motto for this campaign is "She has

stood among the silent ranks with dignity, commitment and pride" (Welcome message, 2015). MFRCs are organizations that support spouses, (not always female spouses) of military members, most often in the form of daycare for children and programs designed to educate spouses about post-deployment stress in returning soldiers, many of their staff members are volunteer military wives.

Although the MFRC considers family to be a strong source of support to the fighting force, this support doesn't always appear to be a priority for the military. On one Canadian military base, MFRC volunteers have been charged for parking while volunteering; when they complained to the base commander they were told to take the bus. For the military wife who shared this story with me, it was a poignant reminder of much of her previous experience with the military, as she explained: "every time I think they can't go lower, they can." Her experiences in the past left her feeling told to "suck it up buttercup" and as she explained, warned: "if we snapped there would be no support for the husbands" (personal communication, September 29, 2014). This leaves military wives with an enormous burden, and a firm message about where their place in the hierarchy is:

> Consider the Canadian Forces course on "Basic Relationship Training," aimed at giving military couples "relationship skills" such as communication or forgiveness. Its rationale is for soldiers to be operations-ready: the brochure for the program urges soldiers to recognize that "strong supportive relationships are paramount to your ability to remain mission-focused," or, in the words of one reporter who covered the launch of the program, "senior military brass recognize that happily attached soldiers are better fighters." Wives are thus enlisted in maintaining the good mental health of soldiers for military purposes. This is unpaid work; moreover, it places undue pressure on military wives and families, while failing to acknowledge higher rates of domestic violence in military families. (Howell, 2011)

These examples indicate that in the military, despite the rhetoric about the importance of families, wives are expected to exhibit their capacity to be strong by standing behind, not beside their partners, being silent, and considering their need for support as secondary to their husband's. Culturally and historically, this understanding has dominated the story of military families, applying to wives, mothers and daughters (Kwan-Lafont et al, 2012). Notwithstanding the evidence that the wounds of war are attachment wounds, and that primary attachment relationships are a healing resource, to an organization whose aim is maintain a fighting force, the needs of anyone but soldiers have been seen as extraneous:

> When asked to characterize the culture of the military regarding soldiers' families, the fathers we spoke with offered slogans they had heard repeatedly from military leaders or colleagues. The most common example was 'mission first, family second.' Another example was 'if the army had meant for you to have a family, it would have issued you one' (this is a good-for-all-occasions slogan used for many things in addition to 'family')… (MacDermid, Schwarz, Faber, Adkins, Mishkind, & Weiss, 2004, p. 12).

One of Canada's preeminent military families, the Dallaires, who are highly respected and honoured advocates for the welfare of war-involved children, child soldiers and soldiers with post-traumatic stress, publicly embrace the military ethic concerning wives. The Dallaires have been a model of resilience and inspiration to Canadians and especially to Canadian military families in transition. Senator and retired general Romeo Dallaire was medically released from the military and his public discussions about his personal and professional struggles have probably proven more effective in the battle against stigma about post-deployment difficulties than the anti-stigma campaigns of the CAF. Madame Elizabeth Dallaire is described by a friend who is also a military wife, in a fashion that exemplifies the archetype of the military wife (Ottawa Citizen, 2007): "She signed on for whatever military life encompassed and carried through with style and

grace and composure… She didn't falter." Dallaire is also described by her husband in such terms:

> A solid reference," he says. "Now, that may not sound very lovey-dovey in the classic sense, but I have always been committing myself to more and more in my career -- as I wrote in my book, my first love being the army -- and I was able to do that because the home front was solid. (Ottawa Citizen, 2007)

Madame Dallaire's own words about how she coped with her family's transition problems and a military life, indicate that she completely understands the ethic of 'control and compartmentalize'.

> There are ways you get through a crisis like that, and one of them is to compartmentalize. Thirteen years after the genocide, Dallaire admits she can't bring herself to read her husband's memoir of the Rwanda experience, Shake Hands With The Devil. But she has seen the movie, and it made her cry -- for Rwanda. (Ottawa Citizen, 2007)

Participants' partners. In the present study, participants who described their partnerships were speaking about women who were not in the military. Participants who are married described their wives as strong women who are successful professionals in their own work-lives. Participants explain that they make decisions, such as participating in the study, together with their wives and have negotiated an understanding of how to have a family life in the 'mission first' culture of the military. One participant explained that in the past, for his family, his own career decisions have depended upon the need for a stable lifestyle for the whole family:

> P: I got out actually from full-time service in 2001, that summer. I was going to be promoted to sergeant and go to Ottawa; I wasn't prepared to go to Ottawa. My wife was very adamant that she wasn't going to go to Ottawa- she had followed me and given up some of her career to follow mine, and we wanted our children to grow up in one spot as opposed to being hop-scotched about the map so, I elected to get out- I took a demotion and took a reserve position here on the base, and have been there doing that ever since…. and I was away more than I was

> home, my wife and I calculated- not deployments but just gone. And when I got back to [*present location*] inside the first year, was gone seven months, and it only was getting worse, and they said: "This [*promotion*] is coming up this July" so: "Sorry you're going to have to pick somebody else."… "Well you know you're going to be promoted to sergeant, this is going to be your last opportunity."… "No-ain't going."

Another participant is looking to his family's needs for a stable future after his medical release, he sees his wife as his most trusted confidante, although there are certain subjects that were better discussed with some, but not all, buddies from the military:

> D: …you described your circle of support around you that you formed yourself, your wife was like your main support right?
>
> P: Yeah definitely. Yeah…Well I think you're probably more willing to … describe in more detail about certain things maybe that are bothering you or not bothering you, whereas the army guys, it's: I don't know, I guess it all depends on the person too, you're probably more willing to go into detail with your wife, than your buddy, maybe. Depends what you're talking about too- sometimes you'd go into more detail with your army buddy than you would with your wife.

The participant below explained that for him, an intimate relationship would always be circumscribed by the choice to compartmentalize his deployment experiences:

> So yeah, I will be very reluctant to… and then there's that whole "How do they see me now" thing; oh my god is that a can of worms! Yeah, best just not to talk about that kind of stuff, just leave that alone. That can- that skeleton will stay in my closet. Is that going to cause problems in the future? Jeez I hope not, but to bring that out into the open I don't think's going to be good for anyone- not in the end. So yeah, that can stay, and yeah, it probably will stay.

Hall (2011), understands such a decision as: "this [*need not to share*] for families, especially spouses … a reluctance to divulge horrible details may very likely be due to the importance of the home relationships, rather than an indication of the contrary" (p. 16). The participant above counts among his personal values the need to protect others; he is aware that this served him and others in his military life and it is part of his

aspirations for his future life. Although military culture undoubtedly influences the relationships of participants, they have also articulated that they can transcend the cultural norms and resist peer pressure (for instance to use alcohol instead of to seek treatment). Below the participant quoted above explains that he makes a conscious choice according to his own values to protect, and that this will continue to shape his life in the area of personal relationships:

> So that need to protect or to help, [Laughs] I think it's always going to be part of whatever personal relationship I have and as part of that, and from what I've garnered from my personal experience of going through whatever I've gone through, I can't share that because I can't communicate exactly what I went through: It's not that I don't think they can understand, [*or that*] I'm not good at communicating it: it's really not a pretty picture- so if they don't need to know about that, then they don't need to know about that! Is it kind of crappy that I've got it inside me- yes, Is it kind of crappy that it might leak out on occasion, you know: "Why did you say that? Why do you have that view?" Yes, but for the most part, it kind of sucks, but it's your stuff, your stuff- so it's not their stuff and you don't need to share that stuff.

Dawe (2013, p. 32) has an additional theory on the reluctance to share details of past traumatic experiences with anyone who can only ever understand them second hand; he posits that silence on the part of the individual who experienced the unspeakable is a means of honouring how profound the experience was: "The call for silence after catastrophe can be a way of respecting, even hallowing. …the 'be silent' addressed to those who have known only partially or from a distance…"

Participants' descriptions of their wives challenge the stereotypes of military wives and partners as silent, forbearing and willing to constantly come second in the family order. They also acknowledge the toll that their post-deployment problems have taken on their partner relationships, their capacity to negotiate problems these together, the

strength of the women they love, and the need for the inclusion of partners in the decisions about allocation of resources:

> D: What does a successful transition to home life mean to you?
>
> P: I can't answer that question. My wife and I are… still have difficult times about these things… I still have nightmares, I'm still afraid to go to sleep; I still don't want to go with her half the time to wherever she wants to go. So... these things do have... there are some tensions right?
>
> D: Do you think that she's getting enough support?
>
> P: No- I know she's not.

Children: He sees…he knows…

> While it has been shown that military service members who have solid families perform better on the job, it is always a difficult balancing act to be a part of two families… (Hall, 2011, p. 13)

Hall (2011) describes the pervasive effect of the military on families as: "the presence that went with them everywhere," and explains that as the effects of the authoritarian structure of the military 'leak into the family culture,' there is an experience of being 'second family,' coming after the mission or job. She mentions that in some cases, military children can feel a sense of difference, especially if they do not live on a military base and go to school in a setting where the culture is understood. The producers of a recent Canadian documentary film, called *Speaking Through Silence: The Voices of Children in Military Families Living with PTSD*, agree; they explain that military children they worked with have also learned about this sense of difference:

> The children of military families are unique among their peers. They experience displacement and repeated parental absences. They move with frequency, with little control. They have no influence over their parent's deployment. They often experience anticipatory and actual loss… (Skyworks Charitable Foundation, 2013, p. 9)

Children experience the lack of control that is a feature of military culture alongside their parents as the above quote illustrates. Mac Dermid et al wrote about how this is from the viewpoint of military fathers:

> In some ways, military life seems to be a lesson in lack of control. Military members may have little choice about their duties, or where or when they must go to carry them out. Fathers commented that they had just a few days to a couple of weeks to get everything in order before being deployed, which caused hardship for their families and delayed activities like family vacations and children's events. (Mac Dermid et al, 2004, p. 15)

The participant who spoke about his decision to forgo a promotion and to change from the regular military to the reserves as a way of resisting effects of the lack of control and frequent separations on his family life explains the consequences of this resistance:

> P: It was then and there that my family… my kids were at the age where it's time for them to know who Dad is. So when I got out I had a little bit more free time, so my daughter was horseback riding and so I went to the farm probably 2 or 3 nights a week and to more soccer practices than you can shake a stick at with my son. My priorities took quite a shift and I'm so glad they did.

After medical release, participants continue to make life choices in the best interests of their families and may now have the autonomy to do this. The participant below previously described his teenage daughter in terms of her resilience and capacity; after his release, he is able to make his career decisions with respect to his daughter's developmental stages. He knows that he is now in the time his life when he is young enough to work hard toward a financial future that will keep his family secure into retirement, and since his release he has retrained in a field that he hopes will provide him with the resources to support this goal:

> D: And then what are your aspirations for yourself? How will your life change then?
>
> P: I'll be going right to work…

> D: How is that going to fit in with your plans and hopes for your family going forward?
>
> P: It'll be good; my daughter is old… She'll be fifteen when I graduate… Well, she's pretty independent.
>
> P: It would be better for me to make more money and put it away now, than to make $60,000 a year but get a guaranteed pension of crap money… More money, more promotions, more whatever- because right now I don't care, I can travel, I can do whatever they need me to do, because I'm at a good age to do that, my daughter's at a good age.

In recent deployments, depending upon the jobs and missions of soldiers, technology has made communication with children and partners easier; as one participant explains: "…when I did my tour in Afghanistan, it was just an email away: "Going out for a few days- try to be safe- let you know when I'm in," those sorts of things you know?" This ease of communication can add to the stress for the deployed soldier when they become aware of family situations where they would like to help, or alleviate it when they feel more connected to their families and able to speak to their children. The excerpt below illustrates this and also how the military ethics of containment and the need to protect others combined for this father in a very practical way:

> P: No, there was one occasion when just my daughter was home, she's now twenty-four, she was eighteen at the time, or seventeen- whatever- and didn't we come under a rocket barrage just when I was on the phone, and you could hear the explosions, one whistled right over my head- probably 20, 30 feet over my head; of course I got down- and the phone's- you know, it's kind of funny now, but this thing landed probably from here to not even where that outside wall is here, but my daughter- she just didn't know what to think.
>
> D: What did you say to her?
>
> P: I said: "Everything's just ok, don't worry about a thing!"
>
> D: So you lied. [Laughing]

> P: Of course! That was certainly a good lie of commission as opposed to a bad lie of omission.

As Coulthard (2011) explains that the deployment of a parent is one of the most widely documented stressors for military families and is a defining aspect of military life. During deployment, there is an inevitable change in soldiers, as the survival skills of secrecy, stoicism and denial, and a restrictive communication style become the default way of operating. When these are combined with the sustained arousal and exhaustion inherent in being deployed to a conflict area, they can coalesce to become the opposite of the skills needed to form and sustain attachment relationships:

> In general, persistent self-reliance among adults is thought to characterize a dismissing attachment pattern where an individual may be aloof or distant, reluctant to become close, and disparaging of intimacy. (Basham, 2008, p. 84)

When these skills are maintained after deployment and into family life in reaction to post-traumatic stress, the behaviors, no matter how intelligent they are (and were) for survival, undermine the capacity for care seeking, caregiving and exploration that are the hallmarks of a secure attachment. Survival focused defences: fight, flight, freeze and dissociate or collapse, are mediated in the subcortical structures of the brain, while attachment behaviors such as play, nurturing and interactive emotional attunement are mediated in more evolved brain regions and only occur when there is a "neuroperception of safety" (Ogden & Fisher, 2015, p. 37). Defensive reactions take precedence in times of danger and perceived danger, especially when they have become entrenched by learning and experiences in combat. In addition, they occur more rapidly than the higher order functions of the brain that are responsible for inhibition of arousal, planning and relational thinking, and so they facilitate what Ogden and Fisher (p. 175) call "bottom up

hijacking" of the brain's functioning. A participant explains the lived experience of this as it occurred in a family setting after one of his deployments:

> I have to be totally honest with you- I was very emotionally confused afterwards because it was beyond my understanding how I was- after that I was reacting differently to different situations- domestically. I had children, two little ones, my wife with whom- we're still married- and she put up with a lot. I think I was probably more volatile, and she put up with a lot because I didn't know what happened to me inside, and the military had no concept of mental injuries.

Children may feel responsible for problems that they see and sense in their families. Depending upon their developmental level they may express their confusion about the changing nature of their household and relationships, verbally or behaviourally, dissociate from their families, act out in school or employ any of the conscious or unconscious means that children have at their disposal to negotiate relationships with their attachment figures. According to Judith Siegel (2013), the behaviors and symptoms that children externalize, or show, are more often treated while those that are internalized are often missed. These patterns are also gendered, with externalized behavior patterns showing up more frequently in boys, and internalized patterns being more common in girls (Garbarino, 2005, p. xii). In cases where these problems need to be addressed in therapy, military culture once again has an effect, as the transient lifestyle can dictate the use of brief models of care, and reduce the ability for follow-up and continuity in a therapeutic relationship.

Voices of children. Stigma also affects military children who have family problems as profoundly as it affects adult family members. In the *Speaking Through Silence* documentary, this experience was referred to as the 'wall of silence:'

> Most children in military families link PTSD with shame and confusion. The stigma is so deep, so much apart of their fabric, that they not only hold their

> experiences and their feelings back from their friends, but they often don't speak about the daily realities of PTSD within their families. (Soldiers' Children, n.d.)

This practice of containing, controlling, and stoicism, is passed from generation to generation when children observe the behavior of influential elders (modelling) and it is maintained culturally. Cultural transmission occurs in ways such as Senator Romeo Dallaire explains in a 2011 (Black, 2011) interview: as a young child "he learned, like the rest of the family, to avoid his father's dark moods." Dallaire also learned about the 'where and with who' of how to process the experiences of war: "At the Legion his father got to laugh or cry with men he could relate to." A participant explained to me that he had also learned by watching his father that he wanted to interrupt a family pattern dominated by separation and estrangement:

> It was in my family; my father was Air Force and he was gone overseas-I was the oldest of four- I saw him gone all the time. I would have liked to have a Dad around in those key years or tender years, or some years. Yeah that was difficult and I did not want to repeat that life-long error. My dad's still alive, I'm not close with him… my relation was unfortunately soiled with him just after I was born. So that's what happened there, and I just didn't want to have that situation with my family. … I worked very, very hard. I never said I'd be the best Dad in the world but at least I tried to be the best Dad.

Relational Therapies for Relational Injuries

Patterns of military parent-child interactions which are dominated by the values of military culture can be positive or negative (Mac Dermid et al, 2004), however even attachment patterns that have been negatively influenced by the post-traumatic stress reactions of parents are responding favourably to relational therapeutic strategies that include whole families, open communication and relational approaches (Siegel, J., 2013). The producer of *Speaking through Silence* explains how this has happened when in the

documentary, the voices of military children were considered along with the voices of their parents:

> This Documentary Project is already promoting a healing process among participants. Kingston psychiatrist Dr. Janet McCulloch, our primary partner on this project, has seen remarkable changes in the families who have been working on this project. In each of the families that include children young or old, there have been significant breakthroughs in the way that they relate to each other and a new optimism about the possibilities of healing and recovery. As examples, Andy, a 32 year military veteran has reconnected with his son and held his grandson for the first time. Rick renewed long stalled conversations with his 3 adult children. Louis, Jessica and Patricia have understood more about each other, and are sharing the pride in each other's courage to speak out. (Soldiers' Children, n.d.)

Intergenerational Transmission of Trauma

When post-traumatic patterns dominate the interactions of family life, the most effective source of healing and resilience for soldiers and Veterans, the family, can become fragmented. Westwood et al. (2010), report that both Veterans and their families experience PTSD, and that one of the strongest themes that emerged from their study of a peer-based intervention for post-traumatic problems was the Veterans' desire for their families to be included. In cases where unresolved grief and anger, divorce, and in some cases, inter-personal violence affect families, children watch and acquire trauma symptoms by emotional contagion, emulate patterns of violence that they observe, blame themselves for family problems or take parental roles with siblings at the cost of being children themselves (Siegel, J. 2013, p. 170), and trauma becomes intergenerational. In the next generation, there is a sense of "the ongoing presence of the historical in the present," (Nicolas, Wheatley, & Guillaume, 2015, p. 37), as the consequences of post-traumatic stress become more pervasive than the PTSD, (Deckel & Goldblatt, 2008; Lambert, Holzer & Hazbun, 2014) for a new generation. This effect has been observed in

the Vietnam Veterans who were the sons of WWII Veterans and may in part be due to a combination of the prevalence of authoritarian parenting styles that align with military values and emotional numbing attributed to high levels of stress in military fathers of the post-WWII era (Deckel & Goldblatt, 2008). There are also influences such as genetic predisposition, gender, age and birth order upon the intergenerational transmission of post-traumatic stress (Smith-Osborne, Wilder & Reep, 2013; Dekel & Goldblatt, 2008), and these factors intersect in ways that can modify or exacerbate the problem.

Participants are very aware of the effects of all of the themes identified in this study, and their words have indicated their capacity to make a difference in the problems these present. The experiences of the following participant and his son, also a soldier, illustrates that Veterans have the awareness and capacity to challenge the problems resulting from military service, and interrupt them from 'flowing through' their families:

> D: You also have a son that was in Afghanistan?
>
> P: Yes, and I knew what was going to happen to him when he chose that path, and despite that I'm proud of him, and probably because I never discussed anything I ever did, ever, at home with family- that's probably why he went down that path.
>
> D: Can you just say a little bit more about that? You think it influenced him in what way- the fact that you didn't talk about your experiences at home?
>
> P: Well, I asked him why he chose to go this way, not that I was going to really stop him; kids are kids, they're going to do what they want anyway. When I told him, or suggested to him that I had a better route for him go, which was skip all that army stuff before hand and just go straight to the air force, he explained that he chose the same path that I had deliberately, and he wanted to experience what I experienced, and he was under the impression that it was, as most people are- that it's noble, that it's the right thing to do; it's all of these things, right- that we choose to do these things. So had I talked about it, maybe had I described… the conflict…
>
> D: The inner conflict?

P: Yes… and I guess what it steals from you at the end of the day… You lose a little bit of your humanity… and you need to, to survive. And I didn't want him to necessarily experience the same…. and I couldn't…. but he found out didn't he? And unfortunately he is experiencing the same thing I experienced. And…so…it is what it is: that's life.

D: That's hard… Did you have a Dad who knew what it was like for you?

P: Oh, no- no one in my family, no one in my immediate family, no one in my extended family.

D: But your son does.

P: My son does, yes.

D: Yeah. So how do you think it's going to be different for him than it was for you, because of you?

P: Well- I guide him don't I- I try… I have to be one on one with him. When it matters. I need to be able to get him to focus. He sees and hears what goes on, he sees how I act and behave, he sees how I treat others, he sees all these different things-his mother, what she does, his extended family he sees how all these people act and behave. He knows what's a virtue and what isn't and what's worthy of mimicking and what's not!

D: So he has his own self–navigating capacity in this process…

P: He sure does and he's pretty tuned in- I have to admit- I'm extremely proud of my son, and the man that he's become. So right now he's got to face his demons just like everybody else does, I guess.

Participants have expressed that their attachment relationships are crucial in their healing, and a source of strength through the difficulties of transition, and they have explained that their families are not sufficiently supported in the present system. Research has shown that it is time for families and partners to be considered in the treatment and reintegration of military families after deployment. The present model of transition needs to be expanded in order to provide meaningful care; this has been realized in the US:

> While 38 US Code § 1782 allows marriage and family therapy services to be provided only insofar as they support of the veterans' needs, the clear interplay between the family system and the veteran's PTSD symptoms suggest that nearly any family service provided to a veteran with PTSD would fit within this legal boundary… Given the association between war-related PTSD in veterans and the later development of medical and psychological problems in spouses, it would be logical to consider the spouses' health problems both service-connected and relevant to overall family health. This provides a rationale for our society to take some ownership over these spousal health problems and to provide care for their psychological needs. (Link & Palinkas, 2013, p. 387)

Welfare of the Men (and Their Families)!

Clearly, society should pay close attention to the way that the war-related injuries of Veterans are prevented from being transmitted from one generation to the next. The military family is the most obvious place to make a difference:

> It is an oddity of wars that those in charge often miss the obvious, which helps explain Canada's astonishing failure to grasp the full mental toll of our long involvement in Afghanistan.
>
> The reality that both official Ottawa and our military planners have been slow to confront is that the psychological after-effects of war don't decrease after a mission ends. To the contrary they can increase year by year, and last lifetimes.
>
> Only three months ago, the military ombudsman reported that many military families …were feeling huge stress because of worries about constant family moves and its effects on their children... even find getting family medical care a challenge. "Military families go through protracted periods of bouncing from one waiting list to the next, rarely making it to the top." …the kind of all-out, well-focused programs to support those who've paid a high psychological price already seems missing. (Stewart, 2014)

The quote below pertains to the British military, and it reiterates the facts that the health and wellbeing of military families needs to be looked at in a more contextual, relational way, and that this is a serious problem that deserves the attention of Western countries that continually put their soldiers, and consequently families 'in harm's way':

> Whilst partners stated that they were aware of the support services that were available to personnel on return from active duty, they were reluctant to engage

> with them. This meant that families were dealing with post-traumatic stress disorder, alongside the general pressures of family reintegration, without formalised or professional intervention. It would seem crucial, therefore, that service providers look not just at the services they provide, but at the very real barriers that exist and that prevent service use. For military-based welfare services, who may well have a greater understanding of the pressures facing military families, this involves making it clear that the service is confidential, professional and will not impact on the career of the military personnel. For welfare services within the community, this involves training to ensure that they are aware of how simply being a military family can have an impact on the roles and expectations of family members. (Williamson, 2012, p. 1385)

Conclusion

Although fostering a sense of connection is far from its primary function, the military has the potential to provide such a community for its members; in fact, it states this in much of its rhetoric about the importance of military families. When soldiers are sent into war they must be received home into well-resourced communities that recognize the impact of their experiences. In some cases, deployment experiences have resulted in profound changes in soldiers who look at military and civilian society and realize that they do not fit the same way they once did. The consequence of this is the ultimate disconnection: medical release from the military, and the disruption of supportive relationship bonds. Consideration of families and relationships in the quest for meaningful change in the interruption of intergenerational trauma, and the successful integration of soldiers after medical release, indicates that these crucial attachments are as influenced by the themes of Covenant, Culture, Stigma and Treatment as individual soldiers are, and that they must be protected and cherished, as participants have indicated they should be.

Chapter 11: Concluding Discussion - Veterans at the Table

Even after medical release, participants' stories are circumscribed by respect for the time-honoured implicit codes of the warrior that soldiers are defined by: 'the right thing," means solidarity, camaraderie, and hegemonic masculinity. When we attune ourselves to these stories it becomes obvious that Veterans value their relationships, honor the covenant they have undertaken with their country, and continue to respect the unique culture of the military. It is also clear that their transitions are shadowed by stigma and limited conceptions of their 'coming back' problems and ideas about how they need to be supported in their processes of reconnection. They know that fulfilling their future goals for meaningful work, and healing and renegotiating their relationships involves having their skills and capacities honoured alongside their wounds; they also know that this cannot happen in a system that has so many paradoxical messages. These messages include: "we have your back, you'll be ok" versus "you are no longer deployable because of your service and you need to leave." Equally distressing is the message: "we understand that invisible wounds should carry no stigma, ask for help" versus "your attempts at integrating your experiences are a mental health disorder, you will be medically released." These failures of policy to match practice indicate to participants that the rhetoric of the institutions responsible for seeing them through their transition is meaningless without systemic change.

Participants Explain Exceptions to the Norm

There are signs of hope, and once again this knowledge is generated from participants' own examples of the exceptions to the broken system, as they indicate what *is* working, thereby illuminating the essential elements of a new transition system. Corbin and Strauss

(1990) advise researchers to look for 'exceptions' or 'outliers' in the data because they can point to new ways of understanding. In this study, the data largely described an overwhelmed, bottom-line, limited and limiting system, however, exceptions stood out in the conversations of some participants. What these exceptions had in common was that someone had gone 'above and beyond' the norm or someone showed that they cared in a concrete manner. The significance of this is that it made a positive difference to the participants, and usually surprised them.

In the discussions about VAC, the exceptions included the 'good case manager, who took responsibility.' Case managers are the VAC employees who are the 'gatekeepers' to treatment and benefits for Veterans; as the participant in the conversation below related, they are "*the only one true entity that can actually form the hub of a wheel of support*:"

> P: They didn't consider me for a case manager until they realized that I was at a heightened risk- they thought I was going to kill myself.
>
> D: So that's what it took?
>
> P: That's what it took. And it wasn't…it was by sheer accident that this happened, and I got, by sheer luck I got the right person, which is this [*VAC employee*] and had she not recognized this- and she's an *analyst*- she put herself at risk by doing this, but she went well above and beyond what she should have done, what she was responsible for, or accountable for, or anything else. She went *far* beyond that to accept the shitload of responsibility, because it could have turned out worse- and bad for her in the end- but anyways it didn't. Had it not been for her I wouldn't have a case manager today, I doubt very much.
>
> D: So she basically acted like a human being that cares about another human being.
>
> P: Yes, yeah.

During a conversation about treatment the story of the 'trusted and well-connected doctor' emerged. The "*Lady doctor with one hell of a network*," is the way that a

participant described this individual who exemplifies the type of treatment provider that can work with Veterans contextually because she knows all of the idiosyncrasies of the transition system and understands the culture, but most importantly: *"she knows who we are, she knows what we are, she knows what we did cause she was there with us… She don't bullshit you and that's a rare thing…she will do everything humanly possible to fight for us and work for us … she's got one hell of a network!"*

Underneath all of these very important qualities is one relational characteristic that matters to this participant above all:

> P: She's a very important part of what we are now, and I would hazard a guess that without her there'd be many of us that are not here today- I know there would be, unfortunately too many.
>
> D: …I'm just wondering if you could identify what it is that she does that supports you guys so well- she's now a civilian, she's making room, she understands…
>
> P: She listens.

The discussion below followed a story where the participant explained that his wife was attempting to mail a package to him when he was in Afghanistan; during this process, she dealt with base staff that could not find his name on the list of deployed members. Below, the same participant describes an exception to this type of treatment: the admin clerk *who kept the connections between home and deployed members, who had connections and was sincere:*

> You know- talk about "fall through the cracks!" … I just don't think that every body gets the full picture: "Ok who's deployed?" Well of course there's only a few people on the base that know who's coming and going and that's the people in charge of deployment and training…Thank goodness there was [*individual's name*]- what's her last name…sergeant female... She was not allowed to call the families- that's not her job...but boy she made administrative things go a little easier for us because she had connections, and she was aware of everybody's

> comings and goings; she was the only support we had and she was an admin clerk!
>
> It wasn't her job to really be that involved in the people she was sending here and there; she sincerely wanted to know how things were going. And every time I got an email from her, you know: "How are things going? This is what's going on here, this might be something you might want to check in on," you know- all business, and… "Hugs and kisses- stay safe" cause her son went over shortly after I did… She knows the job, she knows what it's all about, she knows what it's like to be deployed, so what an asset! What an incredible asset! If I can't say anything positive about anyone else, I can at least say about her- she was on it! … But it wasn't her job! That's the thing!

These stories point to connection in a way that the participants are very clear about. They illustrate what a tremendous difference it makes when a treatment or service provider steps up and challenges the systemic barriers, fragmented and rigid services, and daunting bureaucratic processes. When participants experienced caring and sincerity (not bullshit) in their encounters with the transition system, it touched them - they thought of it as exceptional, which underscores how entrenched the marginalizing discourse of the transition system is. They used terms like 'over and above' and described the exceptional individuals with respect, affection and gratitude. To an outsider like me, it seemed that the exceptional individuals were simply acting with professionalism and basic human decency, however, the participants are living in the transition system, and these descriptions stand out from the rest of their stories, not simply because of the content, but also because of the animation in the participants' voices.

Veterans Have the Capacity to be Policy Makers

Understanding Veterans' transitions with the benefit of their lived experience evidence has acknowledged them as resourceful, self-advocating producers of truth, capable of critical, systems-based thinking and holding authority over their own

processes. This view challenges the practice of excluding Veterans' voices from policy-making about their own transitions. Changes made at this level, with the input of Veterans, will insure that they are treated in a manner that reflects the integrity of their covenant with Canada. In addition to this it will have long-term social and health benefits. McEwan (2009) has warned about the systemic effects of policy on individuals' stress levels and the capacity for adaptation:

> …it should be noted that the social and physical environments in which we live are, at least in part, the products of practices and policies of private enterprise and government and these can be changed by changing those policies. Indeed, virtually all of the policies of government and business have powerful effects on health. Indeed, they have a top down effect via the brain on all the physiological systems involved in stress and adaptation (McEwen, 2007). Therefore, monitoring how the brain is affected by such policies is another important future direction of neuroimaging research because animal models can only give clues, but the study of the adaptability of the human brain is the ultimate goal! (p. 912)

What's in the Way? Neoliberalism

McEwan notes in the above quotation that the policies of government and business have powerful effects even on a physiological level, and as previously discussed, these effects extend throughout the transition system. Mintzberg (2015) explains that Canadian culture is currently defined as globalized capitalism, and indicates that the government of the transition period was "willingly co-opted by corporate forces." This model dictated bottom-line fiscally oriented and insurance model systems, used by VAC and SISIP, which are characterized by Mintzberg to reflect that: "human development and human decency can be considered to be disposable" (Mintzberg, 2015, p.42). Dickens and Fontana (2015, p. 11) agree that stories (such as relentless commodification) about society that carry moral, sociological and ideological meanings can also directly affect

policy significance. Henry Mintzberg explains an alternative to this paradigm, which he calls this pluralism. He describes how a rebalancing is necessary in all of our institutions, and in a radio interview includes the military in this need for more relational, interconnected policy (Mintzberg on Enright, CBC, 2015).

> … people expect democratic governments to act vigorously... but they will not so long as public states continue to be dominated by private entitlements, domestic and global. This leaves but one sector, the plural, which is not made up of "them" but of you, and me, and we, acting together. We shall have to engage in many more social movements and social initiatives, to challenge destructive practices and replace them with constructive ones. We need to cease being human resources, in the service of imbalance, and instead tap our resourcefulness as human beings, in the service of our progeny and our planet. (Mintzberg, 2015, p. xi)

One of the characteristics of a pluralistic society is the sharing of power. During a conversation about how this study could contribute toward a positive change in the transition system a participant spoke about the need for power sharing, which he calls authority, in policy making:

> But what's important is: how do you make it important to someone like a policy maker? … the primary support network is broken, internally, and only high level policy makers can change that… politicians are more than happy to hand over responsibility to somebody else. They want to hang on to the authority, just in case they need it to pull their ass out of the fire, but they don't want the responsibility of making anything happen ... that's what a bureaucrat's for. But they don't want to give the bureaucrat the authority, because then if the bureaucrat acts on their own authority and does something good, that'll make them look like an asshole. That's why they hang on to authority. Accountability? Shit, they're always willing to give that up right! Unless…it's proven to have a long-term positive effect, so two elements: positive, long-term.

Presently, it is clear to the Veterans, to some members of the Canadian public, and possibly to the new Liberal Government that the system is broken and that many Veterans are in trouble. What is not clear is how to move forward in a way that honors

the particular wisdom of Veterans about positive, long-term change, and includes their voices at the policy-making level.

Recalling the definition of stigma, it is clear that there are 'problems of knowledge, attitudes and behaviours' inherent in what the systems of transition: society, government service and treatment providers and military culture, are communicating to Veterans. These attitudes are transmitted through policies in a 'top-down exercise of power,' that results in practices which keep Veterans isolated, shut down and aware that their stories are acceptable only if they do not point out what our society has sanctioned, but refuses to bear responsibility of hearing about. Shay believes that this abdication on the part of society is a part of an implicit message that we, as a society, do not wish to join with Veterans in their reconnection processes, and tell them this by constructing transition difficulties as a disorder in an attempt to remain separate from them:

> By the absence of these collective rituals of transition, the society beyond the consulting room forces veterans to maintain a rigid separation between the world that they experienced in combat, the world from which they came and that to which they return. The veterans' failure to develop a *perfect amnesia* for this recent experience as well as their failed attempts to maintain the *perfect separation that society appears to demand* of them may then contribute to what is subsequently seen as a disorder, PTSD. (Bragin, 2010, p. 318) [emphasis added]

Decker (2014, p. 175) in his book *The Alchemy of Combat: Transforming Trauma in Combat Veterans* explains that in the past Vets caused a stir in the treatment community by insisting that they have input and parity in the design of their own treatment. Participants have drawn my attention to those soldiers who resisted the considerable pressure of the system to be silent, and did step forward to publically name problems out of concern for others. Participants were also aware of the consequences these individuals bore for challenging the entities that hold the power in the present system.

In this study, it has been explained that when soldiers come back from war, the hero narrative, which aligns with the military cultural values of sacrifice and honor and conveys status, may describe their experiences, or, if they have sustained injuries, they may be burdened with an illness narrative, which is stigmatizing and conflicts with the warrior narrative that once defined their life. Typically, as participants have described, they may 'soldier on' until, eventually, if they fail to meet the Universality of Service Policy, they will be told that they do not have a place in the military, which is a denial of the covenant they understand, and means that they will need to be defined according to the Veteran narrative. The study participants have illustrated their capacity in the many ways they resisted the pathologizing aspects of this narrative, challenging it in their own processes of personal growth (Quinn, 2008), which have also been termed post-traumatic growth (PTG) (Tadeschi & McNally) or spiritual growth (Decker, 2014). In various ways, during their transitions, they changed, sometimes expanding their self-definitions beyond the one they went to war with, sometimes becoming advocates for their comrades, and sometimes challenging narrow definitions of what they are now, and are capable of in the future. In this way they add their voices to those who are rewriting the Veterans' narrative. If the transition systems expand enough to once again, as after WWI, receive Veterans into society in a way that enables all of us hear this new narrative, our country may be enriched by the contributions of soldiers who during their service made a difference "on the national and international stage," as Mantle (2013) explains in *In their Own Words*:

> Military service comes with a heavy price: the time away from family and friends; for some, physical and mental scars; for all, the loss of certain personal freedoms enjoyed by the rest of society. Yet, on the other hand, it also comes with many rewards, rewards that most civilian professions would be hard pressed to match:

> immensely profound friend-ships forged through shared, often dangerous, experiences; the opportunity to make a difference on both the national and international stage; a unique and challenging career. (p. 3)

As soldiers end their "unique and challenging careers," they adhere to the framework they were taught in the military and also to their own personal, enduring strengths to contribute to both the collective and their own individual Veteran narratives. Boudreau (2008) has advice for those who want to know how to help soldiers back from war; he tells us to be willing to listen to the stories of Veterans, not just to be informed by their narratives, but because it helps them to feel reconnected:

> …people ask me, "How do you cope?" I said, "I write…I talk. I bore the shit out of people for as long as they'll tolerate it, because I won't shut up."…I'm not here for you. I'm here for me. This is my therapy. If a man comes home to a world of deaf ears, he can feel alone in the most crowded of rooms. (p. 211)

The Elements of a Veteran-centric Transition System

Veterans in this study have helped me to write about their confusion, sorrow, grief, anger and guilt, indicating that they have been changed by their experiences. As result of this, they have explained that when they 'come back,' they sometimes struggle with ideas about what normal is due to highly influential societal narratives. However, Veterans in transition are telling us what they care about with the new Veterans' narrative. If we listen, according to participants, we would hear the following elements: respect the covenant as we did, and tell the truth; respect our culture as we do; care for the men into the future; care for our families, and acknowledge the value of our relationships.

Respect the covenant as we did and tell the truth.

> You know, when you believe in an organization so strongly, so strongly that it's the ultimate- in servitude, really, just to find out in the end the sons of bitches felt the need to bullshit you, all this time, rather than just tell you the fucking

> truth…that's the difficult part to deal with right? Because you still would have done what you did anyway, probably, 'cause that's who you are… (Participant)

In this study, participants have explained that they honor the covenant with our country and value truth telling. Veterans have stated that they understand that the Canadian Armed Forces (CF) and its troops constitute a military family:

> They tell us we are like a big family. If something happens, everyone will be behind you, everyone will back you up….. Once a soldier, always a soldier. (Mercier & Castonguay, 2014)

Adrienne Clarkson, one of our elder stateswomen former Lieutenant Governor and Colonel in Chief of the PPCLI, one of the regiments that was drawn upon heavily in the war in Afghanistan, has written in her collection of essays called *Belonging*:

> The best of our society is revealed in the mechanisms we have created to offer hope and support to individuals in transitional times; our country is renowned for privileging the health of its citizens and for welcoming individuals from areas of conflict to take a place beside us as citizens in our parliamentary democracy (Clarkson, 2014, pp. 99-100).

Clarkson was writing about citizenship, however her quotation could have been an apt rejoinder to the Harper Government, and perhaps it will be considered a piece of sage advice to the Trudeau Government.

Respect our culture as we do. This pertains to research about Veterans, and in this study I am aware that although the transition system may benefit from a feminist perspective, the military is founded upon hegemonic male values, which must be considered when soldiers are described, and that being described within a feminist framework may be difficult for some soldiers.

'Care of the men' (into the future). In keeping with the cultural ethic, participants have highlighted the stories of Veteran dissenters involved in breaking

silence not just for themselves, but only when it would improve the situation of others. Shay (2009), advocates for a new understanding of post-traumatic stress, he discusses how, as a result of a long career working with Veterans as a military psychiatrist, he has learned that they have important ideas about the future of young soldiers who are in danger of being disconnected the way that older Veterans were:

> I have learned over 20 years that though they are a various and contentious bunch who will argue about anything, the one thing that they are unified and solidly agreed on is they don't want other kids wrecked the way they were wrecked. (p. 287)

A participant echoes this concern for the future of younger soldiers in transition:

> And as for the young folks- they see themselves, being young- I mean that's inherent in being young…that they're invincible, that they're invisible, and that no ill will befall them, and yet statistics don't bear that out. Unfortunately it's the young folks, because of their physical capabilities, that are put into harm's way more … even from my own experience it was the young eighteen year-old folks that were providing my security that were most at harm. They said I had a difficult job, and I used to snicker because you know it's the young guy over there standing post that's got the hard job- not me. And because they're young, they don't give any thought to the process, so when it happens the other processes that are inherent in the military right now are…there's the door, and it's…

Stewart (2014), in his article about the way the CAF has minimized the problems of soldiers in transition by selectively quoting suicide statistics, has a warning for the future that aligns with the concerns of the participant above for the welfare of the troops:

> …Add to that the fact that we have only belatedly acknowledged that many of the 120,000 soldiers who served as UN peacekeepers in atrocity-ridden conflict zones have trauma rates as high as Afghan vets…Most ominous still is the finding nearly buried in the same study that notes that the incidence of mental injuries can double with passing years — meaning that fully 30 per cent of those involved in combat operations may need significant psychological and other support over many years.

Care for our families and acknowledge the value of our relationships.

Participants acknowledge the crucial support of their families and also indicate the influence of stigma and culture on their close personal relationships. Their experiences illustrate the ways that they have resisted the dictates of military culture, which prioritize mission over families, and also that their careers sometimes placed great responsibility upon partners and children to bear the challenges of supporting them through their transitions in the present faulty system. Participants' stories illustrate that it is their capacity as partners and fathers that interrupts the transmission of intergenerational trauma through their families, and that the present construction of the military family as a 'homefront stressor,' is an artifact of a system that needs to change.

The Present State of Affairs

At the time of writing (2015-2016) the government and Equitas have suspended the NVC lawsuit in order to negotiate a possible settlement. Issues that are outstanding include the recognition of how profoundly post-traumatic stress affects Veterans and the insufficient data about levels of Veteran and serving member suicide (Sorochan, 2014). Presently, Canadians are watching the new Trudeau Liberal government, which promised to move toward a Pension Act model of financial support for Veterans in their campaign, to see if they were telling the truth and not simply reproducing an empty rhetoric of care.

Future Directions

This study began as a descriptive exploration of Veterans' experiences, and as Marshall and Rossman (2011, p. 69) warned, it grew through an explanatory, or 'how do forces interact to result in the phenomenon?' stage, to one that I hope, in the future could become emancipatory, where participants take positive social action. This wish aligns with the thoughts of at least one participant, as will be explained next.

Paradigm shift: Toward 'positive, long-term change' Recalling the conversation a participant about the importance of policy change for transitioning Veterans:

> P: It doesn't matter if the individual I'm talking to on that phone cares, or doesn't care… they've got rules, and as much as they like or dislike having to follow those rules, they're stuck with following those goddamn rules.
>
> D: And the only thing that'll change the rules is?
>
> P: Policy
>
> D: Right- there we go.
>
> P: …Now the problem with this is… it's like anything else- the more bodies you have out there, the more conflict there is, because the more egos get involved… one of them has to be right… Well, you know, you both could be wrong, actually.

The participant above closes his analysis of the construction of policy with the possibility that we could be *uncertain*. Marsella and Yemada, cultural researchers who challenge narrow constructs such as PTSD and applaud the value of an uncertain, open mindset agree:

> There is nothing admirable about a rigid mindset that denies alternatives because of an intolerance of ambiguity. It isn't even good science, since good science progresses from doubt, not certainty… (Marsella & Yemada, 2010, p. 113)

Groups gain the power they need to explore uncertainty when they join forces and build 'polyvocal alliances.' As previously cited, Coulson, referring to paradigm change explains:

> This is not some smooth political offering but a very human, very rich compendium of research, thought, feeling and experience. The many quotes and references mean that probably a hundred or more voices are all singing the same song: a powerful chorus. (Kalisch, Coulson, Mosley, Manne, Sivyer & Rowan, 1998, p. 48)

Keeping an open mind about solutions, understanding the uses of power, and forming alliances are practices that create such a powerful chorus and make sense in the context of Veterans' transitions, which are very uncertain times. Cross-discipline research can offer other sources of knowledge construction and add to the chorus, as Hooyer (2012), speaking about treatment, explains. Drawing from the field of anthropology, she clearly names two practices that participants have explained are problematic during transitions (help-seeking and narrow treatments):

> Autonomy, expressed through the "peak psychological functioning" for those "willing to ask", is grossly exaggerated. If it is structural forces that are shaping the discriminatory practices then interventions should not be directed at individuals to change their beliefs but to policies upstream that, for example, do not punish those seeking care or deploy traumatized soldiers with 90-day supplies of meds. Anthropology is strategically positioned to divulge these structural forces and inform successful interventions and policy, if the government is willing. (p. 124)

In the quote above, Hooyer locates the problem in the system, as critical feminist thinkers do. Dickens and Fontana (2015, pp. 15-16) explain that feminist methods (congruent with the methodological underpinnings of this study) would be valuable in the search for a new paradigm because: "feminist discourses are oppositional," and deconstruction is a challenge to a "single clear-cut message…suppressing other possible interpretations." Cotten and Ridings (2011) offer an analysis of the politics of inclusion and exclusion, and explain how to advance policy change within a large system. They reason that an understanding of power dynamics and agendas within organizations, and an awareness of which insiders are likely to support the access of other interest groups are essential.

For Veterans in transition, potential allies are: those who are marginalized because of

misunderstandings about mental health (DuBrul, 2014); first responders who are advocating for more comprehensive treatment models (Flannery, 2015); First Nations Veterans who have negotiated for first voice evidence to be included in legal proceedings; and advocates for the wellbeing of military families. Researchers are who frustrated by the constraints that neoliberalist agendas place on their work could also be possible allies. Robbins, Pomeroy, Thyer, Mason and Taylor (2013, p. 366), speaking about the effects of neoliberalist thinking on research, indicate that "Grant funded research has led to a decline in great ideas" as data collection dominates practices on research. They suggest an inclusive, multidimensional alternative: "A 360-degree study would need to address the researchers themselves and their research, the stakeholders, the policy makers, and the funders."

Researchers who are also the insiders mentioned by Cotton and Ridings, such as the Canadian Forces Health Services Surgeon General, Commodore Jung, are beginning to express ideas that indicate that because of the limitations of the paradigm under which they work, they too might make good allies:

> Since the CFHS is primarily a health service delivery organization, our research efforts prioritize essential high-impact, lower-cost research, as well as close research collaboration with allies. While this approach is adequate, it can be significantly enhanced through supplementation by and coordination with the research capabilities of academia, particularly during periods of high intensity operations that present new, grave, and complex health threats and stresses to CF personnel. (Jung, 2011, p. 7)

This quotation is significant, because it is part of a Canadian Defence Academy document, (*Shaping the Future: Military and Veteran Health Research*) which contains the research that Canada's health and compensation policies are influenced by. It reveals a 'crack' that suggests that the academics who are authors of some of the articles

included in the document, could broaden the research agenda beyond the "high-impact, lower-cost… adequate" model described in the Surgeon General's quotation. Perhaps academics would in turn share their access, power and resources with allies, who may not be the health researchers from other NATO countries alluded to in the quote, but actual Veterans. If they also employed the methods of Participatory Action Research (PAR), (long-term commitments of time, sharing resources and power with the study population, results not easily assessed in terms of statistical data), which are the antithesis of neoliberalist influenced study methods, there may be positive momentum toward long-term change. These qualities are what a participant equated with the quality of accountability, one of the hallmarks of responsible policy and also of a warrior.

It is my hope that a participatory effort with Veterans would result in policy that improved all of the aspects of transition that the participants explained to me. Of particular interest to me is the area of treatment, and I am aware that there are many Veterans' groups working tirelessly, mostly on a volunteer basis, to chip away at various aspects of the problem. Because they understand what a complicated effort this is, there are groups addressing the needs of homeless Veterans, individual Veterans donating their private property to be used as healing sanctuaries, groups endeavouring to raise awareness and funds for Veterans' transition homes that include short and long-term, multidimensional support, and many more groups.

It is especially important to be aware of the pitfall of expecting all parties to come to consensus quickly and put aside the rivalry and group loyalty that are aspects of military culture. Fine (2006) warns about the process of truly honouring a polyvocal alliance:

> Once expertise multiplies and dissensus fuels the conversation, participatory action researchers have to think through what constitutes triangulation (should

> distinct forms of data confirm and/or challenge each other?); who needs to be out of the room to achieve "inter-rater reliability," and what happens if they enter and we struggle together toward a thicker understanding of reliability and expertise. (p. 96)

Limitations and Future Possibilities

One of the limitations of the study is that I cannot assume generalizability of the findings to all Veterans. Not all Veterans may be interested in policy reform or as informed about Veterans' issues as the participants are. It also cannot be assumed that all Veterans exhibit the same level of capacity for critical thinking as participants do. Additionally, all of the participants were male, and although our conversations generated many important themes and much illuminating discussion, it cannot be assumed that the stories of female soldiers would be the same, or that the male-dominated language of military culture, and by extension, of much of this writing, reflects the needs and experiences of female soldiers. The stories of female soldiers are an interesting and vital area of future research, especially in light of their treatment in the culture of the military that only recently began to include them in all areas of service. Looking at the practices and approaches of the myriad of volunteer Veterans organizations is also an interesting idea. Another idea emerges from the trauma-wisdom/growth literature, which suggests that trauma in the military is highly related to the model of manhood, and not the man, suggesting that we examine the way that as a society we socialize boys to adopt such an unforgiving concept of what it is to be a hero.

Final Words: Coming Back Together

In our society, we have divorced ourselves from traditional, community healing practices, and by default, we have left our soldiers and Veterans cope with the

ramifications of their deployments in isolation. As a country, we send troops into harm's way when we elect governments that fail to acknowledge the global effects of neoliberalism and prioritize commodities over a deep commitment to global human rights (Mintzberg, 2015, pp. 74, 92-93). This unbalanced, reductive fiscal focus keeps us disconnected from the issues that this causes in the countries we go to war with, and it also influences the transition systems responsible for our returning soldiers. When our Veterans return from war we listen selectively to their stories during the week before Remembrance Day, choosing to attend to those that align with the heroic archetype that that is the narrow definition of 'Veteran' that we approve of.

Most service and health care providers that Veterans encounter in the transition systems are trained according an insurance company standard of care, or the medical model, and work according to the institutional narratives of these entities; rarely, explains Crosby Hipes (2009) do they examine the social structures that they and their clients are embedded in. When they do, as participants have explained, they can greatly improve the effectiveness of their treatments and services by working enthusiastically and in a respectful and connected manner, so that their efforts stand in contrast to the systems they work in. Hopefully, as a new government evaluates their commitment to Veterans, those systems will expand in a way that includes the most culturally competent professionals possible: the Veterans. The following exchange is from a conversation that a participant and I were having about the best Veterans' advocates:

> D: This might be a hard question for you- but what is it about you that would make you good at that job? Do you think?

> P: Oh…understanding the process now after years of being through it… actually caring for the Veterans.

In the present paradigm, the scientific and phenomenological research communities have often been at odds with each other, however they are gradually approaching the same conclusion: our affiliations with each other in the forms of attachment relationships, camaraderie and attuned therapeutic relationships seem to hold the most promise for healing trauma. Until things improve, the Veterans themselves will ultimately take responsibility for their own healing mission, as they have always done to the best of their ability, given the circumstances:

> I equate it to the physical challenges I've had doing endurance-type events- one step, one step, just keep going- you put your head down and keep going, it all gets better.
>
> Yes my wife and I, when we are planning an event, it is the only thing that really propels me on- foot beyond foot- that's what I do.

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Appendix A – Ethics Approval Letter

Research Ethics Board

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ACADIA UNIVERSITY

6 September 2014

Ms. Catherine Denise Landry
School of Education
Acadia University

Re: "Bridging the Gap: An Exploration of Veterans Helping Veterans through the Transition from War to Home" (REB 14-54)

Dear Ms. Landry,

At its meeting of 4 September 2014, the Acadia University Research Ethics Board granted ethics approval to your above-referenced research proposal. In the judgment of Dr. Susan M. Potter, a Representative of Faculty on the Board, the proposed research poses no more than minimal risk of harm to research subjects. Accordingly, your application received delegated ethics review and approval by Dr. Potter and subsequent ratification by the entire Board, as provided for in Articles 2.9 and 6.12 of the Tri-Council Policy Statement (TCPS2) governing research on human subjects.

This approval is for a term of one year and is subject to the following condition: You may recruit participants *only* by distributing information sheets at association meetings and resource centres such as those mentioned in your application. The Board is concerned that recruitment by active members of the associations or by board-members of resource centres may impose pressure on potential participants to agree to participate. They will feel less pressure if they are simply given the option, by you, to respond or not to your written invitation.

If your project will not conclude before 6 September 2015, please contact me at that time for an extension of this term of approval. Please inform me of any significant changes to the research before they are implemented. Please also note this additional requirement: In accordance with Article 6.14 of TCPS2, the Board must be promptly notified when each project concludes; an email notification sent to me will suffice.

The Board extends its best wishes for a successful project.

Sincerely,

S. Maitzen

Stephen Maitzen, Ph.D.
Chair, Research Ethics Board

cc: Division of Research and Graduate Studies

Appendix B – Recruitment Poster

Bridging the Gap

Research Study- Call for Participants

Bridging the Gap is a research study about veterans helping veterans navigate the transition between deployment and home

If you are a veteran who has been deployed outside of Canada and have been home for more than two years, your experiences may help other vets find the way home

If you are willing to participate in two-90 minute interviews between Oct.-March 2014/15

Contact the researcher:

Denise Landry: Graduate Student, Acadia University Wolfville NS Department of Education at cdlandry@gmail.com or 404-0565 or 817-0565

Research participants will not be compensated for their participation

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Appendix C – Screening Interview Questions

Demographic data:

- Age _____
- Gender _____
- Ethnicity _____
- Service (still serving, deployments, medically discharged)

- Contact info:

Address_____

Email _____

Phone number _____

Exclusionary data (self-assessed):

Do you currently meet any of the following conditions?

- Currently in residential treatment for SU?
- Present psychosis that would interfere with informed consent?
- Personal concerns about discussing traumatic memories?

Please describe your present support system. Do you access to physician, mental health support, peer support and social/family support?

_____

_____

_____

_____

Appendix D - Research Participant Consent Form

June 22, 2014

This research project is being conducted by Denise Landry, Master of Education (Counselling) degree candidate at Acadia University in Wolfville, Nova Scotia, Canada. The research project is being conducted under the supervision of Dr. Deborah Day at Acadia University.

Researcher contact information:
Denise Landry
M.Ed. Candidate, Graduate Programme in Counselling
School of Education, Acadia University
(902) 404-0565
cdlandry@gmail.com

Supervisor contact information:
Deborah Day, Ph.D., C.C.C.
Associate Professor, Graduate Programme in Counselling
School of Education, Acadia University
(902) 585-1132
deborah.day@acadiau.ca

Purpose of the study and objectives of the research:

The goal of this study is to explore how veterans have re-connected to peacetime society after their involvement in military operations, and whether they can help support the transitions of Canada's recently returned veterans from the war in Afghanistan. This question is of particular significance in Canadian society today because an increasing number of returning troops are experiencing difficulties as they attempt to re-integrate the experiences of war with post-deployment life.

In addition to the wealth of experience that older veterans have in navigating our government's support systems, they possess a first-hand "lived" understanding of the emotional process of homecoming and re-integration. The voices of these veterans can provide a rich source of knowledge concerning the problems which result in suicide, homelessness and substance use that are indications of post-traumatic difficulties experienced by an increasing number of troops. Current treatment protocols for post-traumatic stress miss a key element of post-traumatic stress, which is the loss of connection to self, family and community experienced by some individuals after intense or overwhelming experiences. The research question being investigated in this study is "What are experienced veteran's ideas about re-connection during the post-deployment transition period and how can these ideas help more recent veterans, especially those being medically released from the military?" The reason for asking this question is to

explore the ways in which veterans can be more involved as a recognized resource in treatments to "bridge the gap" between deployment and post-deployment life experience.
Participant involvement and details of the research project:
Research participants will be individuals who are currently serving or retired members of Canada's armed forces (CF), who were deployed outside of Canada before and during the Afghanistan deployment.

Research participants are invited to participate in one short screening interview and two, 90 minute individual interviews, to be conducted in a confidential manner and convenient setting, scheduled between June and October of 2014. Participation with the research project will require a total time commitment of three to five hours. Optional involvement will include the opportunity to review a summary of your interview transcript and drafts of the research report including verbatim quotes from the transcript of the interview, previous to their inclusion in the final research report, and a final de-briefing interview to be arranged after the study.

The interviews will provide an opportunity for research participants and the researcher to explore participant's stories about their experiences of the transition between deployment and post-deployment life. The interview transcripts and recordings are referred to as the 'data'. The interview will be audio recorded, and de-identified by the researcher before being transcribed by a professional transcription service, preserving the original wording. Transcripts will then be summarized by the researcher who will analyze them, extracting data in the form of quotes and recurring themes. In this way participant interviews will illustrate and suggest new ways of understanding veterans' transitions to home.

Risks:

Potential risks associated with participation in the interview may include discomfort about revealing information about self and others, and the possibility of experiencing strong emotions and difficult memories. Participants are absolutely not required to talk about anything that they are not comfortable sharing in these interviews. Included in this document are the procedures that will be in place to ensure confidentiality for research participants. The researcher is a trained counsellor and will support participants with every effort to minimize the above potential risks. In addition to this the researcher will also provide research participants with a referral to counselling resources with an "arms-length" relationship from the research project if participants so wish.

Benefits:

Individuals have expressed that talking about difficult experiences can help to put them in perspective. As life experiences are integrated, many individuals find value in being part of a relationship where they impart wisdom and skills to those less experienced, this research project may prove to serve such a purpose. Participants may feel that their involvement with the research project acknowledges the fact that they have much value as an "untapped resource" and may help influence future policies concerning veterans' transitions.

Ongoing, informed and voluntary consent:

Participation in this series of interviews is completely voluntary; participants are under no obligation to the researcher and may cease to participate at any time during the process without prejudice or penalty. The researcher encourages and appreciates participant's expressions of concern and questions about all aspects of participation at any time during or between the interviews. The researcher will ensure that verbal consent is affirmed at each contact with the participant and that written consent is indicated before the first interview.

Participants will be provided with a copy of their interview summary in order that they may check it for accuracy; participants will have the right to withdraw their data (interview) for a two-week period after each interview. The researcher may use quotes anonymously without verifying them with participants.

Confidentiality:

The researcher will maintain the information that participants share in confidence. The researcher is the only person who will have identifying details about the participants. The research supervisor will have access to "de-identified" transcripts of the interview that cannot be connected to specific research participants. This will be done by using numeric codes or pseudonyms to refer to participant's interview data.

Research materials including notes, audio recordings, data storage devices and transcripts of interviews will be stored in a locked file cabinet. Computer files containing data will be password protected and stored on an external storage device. The researcher will destroy interview recordings, transcripts and other research materials at the end of seven years after the completion of the study.

According to law, two particular situations require exceptions to confidentiality; these circumstances apply to all confidential relationships between persons. If during the interview a research participant indicated:

- Intent to harm her/his self or another person, it is necessary for the researcher to inform the police or intended victim, or both.
- The disclosing of incidences of child or elder abuse or of witnessing such abuse requires that the appropriate protection agencies will be contacted.

Dissemination of the research:

The research report will be in the form of a Master's thesis including electronic and bound paper copies. The thesis will be publicly defended in front of the research supervisor and a thesis review committee, and subsequently will be a public document with limited circulation. Research participants will have the opportunity to receive an electronic copy of the finished research report upon request.

The researcher will not benefit financially due to commercialization of the research report and knows of no conflicts of interest concerning the research.

Compensation:

Research participants will not be compensated monetarily, but may be reimbursed for travel or parking expenses.

Participant's access to information concerning the research and research process:

The researcher's contact information and that of her supervisor Dr. Deborah Day has been provided above; both are available to discuss any concerns regarding the purpose and conduct of this research and are available to discuss scientific or scholarly aspects of the project. Additionally, included below is contact information for Dr. Stephen Maitzen, Chair of Acadia University's Research Ethics Board (REB):

Dr. Stephen Maitzen
smaitzen@acadiau.ca
Telephone: 902.585.1407
Facsimile: 902.585.1096
Mailing address
Research Ethics Board
214 Horton Hall
Acadia University
Wolfville, Nova Scotia
Canada B4P 2R6

Dr. Maitzen can provide information about participant's rights and/or address concerns about the conduct of the interviews or other ethical aspects of the research.

Participant's legal recourse:

By granting consent the research participants do not waive rights for legal recourse due to harm related to participation in the research project.

Consent:
I _____, have read the consent form and I understand the information it contains. I have discussed any concerns I may have with the researcher, and understand that my participation in the research is voluntary and that I may stop the interview process at any time, without prejudice or penalty. I am aware of the procedures for expressing concerns about this interview process or the researcher that may arise during the interviews or the time between them.

Name of Research Participant (Print) _____
Signature of Research Participant _____
Date _____

Name of Researcher (Print) _____
Signature of Researcher_____
Date: _____

Appendix E - Excerpts from Field Notes: VAC Ombudsman's Presentation, February 4, 2015

Points raised by veterans and partners:

- Fantino's $12 million unspent portion of VAC's yearly budget? Parent reply: "It's program specific- can't be switched- blown out of proportion by the media"
- Long time wait for claims, no satisfaction.
- There's a fiscal study of VAC, supposed to be independent, from Queens University
- Medical decisions are being based on old research (Gastrointestinal issues- GIRD, sleep apnoea)
- From a dual client: "NVC fells like: bought out- kicked out," no responses from VAC, lump sum, this Vet is 44% disabled but retrained in a job that requires standing for long periods
- Translation issues- Francophone Vet waited a year to understand his MRI due to translation issues
- Timeline accountability?
- VAC policy does not match VAC practice
- Need communication- not just reports
- Effectiveness: Ombudsman doesn't have leverage- Parent is at the end of his term (over in November)
- "Comfy bureaucracy"
- Suicide; need a national program
- VAC- no continuity of case managers
- Vocational Rehabilitation makes no sense individually

Veterans' Review and Appeals Board:

- Why do injuries have to be proven by Vets (affidavits etc.) "Where is the benefit of the doubt?" Adversarial process, intimidating process
- Audits can be done after help is given, not before – this model is used elsewhere, why not here?
- System is modeled on an old system meant to expose malingerers
- Appeal process is retraumatizing for Vets and also families "I bottled it up for years" Left the military, "Don't want to go back there and deal with VRAB"
- Parent: "We're an evidence based organization"
- First Nation Vet and his partner: "The stories of the people who are here tonight are evidence." This is from an Aboriginal model First Voices Evidence- acceptable in legal proceedings and based upon stories, memories and knowledge- gives the Veteran the benefit of the doubt
- U.S. uses a Presumptive Judgment Approach
- Vets were in favour of the Internal Review Process (BPA?); not a "judge & jury process"
- Not enough VRAB employees have medical backgrounds; Vets see them as unqualified, overpaid board members. Parent pointed out that now positions are not appointed, but competitive- Vets didn't think this made a huge difference- the

positions are still attractive to unqualified people who don't understand military culture; uninterested advocates; VAC appointed lawyers seen to be a conflict of interest- "They all walk in together," "March the guilty bastard in," uninformed adjudicators

- Appeals process is a huge waste of money and needs to undergo cost/benefit analysis
- "Don't want a medical release- it's a black mark"
- No cultural awareness- First Nations individuals don't swear on a bible- they have no choice of a culturally relevant option

Points raised by caregivers: (They waited until after the Vets had spoken)

- Vets need to give permission for their families to have medical support- Vets are not always able to make helpful decisions about this; families are suffering
- No respite for caregivers. When its crisis to crisis: "There needs to be somewhere for him to go"
- Available option: "If you're not going to kill yourself you have to go home."
- Inpatient treatment in private trauma centers (e.g. Trauma Healing Centers –"no qualifications"); VAC will pay if pre-approved
- Spouse has often had to give up (her) job to be caregiver

Appendix F - Healing Principles from Marsella (2010)

Marsella explains a multidimensional "healing calculus" comprised of many elements (See Appendix F), he advises a contextual approach to research and treatment: "Although arguments can be made in favor of the progress that has occurred, problems in diagnosis, therapy, and prevention continue to exist. These problems can be found in both conventional psychiatric assumptions and models of care, and in the pursuit of ethnocultural determinants… it is necessary to adopt a multicultural and multidisciplinary approach…" Marsella (2010)

Examples of Healing Principles Used in Different Therapy Approaches

1. Beliefs and values (gains new beliefs and values that are salutogenic)
2. Catharsis (expressing emotions of anger, hate, fear, etc.)
3. Confession (confess troubling experiences)
4. Penance (engages in behaviors to express sorrow and responsibility for actions)
5. Empathy experience (communication of shared feelings and understandings)
6. Verbalization of problems (helps clarification and identification)
7. Faith (establish different kinds of "faith" (e.g., religion, family, society)
8. Forgiveness (forgiveness toward self and/or others)
9. Hope (expectation of a desired outcome)
10. Information (obtaining information about many different aspects of problems)
11. Insight (gaining a sudden awareness of the sources of a problem—"aha" reaction)
12. Interpretation (explaining things within a new light or meaning)
13. Locus of control (moves locus of control regarding problems)
14. Unconscious (unconscious memories become conscious, offering new insights)
15. Authority permission (therapist provides permission/acceptance for certain actions)
16. Mobilization of endorphin and immune system
17. Skill sets (acquires new skill sets for social and cognitive functioning)
18. Reduction of negative emotions (e.g., uncertainty, guilt, shame, anxiety, fear).
19. Acceptance (increased acceptance of situation, self, and others)
20. Identification (new sense of personal and/or group identity—indigenous groups)