An Exploration of Recovery from Post-traumatic Stress Disorder in Canadian Armed Forces Veterans: A Qualitative Inquiry Using Interpretive Phenomenological Analysis

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Acknowledgements

Since the opening of the Winnipeg Operational Stress Injury Clinic (OSIC) in 2004, referrals for mental health services from Canadian Armed Forces (CAF), Veterans Affairs Canada (VAC), and the Royal Canadian Mounted Police (RCMP) have steadily increased and are expected to continue over the next several years. As a nurse therapist employed at the Winnipeg clinic, I have spent extensive time with clients and families throughout their treatment and during their recovery from Operational Stress Injuries (OSIs). Over the past 10 years while working at the OSIC, I have grown to appreciate the similarities in the recovery experience for clients, but also recognize the individual uniqueness and very personal components to this journey. In 2011 I was accepted into the Masters of Psychiatric Nursing program at Brandon University. I knew my research interest would be in the area of recovery from OSIs and the research methodology I would utilize would be qualitative. My journey in the graduate program has provided me with the ability to formalize an inquiry about the lived experience of recovery for Canadian Armed Forces veterans. I have been granted the opportunity to meet with three veterans to discuss their very intimate and personal lived experiences of recovery from Post-traumatic Stress Disorder (PTSD). The qualitative findings generated from this exploration are now being shared in the following thesis. It is my hope the findings from this study will help to empower both those veterans who are working on their recovery and those persons who support them along the way. Walking alongside and working in partnership with clients and families over the past 10 years has critically shaped my own experience. For this, I am truly grateful.

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Abstract

The experience of Post-Traumatic Stress Disorder within the Canadian Armed Forces Veteran population has been described as complex but there remains limited empirical evidence on how to best address these complexities (Pare 2013). Although there is significant evidence to support the efficacy of specific evidence based trauma treatments, these therapies are understood as lacking the ability to fully address the experience of recovery from the personal perspective of those with PTSD (i.e., lived experience). This qualitative study captures the lived experience of the PTSD journey as shared by the true recovery experts—those with PTSD. Interpretive phenomenology is the qualitative method of inquiry chosen to capture three veterans’ experiences. Findings from this research will help the reader better appreciate the lived experience of recovery as it has been understood by the participants. This research will also help increase understanding on how treatment fits within the greater recovery journey. Given the heavy reliance on quantitative research within the OSIC network, this study provides important context that has never been accessed before. It is anticipated that this research will fill current gaps in the literature on the recovery journey of Canadian Armed Forces Veterans with PTSD (Pare, 2013).

Key words: military culture, PTSD, veterans, treatment, recovery, mental health
It’s Your Ladder

It’s your ladder.  
Climb at your own pace,  
pause to enjoy the view,  
keep your footing firm.

It’s your ladder.  
Trust in each step,  
exter fear going higher  
or taking a step back.

It’s your ladder.  
Let others help steady it,  
when you’re wavering,  
in need of support.

It’s your ladder.  
Look up, look back, look around.  
Each rung offers lessons,  
meaning, significance.

It’s your ladder.  
Make the pattern of ascent  
unique to you, your dreams  
your aspirations.

It’s your ladder.

Sandi Knight  
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Chapter One-Introduction

Over the past two decades, the Canadian military has increased efforts to raise awareness of Post-traumatic Stress Disorder (PTSD) as a result of the difficulty expressed amongst soldiers about the challenges with decompression and reintegration following military operations (Heber, Grenier, Richardson & Darte, 2006). Consequently there has been growing public attention surrounding service-related mental health injuries occurring within the Canadian Forces (Pare, 2013). However, in the current literature there still remains an unanswered question regarding PTSD within the military (Pare, 2013). Though an abundance of literature on the recovery movement in mental health exists, there is a gap in the research on the recovery in the Canadian Armed Forces (CAF) and Royal Canadian Mounted Police (RCMP) members diagnosed with PTSD. This lack of literature has stifled the understanding of how this phenomenon compares and contrasts with the recovery movement in mental health of the general population.

Purpose of this Study

The objective of this qualitative inquiry is to better understand how veterans of the Canadian Forces diagnosed and treated for duty-related PTSD at the Operational Stress Injury Clinic (OSIC) view recovery.

Research Questions

The two research questions addressed in this study are: how did those individuals who completed evidence-based treatment (EBT) for PTSD interpret recovery, and what factors in addition to or outside of the EBT protocols have facilitated their recovery.

Findings

Three key findings presented as Superordinate or overarching themes are as follows:

1. Culture has an important role in recovery.
2. Recovery is a journey

3. Relationships are critical throughout recovery.

In the analysis portion of this paper, the three Superordinate Themes along with the Supporting Themes and interview extracts will be presented. Future recommendations for additional research and rehabilitative programming within the OSIC and a larger network will be influenced by these findings and shared with the reader in this graduate thesis.

**Benefits of the Proposed Research**

Benefits of this research to the OSIC will be an enhanced understanding of recovery as it is conceptualized by those who have been diagnosed with PTSD and have completed EBT for their Operational Stress Injuries (OSIs). Such an endeavor will expand on current symptoms-based measures, further deepen the understanding of veterans' experiences, and substantiate the importance of both existing programs and programs of the future. There is great value in having former OSIC clients qualitatively express their experiences so there can be an enhanced understanding of the recovery journey, something that quantitative research could never capture. Additionally, comparing and contrasting how the lived experience of recovery for Canadian Armed Forces veterans parallels with the recovery movement in mental health will help enhance the understanding of recovery as a phenomenon, and in turn further augment and formalize the OSIC rehabilitative programming accordingly.

**Definition of an Operational Stress Injury**

Operational Stress Injury (OSI) was a term created by the Canadian military to describe mental health conditions that have resulted from traumatic events soldiers experience during operational duties (Heber et al., 2006). The term OSI, created by the Operational Stress Injury Support Services (OSISS) peer support initiate, was not intended to be a diagnostic term but
rather a term that would encompass all operationally related mental health injuries or service-related psychiatric conditions (Heber et al., 2006). Though the OSIC has been established to treat all service-related mental health conditions, the focus of this particular study will be a preliminary inquiry exploring the lived experience of recovery from duty-related PTSD. An expansion of this pilot project that includes additional inquiry into the lived experience of recovery from all OSIs will be considered in future research.

**Background of the OSIC**

It was nearly 20 years ago that the development and incorporation of specialized mental health clinics, better known as Operational Trauma and Stress Support Centres (OTSSC) set out to address the unique mental health needs of Canadian soldiers suffering with duty-related mental health conditions also known as OSIs (Heber et al., 2006). Following the development of the OTSSCs, efforts continued to further ensure that specialized health care for individuals transitioning out of the forces remained accessible. The collaborative efforts of the Canadian Armed Forces (CAF), Veterans Affairs Canada (VAC), and Royal Canadian Mounted Police (RCMP) started to work on the incorporation of a network of mental health facilities that were to be spread across the nation. These Operational Stress Injury Clinics were established so specialized mental health care for members and veterans of the Canadian Forces and RCMP would be accessible and under one roof. With this addition, it was ensured the mental health needs of members and veterans of the forces and RCMP would be treated in a timely and effective manner.

**Peer Support and Operational Stress Injury Support Services (OSISS)**

During this time, the formal recognition of peer support was also gaining attention. As a result, the national Department of Defence and Veterans Affairs Canada funded OSISS program
was officially launched in 2001 (Heber et al, 2006). As a result, initiatives to incorporate this important component within the system were expanding and being implemented. As this addition was designed to be a component of the healing trajectory, services were to be delivered exclusively by veterans of the Canadian Armed Forces who were hired to provide a non-clinical peer support service to those suffering with OSIs. The two concepts that were to be central to the OSISS program vision were the following: To enhance structured social support for recovery from OSI’s and to help facilitate the reaction of stigma around operational stress injuries and the influence this stigma had over accessing mental health services (Heber et al, 2006; Zamorski, 2011). The collaborative efforts between OSISS, OTSSCs and OSICs had a substantial influence on cultivating a more effective approach to mitigating barriers to accessing quality mental health care in a timely manner (Heber et al, 2006). Today the OSISS program continues to be an integral part of the OSIC in Winnipeg. For many clients, involvement with OSISS has superseded a referral to the OSIC, and in some instances it has been the assistance from OSISS that has led those most in need to the services at the clinic. The importance of having support from fellow Canadian Armed Forces members and veterans emphasizes the significance of camaraderie, both on and off the battlefield. It is this inside perspective that can help breach barriers to accessing mental services and perhaps help facilitate taking the first step towards healing for those who may not have otherwise embarked on this journey.

Overview of Quantitative Measures at the Winnipeg OSIC

A review of the Winnipeg OSIC’s standardized symptom checklists, completed by new clients upon program entry and again upon discharge from the clinic, typically demonstrated a reduction in symptoms as a result of engagement in OSIC services. This reported reduction represents improvement in functioning and reduction in PTSD symptomatology as a result of
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engagement in treatment. However, for many clients who complete the PTSD military version checklist at discharge, (PCL-M), there remains scores that continue to fall above the clinical cut-off, in spite of successful treatment completion and discharge from the clinic. Though Weathers et al., (2013) state that a 5-10 point change in the PCL-M represents achievement of therapeutic gains and a 10-20 point change represents clinically significant progress, critical qualitative information about recovery cannot be captured with such symptom focused, quantitatively based measurement (Zamorski, 2011; Laforce, Whitney & Klassen, 2012). Given this knowledge, it is understood that the gap in the current research regarding what symptom reduction means in the context of recovery warrants exploration (Zamorski, 2011; Laforce et al., 2012). A limitation to the Winnipeg OSIC program evaluation database is the sole reliance on quantitative statistics in the absence of any formal qualitative feedback (Laforce et al., 2012). Though standardized symptom checklists provide important information about symptom severity and response to treatment, data about recovery is missing that cannot be captured quantitatively (Andresen, Caputi & Oades, 2010; Lakeman, 2004; Resnick, Rosenheck & Lehman, 2004). With the lack of qualitative research being conducted and used as a means to supplement and expand on the quantitative findings, there are proposed limitations to the development of client centered care that is actually deemed scientifically necessary by the individuals who are the true experts in this journey (individuals living their own recovery) (Jacobson, 2004).

Evidence-Based Treatments for Posttraumatic Stress Disorder

Treatment of PTSD within the OSIC adheres to standards and guidelines set out in select Evidence-Based Treatment (EBT) protocols. The following are the ‘gold standard’ EBT for PTSD offered at the OSIC: Eye Movement Desensitization Reprocessing (EMDR) (Shapiro, 1989), Prolonged Exposure (PE) (Foa, Hembree & Rothbaum, 2007), Cognitive Processing
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Therapy (CPT) (Resick, Monson & Chard, 2006), and Couples-Based Cognitive Therapy (CBC-T) (Monson & Freidman, 2012). Though there is some flexibility in how the protocols are delivered, most clients are expected to show improvements as a result of engaging in and completing the treatments as they are presented in the treatment manuals. The treatments typically are delivered over a course of 12-16 sessions with the exception of EMDR, which consists of a more fluid protocol with variations in sessions (Shapiro, 1989). In spite of the quantitative and clinical knowledge regarding treatment outcomes, there are gaps around processes within the current rehabilitative programming at the OSIC. This has been a result of the limited information in the current literature regarding what factors outside of the treatment protocols facilitate recovery with the military and RCMP population. Though there is evidence to support good responses to treatment, there are often residual symptoms that persist in spite of completing these protocols. In the past there was the perception that more treatment to target residual symptoms may provide a better outcome. This has on occasion led to discouragement and frustration for the clients, referral sources, and clinicians. As a result, OSIC clients often express a need for other services, some being available at the Winnipeg OSIC. This indicates that in spite of completing treatment and reporting improvement, a significant number of clients do not yet feel ready for discharge. Clinicians often concur with their clients, feeling that a discharge from the clinic could be premature. What has been missing is a rehabilitative program that is structured in such a way that the more natural trajectory of recovery could be supported. What this program may evolve into in the future will be explored in this thesis.
Program Changes at the OSIC

Over the past year, group-based trauma treatment has been added to the list of options offered to clients at the Winnipeg OSIC. Currently the literature on group-based treatment versus individual trauma treatment does not support one modality over another and specific research about the efficacy of group treatment is limited (Schnurr et al., 2003; Sloan, Bovin & Schnurr, 2012). However, specific military versions of group-based trauma focused protocols have been developed and are currently offered at the Winnipeg OSIC. Though the addition of certain group-based interventions at the OSIC has been well received, there has been no formal study regarding outcomes and treatment efficacy published to date.
Chapter Two-Literature Review

A review of the literature on EBT and recovery from PTSD and combat-related PTSD was conducted using the search terms ‘military PTSD,’ ‘PTSD and recovery,’ ‘military culture,’ ‘military mental health,’ ‘mental health and/or recovery’ and ‘adjunctive treatments for PTSD.’ Select databases used in the literature searches were Pub Med and CINAHL and EBSCO host. Additional literature on the recovery paradigm was obtained in accordance with suggested readings by the thesis advisor and committee members, and as per requirements in an advanced readings graduate course. All readings were annotated accordingly in preparation for this proposal.

Terms for Combat-Related Psychological Trauma

The literature presents extensive documentation of combat-related psychological trauma that has fallen under a number of different terms and managed in a variety of ways over the years (Friedman, 2013). Documentation of the early medical attempts to address military-related psychological symptoms date back to the American Civil War (1861-1865), and there are even earlier references to past terms such as war ‘nostalgia’ (Friedman, 2013). The evolution of war-related conditions continued with labels such as ‘irritable heart’ or ‘soldier’s heart’, and became more formalized as diagnoses such as ‘shell shock’ eventually emerged (Friedman, 2013). In 1952 the American Psychological Association developed the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) with the term ‘gross stress reaction’ to help diagnose those who had exhibited certain psychiatric symptoms following exposure to combat and disasters (Friedman, 2013). In spite of this advancement in medicine, the term PTSD was not added to the manual until 1980. This addition to the DSM-3 resulted from further research occurring with very specific groups such as Vietnam veterans, holocaust survivors, and victims of sexual trauma (Friedman, 2013). It was at this point that the connection between the trauma of war and its
impact on life upon return from war was officially established (Freidman, 2013). Currently the DSM is now in its fifth version (DSM-5) and here PTSD no longer falls under the category of anxiety disorder where it had been previously categorized in the DSM-4. PTSD is now reclassified under Trauma and Stressor Related Disorders category which includes four distinct symptom clusters, thus helping the clinician properly assess and diagnosis PTSD (Friedman, 2013).

**Incidence and Prevalence of PTSD**

Regarding prevalence rates of PTSD found across Canada and the US, epidemiologic samples have captured a range between 6-9% within the general population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kessler et al., 2005; Stein, Walker, Hanzen, & Forde, 1997; Sareen, 2014). Conversely, the national Australian samples have been reportedly lower, falling between ranges of 1-2% (Creamer, Burgess, & McFarlane, 2001; Sareen, 2014). Of note, higher risk groups such as military personnel exposed to combat have reported higher incidences of PTSD, falling within a wide range of 10-40% compared to the general population at 6-9% (O’Donnell, Bryant, Creamer, & Carty, 2008; Sareen, 2014). Data from the US military in samples following deployments to Iraq and Afghanistan show rates of PTSD at an estimated increase ranging between 11%-17% compared to a baseline pre-deployment rate of 5% (Hoge et al., 2004). Sareen (2014) states uncertainty remains as to why there is such diversity in rates, suggesting it may relate to methodological differences in assessment or, on the contrary, true differences across the respective populations sampled. What these rates do indicate is a broad range of prevalence and incidence of PTSD which is dependent upon the sample examined and the duration and extent the traumas impacted these samples (Sareen, 2014).
PTSD and Treatment Efficacy

There was an ample amount of literature on PTSD and quantitative reviews on the effectiveness of EBT for PTSD found during the literature search. Of particular relevance was a meta-analysis of PTSD treatment efficacy which concluded that certain trauma-focused therapies showed large effect sizes ranging from 1.01 to 1.63 respectively (Watts et al., 2013). Medications such as sertraline, fluoxetine, risperidone, toperimate and venlafaxine were also found to be beneficial with effect sizes ranging from 0.074-1.20 (Watts et al., 2013). Interestingly for both psychotherapy and pharmacotherapy, studies with larger samples of females had larger effect sizes, while a larger veteran sample displayed smaller effects (Bradley, Greene, Russ, Dultra, & Westen, 2005; Watts et al., 2013). In 2006, authors Solomon and Mikulincer published results from a longitudinal study conducted with Israeli combat veterans from the Lebanon war. Over a 20 year period, the researchers examined the long term effects of combat and found in their research that soldiers exposed to combat stress and subsequently diagnosed with PTSD, suffered from more severe PTSD compared to their non-combat exposed counterparts (Solomon & Mikulincer, 2006). Further, the combat exposed veterans were also deemed to be an increased disadvantage for symptom exacerbation and reactivation in comparison to the non-combat exposed veterans (Solomon & Mikulincer, 2006). The authors concluded that the detrimental effects of combat stress and combat related PTSD contribute to a certain complexity and consequently, a unique recovery trajectory that was not reported or observed in non-combat exposed veterans (Solomon & Mikulincer, 2006). As a result, it can be seen that although there is some insight into the unique recovery trajectory of the military veteran, the remaining limitations of the current literature warrant further research into the phenomenon of service related PTSD, treatment and the over arching recovery trajectory.
Barriers to Care

Canadian researchers who studied barriers to accessing mental health services in the Canadian Forces found the following factors to be a negative influence: fear of negative perceptions from chains of command, career implications, feelings of failure and shame, and a lack of faith in the mental health system (Heber et al., 2006; Zamorski, 2011). Stigma remains a suggested barrier to obtaining true rates of PTSD within the Canadian Armed Forces, and consequently this has affected access to required care (Heber et al., 2006; Zamorski, 2011). Some veterans have reported dissatisfaction with the evidence-based techniques that overlook the occupational context in the treatment of injury with the professional warrior (Castro & Adler, 2011; Hoge, 2010). Further to this, it is suggested that strict adherence to treatment protocols may not always address issues unique to the military such as ethical dilemmas encountered in theatre and survivor’s guilt (Hoge, 2011). Therefore, making room to incorporate a client-centered approach in the manual treatment protocols may help to enhance efficacy within the military culture (Hoge, 2011). According to Leeman and Sandelowski (2012), qualitative inquiries will scientifically generate the practice-based evidence from interventions and experiences in the context of care and innovations that stem from this direct care. In turn, the exploration of the concept of practice-based evidence (PBE) and how it fits with evidence-based practice (EBP) has been achieved in this qualitative inquiry. Given the uniqueness of the military culture, the following section of the thesis will explore the cultural context of military personnel and the relevance of its impact during recovery.

The Cultural Context

It is understood that the relationship between trauma and culture requires a ‘big picture overview’ of each concept of healing (Marsella, 1989). Culture within in the military has been
described as encompassing a constellation of shared ideas, beliefs, language, skills, practices, traditions, values, and customs which are reinforced by the institutional framework that in turn influences both the individual and the collective identity of the group (Lunasco, Goodwin, Ozanian & Loflin, 2010; Wilson, 2008). According to Wilson (2008), there is no individual sense of identity in the absence of a cultural reference point. Litz and colleagues expand on this shared identify, ideals, and fundamental characteristics as the warrior ethos that comprises the military culture (Litz et al., 2014). The expected behaviors of the warrior within the military culture is guided by unwritten rules that both inform and shape the desired performance of the collective group (Greenberg, Langston, & Gould, 2007; Litz et al., 2014). As these culturally-shaped beliefs influence a person’s ability to interpret and ascribe meaning to the world, so too do the traumatic experiences that are encountered within one's culture (Litz et al., 2014; Wilson, 2008). To some extent, the suffering is just as unique as the cultural group affected. Therefore, the importance of this cultural influence needs to be factored into both trauma-focused treatment approaches and other adjunctive types of recovery-based care (Litz et al., 2014).

**Culture of stigma.** Lunasco et al., (2010) describes the efforts to reduce stigma and change perceptions of mental health services within the US military culture an ‘uphill battle’. He attributes this battle to the stigma associated with accessing these services and the difficulty mental health providers have encountered trying to customize traditional mental health interventions and treatment models to this unique military population (Lunasco et al., 2010). The characteristics and differences by way of training between the warrior and the mental health culture have been identified, and distinctions between the cultures of those with mental illness and the warrior have provided additional context for providers (Lunasco et al., 2010). As such, providers are encouraged to think about augmentations to the traditional approaches to treatment,
given the strong cultural influences that affect individuals while serving in the military and afterwards (Lunasco et al., 2010).

Three factors are of particular importance when considering the effects of cultural influence over mental health: a society's perception of the military, the operation in which the injuries occurred, and the way military members and veterans are treated compared to others in that society (English, 2012). Military personnel are unique in their culture with language full of acronyms and clearly defined rank structures (English, 2012). Additionally, the intimate sharing of experiences that are often traumatic in nature, yet so typical in the context of war, makes this cultural group even more unique. In spite of this knowledge and an increased understanding about mental health and the uniqueness of the military, lack of access to culturally competent providers who deliver contextually relevant and comprehensive care for veterans has been deemed problematic (Hobbs, 2008). In turn, the OSIC network remains a relevant resource, given the strict mandate to assess and treat members, veterans, and families of the Canadian Armed Forces and RCMP.

PTSD and the Recovery Journey

The conceptualization of PTSD in the literature ranges from being a rather persisting condition (Kessler et al., 1995; Kessler, 2000; Kessler et al., 2005; Solomen & Mikulincer, 2006; Van Ameringen, Mancini, Patterson, & Boyle, 2008) to a condition where full recovery is expected with timely intervention (Marchand et al., 2006; Phelps, Williams, Raichle, Turner, & Ehde, 2008). Whether recovery from PTSD is described as having a long or short trajectory, the literature suggests there could be an expectation that symptoms will emerge at various points throughout life (Karlin et al., 2010). For example, the Prolonged Exposure protocol has a section dedicated to relapse- prevention and symptom exacerbation (Foa et al., 2007). This section is
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considered part of the treatment package and seen as an essential component to the finals stages of this protocol (Foa et al., 2007). However, for some who are still serving, acknowledging any sign of symptom re-emergence has been difficult for reasons that have been mentioned. Knowing this, the unique qualities and added pressures within the military culture as it relates to accessing mental health services cannot be denied. Addressing these known barriers that are preventing timely access to care as required warrants exploration in future inquiries.

Comorbidity and Effects on Treatment

It has been estimated that over 90% of those diagnosed with PTSD will have comorbid mental health conditions such as anxiety and depression (Richardson, McIntosh, Stein & Sareen, 2010). This comorbidity often complicates both the clinical presentation of PTSD which in turn complicates the treatment plan of care for individuals (Richardson et al., 2010). In response to this, it has been suggested that considering both the comorbidities and associated complexities with multiple diagnoses be on the forefront with any treatment planning and deliverance (Richardson et al., 2010).

Richardson and colleagues (2010) identified key principles to aide in the prioritization and facilitation of treatment for PTSD. Though steps were identified to help ensure safety and stability prior to engaging in the trauma focused treatment, what was missing from the principles was what could be expected after the completion of the trauma-focused treatment (Richardson et al., 2010). As stated, the findings from this inquiry will help add to existing guidelines and rehabilitative principles, knowing that key recovery components missing from the trajectory lead to frustration for clients and others in their lives.

Though guidelines may seem rather intuitive to most treatment providers, clients presenting primarily for treatment of PTSD at the OSIC who also struggle with comorbid medical and physical conditions, such as chronic pain related to musculoskeletal injuries, have
indicated past difficulties with engaging in the treatment protocols when these comorbid conditions have not been addressed. Given this historical difficulty, it has been concluded that rehabilitative programming that fails to accommodate clients’ individualized needs will impede a person's ability to achieve the best personal outcome during the rehabilitative component part of the recovery trajectory.

**Recovery Paradigm in Mental Health and Recovery of Soldiers**

In spite of the known cultural uniqueness and extraordinary experiences often encountered while on duty, soldiers are people; therefore the history of the recovery movement warrants inclusion in this study. By further exploring the cultural uniqueness as well as the similarities between military and non-military persons, it is anticipated there will be an enhanced understanding of recovery in general (Lunasco et al., 2010). With this inclusion, supporting veterans who access mental health services will be better understood and those additional formal components to recovery that fall outside of the trauma treatment protocols can be attended to (Gray et al., 2012). Recovery has been described in the literature as both an elusive and multidimensional concept as well as a phenomenon, often meaning different things to different people (Anthony, 1993; Deegan, 1988). As a result, recovery has been understood to be rather difficult to summarize in any sort of simplistic or exclusive way (Anthony, 1993; Deegan, 1988).

Rehabilitation has been described as a component of the recovery journey, with some of its concepts relating to recovery that are intertwined and interdependent with each other (Deegan, 1988). Hence the literature cites the importance of expanding services to accommodate a more holistic client-driven program extending beyond clinical treatment protocols with outcomes that may not be reflective on standardized quantitative measures (Andresen et al., 2010). Whether recovery is seen as truly the ‘guiding vision’ (Anthony, 1993), or a concept rooted in evidence
with an ideological concept of the phenomenon (Jacobson, 2004), a deeper examination to compare and contrast mental health recovery with non-military/RCMP, military/RCMP and veterans of these organizations is warranted.

**Recovery Defined by DND**

Canada's Department of National Defence (DND), has defined recovery as “the period of treatment and convalescence during which patients’ transition from the onset of illness or occurrence of injury to the point where they are stable and ready to receive longer-term medical care and optimize their functional capacity in various aspects of their life” (National Defence and the Canadian Armed Forces, 2014, p. 15). This definition speaks to the reality that for some, recovery may constitute a medical release or retirement from the Canadian Forces, and for others, retention, re-mustering, or occupational transfer to a new trade may be beneficial. The OSIC in Winnipeg will continue to support individuals and families as they make any transition required during their rehabilitation and as it are required throughout their recovery journey.

**Recovery Movement in Mental Health**

Hunt and Resnick (2015) have reviewed the social justice aspect of the recovery movement in the mainstream mental health system based on patient mistreatment and survivor accounts of their experiences. They found that the formalization of recovery, though more consumer-driven than a partnership between provider and client, continued to present struggles as some of the earliest concepts developed in the movement were negated (Hunt & Resnick, 2015).

In spite of this insight, Aston and Coffey (2012) examined the subjective experiences of recovery in mental health for both service users and the nurses who delivered those services, and concluded that recovery was a concept both service users and providers struggled to define. The
authors acknowledged that even though there was ample literature on recovery in mental health, there remained some discord around the concept and how recovery-oriented care could be implemented in acute mental health settings (Aston & Coffey, 2012). This modest study not only helped elucidate where past discord had occurred, but proposed a new way of educating both nurses and service users; this being more of a mutually constructed approach to recovery-based approach to care (Aston & Coffey, 2012). This mutually constructed way of approaching the recovery described by Aston and Coffey (2012) demonstrate the importance of accessing the clients subjective experience in the recovery journey so that further client centered or individual driven policy and programming around recovery initiatives can be formalized. Relatedly, Kidd, Kenny and McKinstry (2014) explored the meaning of the term recovery to both those who had provided mental health services and those who had accessed the services. Their research concluded there was an overarching theme that recovery was an ongoing process, and was supported by factors such as personal empowerment, relationships with others as well as the influence of time.

Research shows there have been efforts to increase the focus on the development and nurturing of consumer-involved recovery programming at various points of service utilization (Byrne, Happnell, Welch & Moxham, 2013; Deegan, 1988). That said, some providers' attitudes about consumer involvement negatively impacted the progression of these initiatives (Byrne et al., 2013; Deegan, 1988). Byrne et al., (2013) suggested the inclusion of education from those with lived experiences of mental illness occur as part of the academic training for nurses. This echoes what other researchers have discovered when exploring the benefit of early introduction and the enhancement of a client-centered rehabilitative approach more naturally ingrained in the
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minds and practices of care providers (Ashton & Coffey, 2012; Byrne et al., 2013; Deegan, 1988).

The Mental Health Commission of Canada (MHCC) in partnership with the Canadian Nurses Association (CNA) drafted a document to help elucidate that recovery does not fall under one particular definition (Canadian Nurses Association/Mental Health Commission of Canada, 2014). However, these stakeholders of the commission and association have presented the concept of recovery as the ability to live a fulfilling life that is with hope and contribution, in spite of ongoing limitations that mental health problems and limitations may present (CNA/MHCC, 2014, p. 29). As such, it is paramount that recovery oriented practice bridges both professional and clinical interventions while supporting individual’s autonomy through collaboration between the recovering individual and the provider (CNA/MHCC, 2014, p. 30). This collaboration and flexibility has been welcomed by individuals at the OSIC who have occasionally indicated that the previous, less flexible approaches to rehabilitation and recovery were personally and professionally detrimental to the healing trajectory. It will remain our mandate to foster such collaboration with clients and families who obtain services at the Winnipeg OSIC.

The literature presents the history of the recovery movement and highlights the importance of client-centered care (Anthony, 1993; Aston & Coffey, 2012; CNA/MHCC, 2014; Deegan, 1988; Gray et al., 2012; Kidd et al., 2014). This qualitative inquiry will help provide information about the lived experiences of the Canadian Forces veteran, thus providing an important and unique addition to the existing recovery literature.
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Complimentary and Adjunctive Treatments for PTSD

A dearth of literature exists on adjunctive treatments for PTSD. However, a few studies have focused on adjunctive treatments and complimentary approaches to facilitating recovery from combat-related PTSD (Morgan et al., 2013; Plach & Sells, 2013). Specific studies looked at the addition of nature-based initiatives in conjunction with more traditional trauma treatment (Hyer, Boyd, Scurfield, Smith, & Burke, 1996) and the usefulness of mindfulness practice as an aide in trauma processing (Lang et al., 2012). The findings suggested that the combination of mindfulness and other skills may help strengthen emotion regulation and improve outcomes when providing evidence-based PTSD treatment (Lang et al., 2012; Vujanovic, Niles, Pietrefesa, Potter, & Schmertz, 2016). However, the potential benefit of integrating such mindfulness-based adjuncts to the PTSD treatments was viewed as lacking sufficient empirical support (Follette & Vijay, 2009). According to another study, the most frequently used complementary and alternative treatments used to address emotional and mental problems associated with PTSD are the mind-body treatments such as mediation, relaxation and exercise therapy (Libby, Pliver, & Desai, 2012). In spite of the mounting anecdotal evidence, there remains limited empirical evidence to substantiate the declared benefits (Strauss, Lang & Schnurr, 2012). The augmentation of evidence-based treatments with such complimentary and adjunctive approaches is understood to have a role in recovery; however, further research to help substantiate and integrate such strategies is required (Hoge, 2011; Veterans Affairs/Department of Defence Clinical Practice Guidelines, 2010; ). This inquiry will provide some insights into the information currently missing in the literature. However, future inquiries that concentrate more on complimentary and adjunctive treatments in OSI rehabilitative programming, is warranted.
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In conclusion, in the literature there is evidence that although there are effective treatments for PTSD, there remain some gaps in the literature and in our understanding about the concept of recovery as it is experienced by those who have completed treatment for PTSD. Therefore, the purpose of this research is to explore how individuals diagnosed and treated for service related PTSD, conceptualize recovery. The following section will explain how this research was conducted and the findings that were generated as a result of the interviews with the three study participants.
Chapter Three – Methodology

The chosen methodology for this study was Interpretative Phenomenological Analysis (IPA). IPA is grounded in phenomenology and considered both a “theoretical foundation and procedural guide” (Brocki & Wearden, 2006; Smith, Flowers, & Larkin, 2009). The conceptual foundation of this inquiry is maintained by Heidegger’s ontological approach to the research of trying to understand the meaning of being for individuals and the influence of the context of time and space on this experience of being (Mackay, 2005). Similar to philosophers Bachelard, Marleau-Ponty, and Wittgenstein, Heidegger turned his focus from looking exclusively at the thematic meaning of events to the expressive dimensions ascribed to describing these events (van Manen, 1997). This in turn allowed for exploration into not only what the text represented but the context or how it was being said during the inquiries (van Manen, 1997). The conceptualization of a person’s being in the context of time and place in his or her life journey helps to emphasize a human’s temporality and constant state of interpretation that underpins the IPA method of inquiry (Todres & Wheeler, 2001). Smith et al., described Heidegger’s conceptualization of people in ‘context’ as their interactions and ‘being in a certain time’ as what most has influence over their ability to make sense of both one another other and in the world (2009). As such, conceptual underpinnings, as described by Heidegger, seemed the most suitable philosophical foundation to guide the subsequent exploration into the lived experience of recovery from service-related PTSD. Heidegger’s philosophies provide the foundational tenants of IPA and resonate with the philosophical position of the psychiatric nurse who so often needs to explore beyond the obvious and look deeper into what is being said, as well as discerning the meaning people make of their experiences.
IPA as a research methodology facilitates the exploration of the subjective experience as a means to help the researcher understand and describe the participant’s process of making sense of their experience (Brocki & Wearden, 2006). IPA is comprised of phenomenology, the study of the lived experience (Langdridge, 2007); hermeneutics, the theory and practice of interpretation (Rennie, 1999); and ideography, the study of unique individual experiences in their context (Eatough & Smith, 2008; Smith et al., 2009; Smith, Harre & Van Langenhove, 1995).

Phenomenology is described as both a philosophy and a way of research, aiming to understand and explore the lived experiences of human beings (Smith et al, 2009). In IPA, phenomenology has been categorized into two streams, better known as descriptive and interpretive (Langdridge, 2007; Smith et al., 2009; Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013). Descriptive phenomenology maintains roots in trying to stay true to the phenomenon as it appears in consciousness (Giogi, 2008; Tuohy et al., 2013). In contrast, interpretive phenomenology or hermeneutics is focused more on the interpretation of these life experiences than the description alone (Pietkiewicz & Smith, 2014). The ideographic component unique to IPA allows there to be a focus on the distinct and particular experiences of the participants as well as the unique contexts in which they occur (Eatough & Smith, 2008; Smith et al., 2009; Smith et al., 1995).

Given the importance of ideography in IPA, the central component of the research is the individual case, and the exploration and understanding of it as much as possible before moving on to the next case (Smith et al., 2009).

**Bracketing, Reflexivity and Reflective Journaling**

Two essential techniques used to maintain adherence to the ideographic and interpretative components of IPA are better known in the research domain as bracketing and reflexivity (Smith et al., 2009). In bracketing, the researcher approaches each new case with objectivity and
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openness, thus maintaining an idiographic approach that is integral to IPA (Smith et al., 2009). That said, the researcher cannot completely separate his or her own experiences and so must diligently seek to understand the effects of one’s own experiences as related to the phenomena (Porter, 1993). Like the psychiatric nurse who brackets his or her individual or subjective views and biases when providing care, the research investigator will also strive to maintain this same unbiased approach when conducting the qualitative inquiry. Bracketing entails recognizing and separating one’s own interpretation from the participant’s interpretation, and carefully accounting for the relationship between various levels of interpretation. Bracketing requires reflexivity.

Reflexivity has been described as a means to reflect and turn back upon oneself in order to see oneself within the world he or she chooses to study (Frank, 1997; Myeroff & Ruby, 1992). This technique has been further explained as occurring on a continuum and operating under the assumption that the knowledge gained during an interaction cannot be fully separated from those involved in the research (Bradbury-Jones, Irvine & Sambrook, 2010). With this insight, the investigator is considered to be a dynamic part of the research, who co-constructs an understanding of the lived experience, alongside the participant (Pierson, 1999; Smith et al., 2009).

According to Tanner, Benner, Chesla & Gordan (1993), it is this inter-subjective process of interpretation that enables the nurse to clinically access information about the client in order to understand the situation and the theoretical underpinnings that govern the situation. It is within this qualitative context that the inter-subjective process facilitates the joining of the researcher with the participant (or psychiatric nurse with client) to uncover, explore, and interpret the meaning of the phenomena under review (Pierson, 1999). Within this process, there is no
expectation to maintain complete objectivity or neutrality as this is impossible for the researcher to do (Guba & Lincoln 1989; Lather, 1991; Merriam, 1988). The hermeneutic component of IPA is the theory and practice of the investigator’s interpretation of meaning as it has been created and described by the participant (Rennie, 1999; Smith et al., 2009). Due to the co-constructed dialogue that is unique to the IPA inquiry, the investigator must engage in what is called a double hermeneutic process, which is the combined perspective of the phenomenon by the collaborative efforts of the participant and investigator (Smith et al., 2009). The hermeneutic circle is described as being a component of the analysis and writing process of IPA (Smith et al., 2009). It is further described as the dynamic relationship between the parts and the whole of the particular phenomenon under review (Smith et al., 2009). As the context is regarded in the analysis, there is a deeper meaning and a reciprocal relationship between parts of the phenomenon and greater phenomena under examination (Smith et al., 2009).

What is distinct to IPA is this process of trying to make sense of and interpret the participant’s interpretation of the experience along with the researcher’s process of interpreting the participant’s interpretation of their experience (Smith et al., 2009). Therefore the investigator is seen as the primary instrument who engages in the hermeneutic circle, immersed in this reciprocal experience of tapping into and presenting the mutually understood meaning of the phenomena that has been co-constructed by the investigator and participant (Pierson, 1999). By maintaining a reflective journal during the research process, the investigator remains cognizant of thoughts, beliefs, revelations, and opinions as they emerge (Smith et al., 2009). The utility and importance to bracketing and reflexivity of keeping this reflective journal became apparent at the outset of this qualitative inquiry.
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The Suitability of IPA

Though IPA research has historically focused on disease and impairment, recently there has been a shift towards exploring positive factors that may contribute to the well-being of individuals living with certain conditions (Reid, Flowers & Larkin, 2005; Reynolds & Prior, 2003; Reynolds, Vivat & Prior, 2008). This advancement in the application of IPA exemplifies why, as a guiding philosophy and methodology, it would be particularly suitable for this inquiry.

Sample Size

Though previous studies have been successful with one participant (n=1), most recruitment numbers for IPA has ranged between one to 35 (Brocki & Wearden, 2006). For this particular study, a modest sample size of four was decided upon. Cross-case analysis of small samples is described as most suitable for focusing on and comparing individual experiences (Eatough & Smith, 2008; Smith & Eatough, 2006; Smith et al., 2009). With this smaller sample, the phenomenon under review was captured in a way that conveyed the experience of the individual while tapping into the overarching and collective shared context (Smith et al., 2009). Given this knowledge of IPA, it seemed like a very fitting methodology for clinicians who are new to the research world. Clinician-research investigators who embark in the area of research are often in unique positions, with opportunities to create research projects and access program evaluation data that may not be so readily available otherwise (Fox, Martin & Green, 2007). At the same time, the unique position of the clinician-turned-research investigator highlights the importance of reflective journaling and maintaining a reflexive approach before, during and after the research is complete. The clinician/researcher role also has ethical implications for research design as addressed below.
Study Design

The intended sample for this study was four male Canadian Forces veterans who met the following criteria: they were diagnosed with service-related PTSD, they had completed a course of evidence-based trauma treatment at the OSIC, and they were subsequently discharged from the Winnipeg OSIC. The method of participant recruitment was purposive sampling, as fitting with the IPA methodology which emphasizes the importance of homogeneity in a sample (Pietiewicz & Smith, 2014; Smith et al., 2009). A recruitment poster was placed in the outside corridors of the North Pavilion building at Deer Lodge Centre in Winnipeg. Information was provided on the poster so those interested veterans who had been discharged from the OSIC could contact the principal investigator for more information. Word of mouth also generated some additional advertising of the study within the community of veterans who subsequently found out more about the project. For those who expressed interest in participation, a brief screening questionnaire was conducted over the phone to explain study goals and confirm their eligibility for participation. It was also emphasized during this call that there was absolutely no obligation to participate in this inquiry and withdrawal from participation would be possible up to transcribing the interview.

After two months of recruitment, three participants were screened and deemed eligible for participation in the study. It was decided at this point that recruitment would cease and the study would proceed with a sample size of three rather than the intended four. With eligibility determined and the veterans' participation was confirmed, arrangements were made for in-person meetings to review the informed consent via hard copy, followed by participation in the qualitative interview.
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The meetings were coordinated on the days when a psychiatrist was available to provide medical support and/or debriefing if required. This additional support was ensured under the direction of the Brandon University Ethics Committee who emphasized the need for implementing safeguards which were in accordance with regulations pertaining to conducting research with participants who were deemed to fall under the moderate risk category (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014, p.46). To further ensure these safeguards were maintained and to enforce the point that participation in this study was voluntary, it was emphasized in the informed consent form and verbally during review of the consent that participants could withdraw from the study with data from the interviews removed up to the point of analysis and data de-identification. No demographic information was included in the transcripts and the demographics associated with the initial screening was stored in a locked cabinet, separate from the transcribed interviews. The participants' names were replaced with the identifiers of participant one, two and three. Although the investigator remained aware of whom each participant was due to the small sample size, there was this ability to conceal identities by replacing names with the assigned participant number.

Ethics. Ethical approval was obtained first from the Brandon University Research Ethics Committee (BUREC) and subsequently by the Deer Lodge Centre Ethics Review Board (DLC ERB). A letter of site support indicated the OSIC manager and manager of research were also obtained in accordance with BUREC and DLC ethical guidelines. As stated, an OSIC psychiatrist, was available during the interviews for debriefing or medical intervention in the event of any adverse or abreaction to participating. As it turned out, there was no indication of
any adverse reaction to the discussion about recovery, thus there was no need to access the psychiatric services before, during or after the inquiry.

**Dual role as therapist and researcher.** In accordance with the guidelines established with the Brandon University Ethics Committee, potential participants were only eligible if they had engaged in PTSD treatment with an OSIC provider other than the investigator or psychiatrist designated for debriefing. This clear boundary between the roles as a researcher and clinician at the OSIC helped to safeguard against any ethical infringement and mitigated the actual and perceived conflict of interest that could arise from such a duality in the role as therapist and investigator (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014, p.107).

**Participant demographics.** As stated, in order to maintain confidentiality, participants in this research project were de-identified by referring to them as participant one, two and three. It was decided that the use of numbers as opposed to creating pseudonyms would assist the participants in detecting their quotes and extracts shared upon the final review of the findings once the research was complete. Additionally, the use of pseudonyms was avoided given the small community of past and current clients at the OSIC and the risk of misidentifying someone by their pseudonym.

The participants of this inquiry ranged in age and in deployment experiences. Each conflict was from different era, however, the experiences of war, contributed to the homogeneity of the sample. Participants were all assessed and diagnosed at the Winnipeg OSIC. They had been discharged from the program upon completion of treatment. The sample was fairly homogenous as the criteria for approval to participate were the following: male, diagnosed with
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deployment-related PTSD, discharged from the OSIC, and having veteran status. However, the variation in time between symptom onset, referral to the OSICs for diagnostic assessment and treatment varied. For one, the initial assessment and diagnosis of PTSD did not occur at the OSIC; however, once engaged in the evidence-based treatment for his condition, a diagnosis was made. For another participant, his symptoms of PTSD were managed independently with some periodic medical intervention over the years. But it was not until he attended the OSIC that he engaged in a comprehensive diagnostic assessment and in turn received compensation in the form of a pension from Veterans Affairs Canada for his service-related PTSD. It was during the post-deployment screening that this participant was flagged for symptoms suggestive of an operational stress injury. As a result, he was subsequently referred for further assessment at the Winnipeg OSIC. For this participant, there had been little time between deployment and initiation of mental health services. This method of earlier detection and initiation of services is part of the Canadian Forces' new mandate to provide early detection and intervention for operational stress injuries such as PTSD (National Defence and the Canadian Armed Forces, 2014).

**Interview structure.** The interviews consisted of a series of set questions although the nature of the semi-structured interview was conversational in style. A set time of 120 minutes was reserved for every interview, although each one was completed in 90 minutes or less. The interview setting was in an office down the hall from the main reception of the OSIC, which helped enhance familiarity of the milieu for the participants while drawing a boundary between the research and the clinical setting. At the outset of the meeting, consent forms were reviewed carefully as were the limitations to the confidentiality (risk to self or others were verbalized during the interview process). It was emphasized that a psychiatrist was available onsite and
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readily accessible should the participant feel the need to debrief during or after the interview. It was also emphasized during the review of the consent form that one's participation could be rescinded to the point where the data became aggregated and de-identified as names were replaced by the participant numbers.

Data Analysis

Data collection consisted of recording interviews with a digital audio recorder. Written documentation in the form of field notes was also kept during the interview process. Reflective journaling pre- and post-interviews was also kept in a separate book and stored in a locked cabinet along with the field notes. Audio files were sent via confidential Drop box and transcribed by the study transcriber who was hired for this project. As part of the contractual obligation the transcriber was required to sign an oath of confidentiality which was returned to the investigator prior to having access to the participants' data. Transcribed interviews were returned for analysis and copies of the audio files were immediately destroyed once the transcribing was complete. Transcribed material, field notes and the reflective journal were all stored in a locked cabinet in the investigator's office which was only accessible by her. Guidance in the data analysis was facilitated by referring to the writings of Smith et al., (2009). Though data analysis at this point was considered complete and no further augmentation to the report was expected, interview transcripts were retained in a locked cabinet and then destroyed six months after the completion of the study. Following this time period, documents were to be shredded and discarded in the confidential recycling bin. The following are the steps used to guide the process of analysis with details on how each step in the analysis was adhered to and implemented.
Step 1: Reading and re-reading the transcripts. This first step was described as essential to ensure the interview participant becomes the main focus of the analysis, as it is at this time that the investigator immerses herself fully into the participant's world. By slowing down and taking the time to do this, the investigator can note how her own insights have emerged, and then document them accordingly. This process of reflection occurred in addition to earlier bracketing and reflective journaling that had occurred before the first interview. Similar to the pre-interview bracketing, the documented insights logged at this stage played a key role in the later analysis and throughout the duration of this study. The investigator began this process by immediately listening to the audio recordings after each interview. It was at this time the field notes were documented for a later review that would coincide with an analysis of the written transcripts as they became available. The investigator relied on the transcripts and field notes once the audio recordings were destroyed in accordance with the ethical guidelines established for this inquiry.

Step 2: Initial noting. Smith et al., (2009) described this level of the analysis as the most detailed and time-consuming part of the process, where the investigator must maintain openness to the data while documenting anything of interest that appeared in the transcript. There was no format or template used to help divide or place insights into categories as at this time the goal was to focus on better understanding the participant’s dialogue around the phenomena under review (Smith et al. 2009). That said, Smith et al., (2009) comment on the need to strategically organize one’s interpretive noting to explore both how and why the participant is thinking about the phenomena. This preliminary noting is used so one can eventually refer back to it and start to determine the abstract concepts as they emerge during the analysis. As suggested by Smith et al, (2009), the left margin of the transcript was reserved for initial comments and remarks during the
Step 3: Development of emergent themes. At this stage, combining the transcripts with the field notes to form a larger data set helped to detect emergent themes that transformed the data into a more integrated ensemble. The hermeneutic circle, previously described in the methodology section, was incorporated as a means to deconstruct the interview findings into select segments so a new whole could be created from key parts of the whole (Smith et al., 2009). As stated earlier, the investigator is seen as the primary instrument who engages in the hermeneutic circle, immersed in this reciprocal experience of tapping into and presenting the mutually understood meaning of the phenomena that has been co-constructed by the investigator and participant (Pierson, 1999). This was conducted by first interpreting sections, and then merging those sections into the newly-constructed whole. The incorporation of the hermeneutic or interpretive circle allowed for a deeper understanding of the participant’s lived experience as he had come to understand and ascribe meaning to it.

Step 4: Searching for connections across emergent themes. At this stage, emergent themes were established and listed chronologically in the order they had come up during the transcription review. It was also at this point that the development of a chart helped with mapping the emergent themes. The incorporation of mapping allowed for a better visualization of the themes so moving and clustering accordingly could continue to occur. By mapping and visualizing the thematic clusters, Superordinate Themes started to appear. From here, additional mapping and remapping of the themes occurred and Supporting Themes started to appear. It was also at this point that contextualization became more influential over the connection between emergent themes and the overarching Superordinate Themes. Further to this, the frequency in
which themes were emerging in the transcripts was also implemented to further the analysis. This particular strategy was termed by Smith et al., (2009) as “numeration”. Despite this style of extrapolating data being more frequently used in quantitative research, Smith et al., (2009) have described its utility in IPA as identifying potential relevance of emergent themes according to frequency of their mention. Although they state that not all strategies described in the IPA book are required during the analysis process, each has its own qualities and benefits. They added that trying to use more than one strategy can enhance the creativity in the analysis, and thus push it to a higher level of analytical discovery. In this particular study, abstraction, contextualization and numeration were the three strategies implemented in both the individual and cross-case interpretation of the three participants’ accounts. By using abstraction as it was described by Smith et al., 2009, the ability to identify patterns between the emergent themes gain a better sense of what would be eventually called a superordinate theme, was orchestrated. Further to this, the use of contextualization as it was defined in the literature, facilitated the ability to examine connections between these emergent themes by factoring in the contextual or ideographic elements within the analysis (Smith et al., 2009).

**Step 5: Moving to the next case.** Smith et al., (2009) state that although it is possible in IPA to have a single case study, it is typically more common to conduct this research with more than one case. Therefore bracketing is used diligently so the investigator can move from case to case to freshly engage in repeating steps one through four of the analysis. It is here that the use of bracketing helps the researcher to remain committed to maintaining the idiographic component of IPA, and thus new themes can be clearly seen with each new analysis (Smith et al., 2009). As stated, the use of reflective journaling and the investigator’s diligence in maintaining a reflexive approach throughout this project helped to create a reflective awareness of personal
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biases and influences prior to conducting each interview. Strubert and Carpenter (2011) have written about the importance for the qualitative researcher to regularly engage in the self-reflective experience so there is consistent regard for how one will inadvertently influence all domains of the research process (2011). The authors and emphasize the importance of maintaining an accurate appraisal of these influences and bracket them accordingly, throughout the research (Strubert & Carpenter, 2011). Though there was an awareness of the details of the previous interview in this project, there was a dedicated effort made to adhere to recommendations in the literature around bracketing assumptions in order to objectively see data in a wider context, as the investigator embarked on each new interview (Jootun, McGhee & Marland, 2009). This same type of ‘clean slate’ and subjective openness was exercised during the analysis portion of the research. This enabled the investigator to stay true to this important ideographic component of IPA from the outset of the research journey and through to the end.

**Step 6: Looking for patterns across cases.** Following the in-depth exploration and analysis of each case, the investigator proceeded to look for thematic patterns across the cases; this is also known as the cross-case analysis component of IPA (Smith et al., 2009). It was at this phase that the investigator started to identify the themes most prevalent in the analysis, so the re-labeling and reconfiguring of themes into emergent and Superordinate Themes could be facilitated accordingly in the analysis. During this exercise, there was adherence to the dual commitment to the individuality or ideographic component of each case as well as the higher order concepts emerging across cases. The maps that had been previously created were reconfigured into tables and the themes falling under Superordinate Themes had presented in all individual interviews. Though Smith et al., (2009) describe both the individual and cross-case interpretive process in IPA as complex and having great variation for any investigator, sharing
the analysis chapter with the thesis advisor and subsequently with the thesis committee helped to further interpret and provide additional insights reflected in the discussion and concluding chapters. This additional layer of interpretation was described by Smith et al., (2009) as being the essence of IPA analysis, stating that with each new reader, there is another layer of interpretation that occurs.

Smith et al., (2009) emphasizes the incredibly creative process and inherently interpretive quality of IPA. This process occurs both during the examination of the individual conceptualization and upon review of the collective experience. Given the interpretation is ongoing and the analysis never complete, presenting findings that are succinct and relevant to the reader will help determine whether good quality IPA research was conducted (Smith et al., 2009).
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Chapter Four- Findings

The objective of this qualitative inquiry was to better understand how veterans of the Canadian Forces, diagnosed and treated for duty related PTSD, viewed recovery. The two research questions that were addressed in this inquiry were: how did individuals who had competed EBT for PTSD interpret recovery and what factors in addition to or outside of the EBT facilitated or influenced their recovery.

Introduction to Findings

By following the steps of data analysis as they have been outlined by Smith et al., 2009, three main Superordinate Themes (or overarching themes) emerged. The investigator continued to maintain a reflexive approach throughout the analysis component of the research process given the highly interpretive and abstract nature of the IPA methodology (Smith et al., 2009). Supporting Themes also were developed during cross case analysis and categorized under their respective Superordinate Theme accordingly. The three Superordinate Themes generated from this research are as follows: Culture has an important role in recovery; Recovery is a journey; Relationships are critical throughout recovery.

In this section, each Superordinate Theme and Supporting Theme are explained and contextualized by sharing the participants’ understanding of their experiences. To start, participants’ interpretations have been included in an overview of their individual interviews. This allows for the reader to appreciate the individual uniqueness and ideographic account of the recovery phenomenon. Subsequently, the Superordinate Themes and Supporting Themes are shared to help provide further context to what emerged from the analysis of the interview transcripts. Finally, key verbatim extracts are included under the relevant supporting themes so that credibility in the findings and rigor in the research is shown.
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The following are summaries of participant’s individual responses to the questions asked during their interviews (definition of recovery and recovery-facilitating factors outside EBT) and the relationship of EBT to those facilitating factors.

Ideographic Accounts

One participant described his experience of recovery as life long process of learning to accept and live with symptoms and achieve a fulfilling life. He emphasized the importance in having the ability to recognize a problem as it emerged and accepting it for what it was. Using tools and techniques such as mindfulness and medication was identified as helping to manage and mitigate residual symptoms. The participant described the insight that he had developed during his time in therapy and since, and reflected on how this awareness enabled him to know when and how to reach out for help when it was needed. He credited the treatment and his growth from the treatment as helping him to be more attuned to the warning signs of a relapse such as when he started to isolate himself and push those away who were the closest to him. Regarding relationships, this participant reflected on the importance of his family and the expertise they had developed about him as they too progressed in the recovery journey. The participant reflected on the military culture and the influence this culture had on his experience with PTSD and recovery. The participant described a key part of the recovery journey as learning how to recognize and manage his PTSD triggers and accept limitations; stressing the importance in maintaining realistic expectations throughout the journey. These revelations were understood as being part of the growth that occurred in treatment as well as part of the revelations that had continued since treatment had ended. The participant understood recovery to be a journey that was continuing in this present time. He did not regard symptom exacerbation or any sign of condition relapse as a failure in recovery but rather, simply part of his unique experience of
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healing. Treatment was therefore regarded as part of the journey but not the sole factor towards healing.

Another participant reflected on his understanding of recovery and the role of treatment in the journey by sharing similar insights as participant one when exploring these phenomena. He described recovery in terms of the ability to function in life with ongoing PTSD. He reflected on the importance of what he learned in treatment, stating that he continued to implement these teachings in his daily life. He described grounding techniques such as counting backwards in his head (mental grounding) when feeling overwhelmed and triggered. He emphasized the importance of using various mindfulness techniques daily. Mindfulness was understood as being in the present moment and was described as being uniquely cultivated by going on long rides on his motor bike, going out to his family cottage, and spending time with members of his family. These strategies were all explained as not having such therapeutic relevance until he had engaged in therapy. The participant spoke openly about how indoctrinated he had been in the military culture and the impact this culture continued to have on him when first realizing that he had PTSD and throughout his recovery. The participant’s relationships with key people and his identity outside of the military had significance in finding additional purpose during recovery. Treatment was regarded as having impact and importance to date, even though time in therapy had concluded a number of years ago. The treatment was described as what allowed him to open up to others and get out of what he described as the “black hole” of PTSD. Like the others, the participant did not regard treatment as the only part of the recovery journey however; he did see it as an integral part of his journey. Treatment allowed him to see the importance of relationships throughout recovery. Repairing and maintaining the close relationships provided him with the ability to persevere and cope with the ongoing symptoms of
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PTSD. It was clear from this interview that this participant could not have done the work required in treatment, in isolation. He conveyed that his commitment to the difficult work required in treatment was solidified by the need to get better for those closest to him. He also remarked on how the coping with the difficult tasks required in treatment would have been more of a challenge in the absence of the support from these individuals. For the participant, it seemed as though treatment was the starting point of his recovery and the skills learned in this stage of healing have remained important throughout the journey.

The final participant spoke almost exclusively about how he was able to manage both his PTSD symptoms and life in the present moment; recovery is being able to manage both realities. The memories of war co-existed with the participant’s dedication to his family and friends. In this interview, he reflected on his experiences and concluded that he had lived “a good life.” As this participant was the oldest of the three interviewed, it was speculated that his stage of life and natural tendency to review one’s experiences, both traumatic and not, contributed to the degree in which the memories of war were present. The cultural influence of the military was slightly different for this individual in that he seemed to separate himself from the military culture once the war was over. With this particular participant, the military culture was of relevance in the development of PTSD but relevant in the context of recovery and integration into the larger societal culture. This particular individual had the longest period of time between his time in war and being diagnosed with PTSD. It remains unknown how much influence time had on recovery for him however; it appeared that this individual had a fulfilling life that co-existed with PTSD for many years. Developing the ability to connect with others and to share his war experiences was identified as resulting from treatment. This ability to eventually share stories that he once avoided, was an indication of the gains he had made in his recovery journey. The participant
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also spoke about a higher power protecting him at various points in his life. It was clear that there was some comfort in believing that what he was part of had some greater purpose that he could not explain.

The following Superordinate and related Supporting Themes were developed as a result of the ideographic and cross case analysis of the responses to the interview questions. The themes are represented in Table One below.

**Table One – Superordinate Themes and Supporting Themes**

<table>
<thead>
<tr>
<th>Superordinate Theme #1</th>
<th>Superordinate Theme #2</th>
<th>Superordinate Theme #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture has an important role in recovery</td>
<td>Recovery is a journey</td>
<td>Relationships are critical throughout recovery</td>
</tr>
<tr>
<td>Supporting Themes</td>
<td>Supporting Themes</td>
<td>Supporting Themes</td>
</tr>
<tr>
<td>• Pre-military</td>
<td>• The journey is evolutionary</td>
<td>• Relationship with soldiers</td>
</tr>
<tr>
<td>• Military culture</td>
<td>• Journey is never ending</td>
<td>• Relationship with family</td>
</tr>
<tr>
<td>• The subculture of veterans with PTSD</td>
<td>• Expertise is derived from experience</td>
<td>• Relationship with self</td>
</tr>
<tr>
<td></td>
<td>• Treatment is one part of the journey</td>
<td>• Relationship with the treatment provider</td>
</tr>
</tbody>
</table>
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**Culture has an important role in recovery**

Military culture was understood as possessing both an overt and covert influence over participant’s experiences of recovery. There is a shift in one’s identity that results from deployment and a further shift that derives from sustaining an Operational Stress Injury such as PTSD. The cultural influence of the military that transcends or surpasses individualism is difficult to disengage from, even one has left the CAF. What was understood from the interviews was that the influence of pre-military culture, military culture and the subculture of those who have been injured with an OSI such as PTSD, persists throughout recovery.

**The pre-military culture.** One participant described his cultural connection to his community prior to deployment and reflected on how this connection persisted throughout war and upon their return home:

> I had a buddy, who lived very close to where I lived growing up, and, we decided we were going to go and enlist in the service. And we did that. He ended up being a truck driver and he didn’t mind that. I was disappointed really that we weren’t together because we had been together, walking back and forth to school and everything. That connection continued after we were back here and we got together once or twice a month. Of course I bought a business out of province and we didn’t see each other as much, but every time I came to the city, of course we would get together.

Although this participant did not outright say that this particular buddy from childhood helped him in his recovery, when asked the question in the interview about who and what outside of the treatment protocol had been helpful or had impact on his journey, this participant reflected on his childhood friend. It was clear that this relationship was of significance in the context of surviving the deployment and coping with the effects of the deployment upon his return home.
Military culture. The uniqueness and distinctiveness of the military as a cultural group was understood to be of relevance to recovery for all three study participants. Each participant appeared to struggle with coming to terms with the nature of their experiences overseas and how this may fit within the Canadian cultural norms upon return home from deployment. Though there were positive components to this cultural uniqueness that was understood to provide perseverance and stamina during recovery, there was also a burden to being part of this unique culture. This uniqueness was understood create feelings of alienation as individuals reintegrated back into their Canadian culture. One participant shared the following insights about the influence of military culture, even after release from the CAF. He shares his experiences of the military cultural influence over recovery in the following extract:

Always you want to do better (in recovery). I always find that, even with this job [current civilian employment], I have a good friend [at work], we go for walks all the time and we always talk. He was in the military too so we’re always bugging each other. One of the things we realize is that we’re always thinking that we’re not doing enough. How can I do more? How can I correct this [PTSD symptoms].

This particular participant reflected on his experiences in trying to secure employment in the civilian sector upon his release from the CAF. He spoke about the struggle with trying to integrate into the workforce and how this struggle seemed to be mitigated upon finding other veterans in his workplace who were also trying to reintegrate into the civilian world. All three of the participants reflected on the camaraderie within the military and the influence this had over both PTSD and recovery. What was of particular interest was the distinct, yet related subculture of those with PTSD embedded within the both larger military and societal culture. This distinct
influence over recovery was represented as a supporting theme that will be explored in the following section.

**The subculture of veterans with PTSD.** Each participant reflected on their individual experiences of recovery and reflected on re-integrating into the larger societal context during recovery. One participant shared his particular struggle with trying to fit into a place of employment upon release from the CAF. For him, nothing felt comfortable until he secured a position where many other veterans were employed. For all three participants, deployment related experiences changed them as people. As a result, there was a need to make sense of this change and integrate being part of the subculture of veterans with PTSD into the larger societal culture. This was understood to be of great significance throughout the recovery journey, given what had occurred overseas, and it could not be shared freely with others in within society. For each participant, the sharing of these experiences was important in breaching some of the cultural barriers existing between the military veteran who had been injured overseas and the civilian society within which he was attempting to re-integrate.

One of the participants described his experiences with being part of the subculture of veterans with PTSD in the following extract:

*When you dig deeper, you realize that this is a guy who’s chicken shit in various ways, who deals with a lot of struggles, and he belongs to a culture or a group of people in our culture, who transcend every ethnic barriers, or ethnic differences, yet they are collective in that. So it’s a culture [those diagnosed with operational PTSD] which transcends every other culture, but yet we all have common issues.*
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The struggle with trying to fit into the larger context of life and community came up in the investigator’s discussion with participants. This is where one participant in particular spoke about how the importance military culture and the subculture of those with deployment related PTSD still persisted in his current civilian employment where other veterans were employed. It was not until this participant entered this specific workplace and reconnected with veterans that he realized the importance of the camaraderie within his former cultural group. Once he was able to establish trusting relationships in this workplace, he then came to understand that other veterans in his workplace had sustained OSIs such as PTSD overseas as well. The subculture of injured veterans embedded within the military culture as well as the larger societal culture was seen as a critical factor that influenced the recovery journey for all participants of this inquiry.

**Recovery is a journey**

Although the investigator understood recovery to be both complex and highly individualized, there were some shared insights that were thematically represented across all three cases. Although the study participants had experiences that derived from different deployments and different eras, what came to fruition during this research was that there were no concrete rules or guidelines to follow in the journey. For participants, life continued to change and evolve as their journeys progressed. No one in this study considered themselves to be at the end point of their recovery as there is no end point that can be defined. Participants demonstrated that, through their experiences, there was an expertise that developed. Although treatment was considered an important part in the earlier phases of their recovery, it by no means was considered the only factor in healing.
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**The journey is evolutionary.** The realization that life had changed as a result of deployment was a phenomenon that occurred at various points of participants’ recovery journeys. It was clear that there was even further realization of the extent to which this evolution continues to occur during the interviews for this qualitative inquiry. It appeared that further meaning to the recovery experience was unfolding as the dialogue with the investigator occurred. This correlates with how Smith et al., 2009 describe the ongoing transformation that occurs during IPA. As further realization and attribution of meaning occurred for participants, so too has it occurred for the investigator. As a result, it can be concluded that with each reflection and interaction about recovery, further transformation in the journey is occurring.

**Journey is never ending.** As described with Superordinate Theme two, no participant identified himself at the time of the interview as ‘recovered’ and all described their recovery journey as a very individualized, ongoing journey that remained part of their daily reality. Recovery was conceptualized in this inquiry as ongoing yet punctuated with key events at various points. These pivotal events were highly individualized and unique to each participant. One participant spoke about the process in the following extract:

> I think it’s a process. I don’t think there’s an end date. I don’t think it is, you know, having an ingrown nail and it gets taken care of, and I’m recovered from that. I think perhaps a better way to look at it would be living with diabetes. I can control it, but I have to do everything right.

This particular extract demonstrates that PTSD was perhaps a condition as opposed to an injury. The term injury implied more of an expectation that complete remission or return to baseline would occur whereas each participant spoke about their PTSD more as a condition requiring ongoing monitoring and management.
Expertise is derived from experience. From the interviews and subsequent analysis the investigator started to better understand the recovery process as a diverse experience and the participants were the true recovery experts. Although having support from others was collectively regarded as a critical component to healing, what was crystalized in the interviews was the individuals’ experiences of being in the driver’s seat during the recovery journey. For each participant, this realization was understood as something that did not occur overnight. The expertise that was shared in during the interviews was described as being achieved through experience over time. The following extract provides some further context to this interpretation:

There are a lot of people of different ethnicities living in this city, well within Canada. And they come up; they ask questions, if we would mind sharing one of our episodes [of war]. And initially I wasn’t…. I didn’t want to do it. Because you relive it, but I decided that was part of it [healing]. And as time went on, it became less difficult for me to do.

For this particular participant, the experience that was deemed impossible at one time proved to be healing as recovery continued. This wisdom that derived from the experience was a very individualized component to the participant’s healing. Participants learned about what was helpful for them in their recovery and how to manage certain hurdles when they occurred during their journey. The participants demonstrated being the true experts in their recovery by sharing the wisdom gained during their experiences. With this wisdom, participants clearly had developed unique knowledge that generated personal empowerment which, in turn, facilitated the further development of expertise in the personal journey of recovery.

Treatment is one part of the journey. For participants in this inquiry, it was understood that even though formal intervention at the OSIC was a critical component in the recovery trajectory, by no means was it the only healing factor in this journey. What was demonstrated in
the interviews was that the recovery phenomenon was rather intuitive, nuanced, and highly individualized. For each participant, it was evident that recovery had continued post discharge from the OSIC program. However, for each participant, it was also clear that the seeds planted during the treatment phase of the recovery journey continued to have influence over them to date. One participant spoke about the ongoing influence of treatment in the following extract:

And I knew that every day when I would get on the bicycle (treatment) they (therapists) were holding it and running with it and supporting me. But now I’m running on my own, but they’re still running with me. Because they’ve equipped me or they’ve transferred their knowledge to me. I may have to go back and get some people to see me ride again; not hold my bike but see that I’m riding the right way or if there are certain things to be done.

This extract demonstrates the tangible or concrete components to the treatment (i.e., when individuals are actively involved in the treatment protocols). However, this extract also helps to further explain the lasting impact and influence treatment has on the recovery experience, even after protocols have been completed and individual is discharged from the program. This extract demonstrates the ongoing influence of treatment as well as the relationship with the therapist. This also illustrates how all supporting themes are interrelated, however; they have been split into categories for the purpose of this thesis.

One participant expressed significant frustration regarding the pressure and expectations about the role of treatment and with the belief that completion of the recommended protocols should equal cure or full remission from PTSD. Although this experience appeared to be more problematic for one of the participants in particular, there appeared to be some misconceptions about the role of treatment in the recovery journey that all three participants had been subjected
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to. What was learned during the interviews and further explored in the analysis was that part of
the journey in recovery was in fact the realization that that treatment was only one part of it.

One participant spoke about his experience of recovery in the following extract:

\textit{It never goes away, I’ll tell you that right now, it never goes away, but I use the teachings
[from therapy] and that’s how I deal with it and move forward.}

This extract elicits how recovery is in fact a journey, there are symptoms that persist through the
duration of this journey and the therapy/treatment has a critical role throughout this journey.

\textbf{Relationships are critical throughout recovery}

Interpersonal relationships were identified as important to recovery in each interview.
Though each individual identified family as important in their recovery, it was clear that other
relationships were also of importance during the journey. For example, relationships between
fellow soldiers, the relationship with oneself, and the bond with treatment providers were also
regarded as relevant in the recovery journey. Though certain components of these key
relationships presented with some complexities and were at times seen as paradoxical, they were
regarded as critical throughout the recovery process.

\textbf{Relationship with soldiers.} What was of particular interest during this inquiry was the
realization that although all relationships were important, different relationships played different
roles throughout the recovery journey. For example, the camaraderie shared while overseas could
never be duplicated with family or friends back home. However, there was also undeniable
importance to having the support and unconditional love from family and friends during
recovery.

One participant discussed a unique relationship with the opposition military through an
encounter with an enemy soldier:
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I take a cracker out and you know when you take a bite sometimes a piece falls out? A piece the size of my fingernail here fell out and I saw it go and so did the enemy soldier. He looked at it and he looked at me. And by this time I’m eating. Then I notice that he’s looking at that. So he points to it and he points to his mouth and I said go ahead. He reached out and he picked this thing up and he ate it as if he was savoring a hot dog or something. He was really hungry. So I opened up another can and gave him that one for himself. He really liked it, he was starving.

For this participant, the realization that the enemy was not just the enemy but in fact a fellow human being, emerged upon the reflections and revisiting of events throughout his recovery. During his journey, the participant explored and re-evaluated this particular exchange with another human being, who had been depersonalized as the enemy soldier in the service of war. Regarding camaraderie and the relationship within the military, one participant spoke candidly about the brother and sister hood that was inherently part of this relationship. The camaraderie was understood as a unique and unspoken understanding that existed amongst soldiers. The tragedies of war were described as further solidifying these complex bonds. One participant reflected on the unspoken understanding between soldiers exposed to operational stress and trauma in the following extract:

You never mention it [PTSD], you can see who has it, and you can actually see how they’re acting. Yeah and that’s important. You see it by the way they act, where they’re going, where, you know.

This unspoken understanding and bond seemed to serve as part of the glue that protected comrades from falling apart upon their return home. At the same time, the stigma and the strong message to keep silent contributed to not talking about their shared experiences of PTSD. This
paradoxical relationship also apparent when the participant reflected on the impact PTSD had on him and his loved ones.

The relationship with family. There was an ongoing duty to protect family from certain aspects of PTSD that persisted throughout the recovery journey. During his interview one participant reflected on the paradox he had experienced within these family relationships. During these reflections, he remarked that the very people, who were most important to him, were the ones he was initially most distanced from. The following extract demonstrates the struggle to maintain closeness within these important relationships at pivotal times during recovery:

It has effects on my relationship because the way I interact, the way it manifests itself is to walk away from relationships. And I do walk away from very close people. I don’t walk away from acquaintances.

It was understood in this interview that the participant saw his family as being so attuned to his relapses or setbacks that he felt compelled to protect them from this pain. Consequently, this was understood as a way to protect others from the pain experienced by participants. One participant reflected on his symptom exacerbation by stating that his family would suffer with him equally at these times. It was apparent that this was a painful revelation for this participant who showed emotion when reflecting on the impact PTSD continued to have on his family. All participants elicited emotion when reflecting on this part of their journey. Similar to what was described in the context of military relationships, there was a paradoxical component to relationships between participants and family. Family were identified as participants’ main supports however, they were also the very people who participants would work so diligently to protect them from the experiences of war and of PTSD. These paradoxical components of key relationships helped to
demonstrate both the complexity of the human suffering and the relational experience of recovery.

**Relationship with self.** The relationship with oneself was also of particular relevance in this study and was understood as both dependent and interdependent of relationships with others. There was a realization that this evolution in the relationship with oneself influenced a change in how others were viewed and related to. This phenomenon influenced how participants made sense of their war experiences and ascribed meaning to them also. One participant spoke about this experience by sharing the following:

> So in that recovery process it was just to reconnect and the thing was to reconnect with myself. And that was a thing that I had, I didn’t realize how much I had lost of myself, how much my personality had changed. That somebody who could not stay in the house for ten minutes by himself because of extreme extraverted tendencies now loved to be inside, watching television, on the Ipad or just lying down.

Although participants realized that war had changed them, the magnitude of changes was not fully appreciated until they reflected on the changes to self in therapy. The time passed between deployment to a war zone and seeking mental health services varied significantly for each participant. Thus, it can be said that the timing and overall process of recognizing and coming to terms with the changes in oneself was also highly individualized. This unspoken understanding and bond seemed to serve as part of the glue that protected comrades from falling apart upon their return home. At the same time, the stigma and the strong message to keep silent contributed to not talking about their shared experiences of PTSD. This paradoxical relationship also apparent when the participant reflected on the impact PTSD had on both him and his loved ones.
**Relationship with the treatment provider.** For the study participants, the connection with a mental health professional at the Winnipeg OSIC was also pivotal in their recovery. Each participant credited the gains made in treatment as providing them with the ability to reach out to others in their supportive network to work on the relational part of their healing. The relationship with the treatment provider was not only important during treatment but after treatment had ended. One participant described the continuation of this relationship in the following extract:

*I still have the number in my wallet that I can phone. I still have a little thing on my fridge that I can call. I know I’ve got access, it’s his card, it’s almost beaten up, should get a new one. It’s in my wallet. But I can call him, and he knows that. If I didn’t have that, it would be really hard. Because even just the knowledge of having that in your pocket [OSIC therapists phone number] made a huge difference.*

This extract demonstrates both the importance of the therapeutic relationship during and after treatment. This example helps to illustrate the lasting impact and influence both treatment and the provider of treatment has on the recovery experience.

It was evident that participants continued to experience benefit from therapy even after treatment had ended. The gains made during the therapeutic relationship with the treatment provider helped to address some of the relational paradoxes that had been described in the context of relationships with comrades, family and self. Though distinct, each relationship was interrelated. The following extract demonstrates the importance of relationships and the different albeit interrelated significance they have over recovery.

*I think if you don’t have supports, I think that’s where you are losing out. I thank the OSIC for saving my marriage, because it was going. Without my wife and that support,*
and my little brother, I don’t know if I would have made it. To be honest, I’d probably still be in that “hole.”

Participants described how they came to understand the changes within themselves as a result of war and the impact this had on their relationships. This was a painful topic to discuss in the interviews, as evidenced by the emotion elicited when speaking about this during the inquiry. They credited formal supports and professional intervention for facilitating progression through some of these relational hurdles. Thus, it was apparent that although there was variation in key relationships during the journey, all had significance and importance throughout the participants’ healing.

Assessing Validity of Findings

There have been a number of guidelines developed to assist in assessing the validity of qualitative research. For this inquiry, the investigator used Yardley’s (2000) four broad principles of verification which are as follows: sensitivity to context (including the socio cultural milieu of where the research is conducted); commitment and rigor; transparency and coherence; impact and importance. Smith et al., (2009) find that, given the breadth within Yardley’s principles of verification of validity, there is opportunity to creatively engage in the process of interpretation as it is experienced by the participant, the researcher and the reader. As such, Yardley’s principles are a great fit for IPA (Smith et al., 2009).

Sensitivity to context was maintained throughout the research process and demonstrated in the following ways: a literature review sensitized the investigator to the context of issues faced by veterans with PTSD; continued efforts to be reflective and reflexive during the inquiry; and the investigator’s experience as an OSIC therapist enabled an awareness of the impact the discussion might have on the participants. Although this type of insider knowledge allows for a
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deeper understanding of participants’ experiences, there is also a need to adhere to maintaining a balance between having this prior knowledge and discovering new knowledge in the research process. One way of verifying the researcher’s interpretations is to continuously return to the text to verify the interpretation (Smith et al., 2009). These exercises, along with the inclusion of the interview extracts, helped to ensure rigor and demonstrate validity (Smith et al., 2009).

Transparency of the study was reflected in the description of the methodology, the maintenance of field notes, the use of reflective journaling and in creating and sharing the table derived from the analytic process with the readers of this thesis. Coherency of an IPA study has been described as highly interpretive (Smith et al., 2009). The reader has a role in forming an understanding of the interpretation of the lived experience as it has been co-constructed by the participant and the researcher (Smith et al., 2009). As stated, a self-reflective journal was maintained as a means to record the investigator’s experiences throughout the study. This enabled documentation of insights, observations so that potential biases could be mitigated. Reflective journaling helps to maintain the reflexive process of identifying and checking the investigator’s assumptions and potential biases that derive from prior knowledge and biases are naturally present the interpretation of the material. With each interview, and subsequently review of audio recordings, additional insights and reflections were documented accordingly. This not only helped with reflexive thinking and bracketing between interviews, it also helped to document additional reflections and interpretations that were emerging.

Impact and importance was demonstrated by the emergence of three main findings or Superordinate Themes in the research. It is anticipated that these three Superordinate and Supporting Themes will be particularly relevant for injured members and veterans, health care providers, families and employers including the CAF and RCMP organizations.
In conclusion, adherence to Yardley’s (2000) principles for verifying validity, helped to substantiate the research findings by remaining true to the analytical principles that guide IPA.
Chapter 5- Discussion

During this inquiry participants described recovery as an individualized journey comprised of peaks, valleys, and punctuated with pivotal moments throughout. For each participant in this inquiry the existence of residual symptoms, in spite of receiving and completing trauma focused treatment, was part of their new life following exposure to war and related traumas. Participants reflected recovery as a life long journey consisting of ongoing or recurring symptoms within a life of meaning and value. These reflections are similar to the lived experience of recovery as it has been described in the literature on the recovery movement in mental health (Anthony, 1993; Deegan, 1988; Slade, 2009).

In this chapter, the findings from the three interviews will be tied into the relevant research that was included in the literature review. Making connections between the literature and the accounts of participants provides a broader context for interpreting the participants’ accounts and, in turn, serves to fill gaps identified in the literature. This research project addresses two gaps in the literature: exploration of the qualitative experience of veteran’s recovery from PTSD beyond formal treatment; and contribution of veteran’s PTSD recovery to the recovery in mental health literature. The three superordinate themes found in this research will guide the following discussion in this chapter.

The three superordinate themes that were generated by this research were again as follows:

1. Culture has an important role in recovery
2. Recovery is a journey
3. Relationships are critical thorough recovery
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Role of Culture in recovery

This study helped to further verify the importance of culture in both the development of duty related PTSD and the recovery journey as it had been indicated in the literature on the impact culture has on the individuals both overseas and upon return (Litz et al., 2009; Litz et al., 2014; Lunasco et al., Marsella, 1989; Wilson, 2008). The shift in identify and place within the military culture was something that the participants saw as being critical in their journey. However, this struggle was not described as overt or always apparent to others within and outside of their military community. Also demonstrated in this inquiry were the unique experiences of the CAF veteran as he integrated into the larger societal context back home. The insights shared about this part of reintegration ties into what had been expressed in the literature about the uniqueness around transition and military cultural identify that remained after war and military careers had ended (English, 2012).

As part of their recovery trajectory, how and when participants communicated details related to their war experiences was of particular relevance. The realization that life was now different and would not return to the way it was before deployment came from self- exploration and was part of the self-evolution. This ‘redefinition of self’ occurred within the context of culture and relationships, with not only oneself but with family, fellow soldiers, and within the larger cultural milieu. These revelations were understood as not occurring overnight, but at various individualized points throughout the recovery journey. As such, Hobbs’ research on the importance of the provider’s ability to appreciate the uniqueness of the veterans’ experiences so that contextually relevant and comprehensive care is provided was substantiated by the findings from this inquiry (2008).
Recovery as a Journey

The recovery movement has generated an attitudinal shift in the way mental illness is viewed. Consequently, recovery has been more appropriately recognized as an ongoing quest for a meaningful, valued, quality life that can be achieved in conjunction with symptom persistence or relapse (Anthony, 1993; Davidson & Roe, 2007; Deegan, 1988; Kidd et al., 2014; Slade, 2009). As such, recovery, including recovery from duty related PTSD is understood to be highly subjective and somewhat variable in its description and conceptualization. Recovery has been conceptualized in this inquiry as learning to live a life of value and meaning, in spite of the invisible wounds and scars that remain. Participants described recovery as living with symptoms in spite of engaging in the Evidence Based Treatments [EBT] for PTSD at the OSIC. That said, in spite of the residual symptoms, not one participant said that he considered himself to have failed at recovery. No participant saw himself as failing at treatment as a result of persistent symptomatology. As a result of these revelations, learning how to navigate oneself through unfamiliar terrain and becoming the expert of his experience was a critical part of the recovery process. Recovery was understood to be more of a verb rather than a noun. It was understood by the investigator to be more of a fluid concept as opposed to a static one. This understanding of recovery as a fluid and ongoing phenomenon, corresponds with Deegan (1988) and Anthony’s (1993) description of the continuous and individualized vision of recovery.

Although treatment was deemed important by all three study participants, by no means was it deemed the only component to healing during this inquiry. Each participant experienced transformation in their journey before they had been referred for treatment, during treatment and after treatment had concluded. Each indicated that recovery continued to this present moment. The role of treatment seems to be the application of past teachings and insights gained from
therapy in spite of the conclusion of treatment. These insights help to further substantiate the importance of adjunctive and complimentary approaches to treatment for PTSD such as mindfulness, meditation and relaxation strategies (Lang et al., 2012; Libby et al., 2012; Vujanovic et al., 2016). Each participant identified specific techniques that continued to help him in his recovery to date and each presented their own variations in how these additional strategies were implemented and of benefit in their personal journeys. Treatment is only one part of the recovery journey.

**Role of Relationships in Recovery**

It is clear from this research that there is an important role key relationships play in helping individuals in their recovery journey. It is also apparent that these very relationships have been complicated and affected by war and PTSD. Coming home following experiences that contradict and challenge a soldier’s sense of ethics and moral code often leaves a lasting impression, often leaves a residual struggle that persists in spite of treatment (Litz et al., 2009; Litz et al., 2014). It appears as though the quality of the relationship with the therapist has great influence over the impact of the treatment delivered. These relationships also had great impact on reconnecting with other key relationships outside of the therapeutic setting.

The relationship with the mental health therapist was deemed as an important component in the recovery journey by the three study participants. These findings support the literature on the importance of co-constructing treatment plans and the emphasis on the individual in recovery to be an active participant, if not the driving force, in the recovery journey. Though authors Aston & Coffey (2012); Byrne et al., (2013) and Deegan (1988) wrote extensively about barriers to the successful implementation of such client-clinician partnership, the participants in this study demonstrated success from this type of collaborative approach during their time at the
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OSIC. This inquiry suggests that these participants did not encounter, in their experience with the Winnipeg OSIC, what Hunt and Resnick (2015) cautioned about in their writings—the disempowerment of the client with the formalization of recovery. The relationship between the client and the provider at the Winnipeg OSIC was regarded by the participants as an egalitarian and collaborative one from the beginning of their journey in treatment, right through to the end.

The relational aspect of recovery was conceptualized by the investigator as a kind of a stepping stone. With each step on each new stone (each relationship repaired or strengthened), there seemed to be progression or an evolution occurring in the recovery journey. Each progression not only facilitated the reconnecting with key people from the past and present but also opened up the opportunity to let new people in and develop additional relationships as a result of this healing. Further to this, there was also the enhanced ability to reconnect with oneself. It was evident in the inquiries that participant’s sense of self had been affected by war and PTSD. The relationship with the therapist as it was reflected upon in the interviews enabled the participants to access delicate areas related to their PTSD that were driving much of the relational paradoxes. It was understood that due to the progression in therapy, further reaching out and testing of the relationship waters, were subsequently embarked upon. Further to the relationship with the treatment provider, the role of social support and the building and enhancing of resilience through peer relationships will be covered in the concluding chapter of this thesis.
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Chapter 6- Conclusion

During this inquiry, each participant reflected on how war, PTSD, treatment and recovery had transformed them. No one expressed a return to baseline or felt they had returned to their pre-trauma state in the healing process. However, each was able to identify the gains that had been made and success that had been achieved since embarking on the recovery journey. The overall consensus in the findings was that recovery could not be defined; however, there was a shared understanding of what would help facilitate ones progression in this journey. Given that each participant continued to experience symptoms to date, success was determined by the wisdom gained about the unique recovery journey as it was presented in this qualitative inquiry. It became apparent in the research process that there was an expertise developed from the participants’ recovery journeys that could not be manufactured without having such firsthand contact with their unique experiences.

Value and Limitations of Study

The importance and utility of diagnostic check lists and quantitative measures to help assess symptomatology and treatment response will remain part of the clinical program evaluation and outcome monitoring at the Winnipeg OSIC. However, this qualitative inquiry has helped to shed light on some of the issues that could not be captured on these types of quantitative measures. The qualitative addition as helped us to better understand how past clients of the OSIC experienced and understood their recovery. The qualitative inquiry helped us to see the variability in the recovery experiences while at the same time, some of the themes that have derived in spite of this journey being individualized and unique to all. Given the modest sample size in this preliminary inquiry, future qualitative studies to expand on the recovery phenomenon within the CAF and RCMP culture are recommended. While quantitative research will remain
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pertinent in program evaluation and policy development, the unique richness and undeniable expansion to the quantitative statistics only achieved through qualitative inquiry should not be negated. It is the hope of the investigator that this qualitative inquiry provides the rationale for changing the way in which the voice of the veteran can be heard. It will be the future goal of the investigator to continue with future qualitative inquires. With continued research, the ability to scientifically examine and share these profound and personal interpretations of the recovery journey, experienced by both veterans and members of the CAF and RCMP will provide an invaluable consumer based component to research and program development at the Winnipeg OSIC.

**Systemic Issues**

Regarding the some of the insights shared about the external pressures and recovery, there has been some dissonance between where a person may be at in his or her recovery after trauma treatment versus where others may expect this person to be. The main struggle with this view of recovery is that the systems in which clients may be involved (CAF, RCMP) have not traditionally been structured in a way that permits such fluidity and flexibility that is the lived experience of recovery. To construct a program where there is an appreciation of both the unique military and RCMP culture and the impact of this culture has on the recovery journey will help foster a collaborative network between organizations involved in the rehabilitative process. The importance of this collaboration in a rehabilitative setting has been described as critical to recovery in this inquiry and in some previous recovery literature. (Anthony, 1993; Deegan, 1988; Scott, 2008).

The CAF and RCMP health services are part of a larger system where there are professional and institutional pressures to set appropriate timelines and benchmarks for
EXPLORATION OF RECOVERY FROM PTSD

rehabilitation. The road to mental Readiness (R2MR) is an evidence based intervention that was designed by the Department of Defence as a means to reduce stigma and address stigma related barriers around accessing timely mental health interventions as they are indicated (National Defence and the Canadian Armed Forces, 2015b). R2MR was developed as a means to increase awareness of mental health in the workplace and offer timely and appropriate resources to help adapt to stressful situations (National Defence and the Canadian Armed Forces, 2015b). The R2MR uses a mental health continuum model (MHCM) which is some respects, is similar to the continuum of the recovery journey as described by participants in this inquiry. The continuum has been designed with a fluid and bi-directional trajectory through the spectrum of mental health symptoms so that service personnel can assess, determine and communicate current health and functioning (National Defence, 2015). In October, 2015, R2MR initiative was launched nationally by the RCMP. This was part of the RCMP organization’s five year mental health strategy which included adopting the Mental Health Commission of Canada’s voluntary standards for both the psychological health and safety for all individuals in the workplace (Mental Health Commission of Canada, 2012; Royal Canadian Mounted Police, 2016)

Future directions

It is anticipated that as each organization is trained and adopts the R2MR initiative to assist with early detection, intervention reintegration and system collaboration, there will be enhanced organizational and peer support around maintaining a healthy workplace. Further, the R2MR initiative will help the OSIC, other providers and key stakeholders in the CAF, VAC and RCMP system speak more of a universal language as to where a client may be on the mental health continuum model. This is expected to enhance collaboration and more seamless transition between various stages of recovery with the relevant parties included in this process. Though the
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participants time in the military and experiences overseas predate the R2MR initiative, it is the investigators belief that if the R2MR would have been in place some of the barriers described in the interviews (stigma, silence within the military culture, lack of organizational understanding about recovery, lack of individual insight into what was happening during the earlier phases of injury) there would have been some decrease in these barriers to accessing care and post care reintegration; this as indicated by the study participants and in the literature (Heber et al., 2006; Litz et al., 2009; Wilson, 2008 & Zamorski, 2011). Future studies where the examination into the effectiveness of R2MR as it is applied within the context of facilitating rehabilitation and reintegration/release in the recovery journey should be considered. It is the opinion of the investigator that quantitative and qualitative inquiries into the effectiveness of integrating R2MR into the healing trajectory would be of benefit to treatment providers, stakeholders and most importantly, clients and families who should be at the center of the rehabilitative programming.

Social Support in Recovery. Social support, depending on whether it is adaptive or maladaptive, has been regarded as both a potentially protective factor and a possible contributor to the development of PTSD (Charuvastra & Cloitre, 2008). Though strong social support helps to mitigate the impact of PTSD, the absence of supports or unhealthy relationships have been found to exacerbate the condition (Charuvastra & Cloitre, 2008). Successful initiatives through the CF and VAC have shown that peer support programs are of great assistance in influencing recovery (Heber et al., 2006). Given the recent addition of adjunctive therapeutic groups to the rehabilitative program at the Winnipeg OSIC, the question of how and when the peer support initiatives should be implemented will remain part of the individualized recovery journey. The partnership between the OSIC and OSISS is expected to remain an important component to recovery for many individuals. The utility of group therapy and peer support has been regarded
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in some literature as helping individuals assess their behavior and how others within their
cultural group experience their behavior (Golder-Vukov, Moore & Cupina, 2007). This helps
individual safely assess how others view them which in turn helps them assess and internalize
how they view themselves (Golder-Vukov et al., 2007). With future studies, the investigator
suggests that there remain a cognizance about the importance of social context in the recovery
journey within OSIC clinic and beyond. Given the known risk associated with having a lack of
social supports during recovery, continued efforts to foster and help repair relationships will be
critical (Charuvastra & Cloitre, 2008; Scott, 2008).

The Winnipeg OSIC

The objective of this research project was to explore how participants understood their
recovery journey and provide the opportunity to share their experiences in a way that had never
occurred. It can be said with confidence that goals of this research not only were met, but exceeded. As a result of this study, a new document entitled the Recovery Road Map has been
added to the information provided to new clients at the OSIC (Appendix G). This document,
inspired by this inquiry, will now be added to the information packages for new clients at the
Winnipeg OSIC. It is hoped that providing this written document at the outset of an individual’s
journey will help to alleviate some of the anxiety about the rehabilitative process at the OSIC and
shed some light on where treatment typically fits in the context of the recovery journey. This
document will echo what is discussed with clients as they collaboratively engage in the treatment
process with their providers, families and other supports during this phase of the healing
trajectory.
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Summary

The key findings that were developed from this qualitative inquiry were as follows:

1. Culture has an important role in recovery
2. Recovery is a journey
3. Relationships are critical throughout recovery

For each participant, the existence of residual symptoms in spite of completing the recommended trauma focused treatment was part of their current reality. Participants’ recovery journeys were conceptualized by the investigator as an experience that continues to evolve and transform each day. Participants collectively and individually reflected on this phenomenon as learning to live with these symptoms while crafting a life of meaning and value for themselves and their families. In summary, the true experts of recovery have been consulted with in this inquiry. The investigator will be forever grateful for having this opportunity to co-construct such an important document in partnership with remarkable individuals who have demonstrated true expertise in this important area of research.

The incorporation of the findings from this research with existing literature on recovery is expected to clarify some questions about the recovery journey for those who have been diagnosed and treated for PTSD. Recovery is clearly a unique and individualized experience where relationships with oneself, with others, and the society at large are of key relevance. The message that recovery does not occur in isolation, recovery is a process, and that the role of relationships is critical during this journey, will also be of relevance to all who are part of and have been affected by recovery process. Additionally, the insights and personal wisdom shared by the three experts can now be accessed and utilized by a wider audience of readers. These findings are expected to have impact on validating the lived experience of fellow members,
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veterans, and their families. As part of the OSIC mandate, there will be continued efforts to establish connections with others in the community so that the insights and developments that may enhance the recovery process can be shared. The Winnipeg OSIC has developed a therapeutic community where extended after care and graduate groups, falling outside of the evidence based treatment protocols, have been integrated into the clinical programming. Thus, the OSIC has organically expanded services based on feedback from former clientele. With this expansion, the convergence of the social context of the recovery (Anthony, 1993; Charuvastra & Cloitre, 2008; Deegan, 1988; Scott, 2008) and clinical philosophies of care is, in fact, occurring. It is again with sincere gratitude to the three study participants for so eloquently and candidly sharing their lived experience of recovery from PTSD. The insights and wisdom shared about their unique journey of healing is expected to be of great significance and positive impact to many, at this present time and into the future.
References Cited


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EXPLORATION OF RECOVERY FROM PTSD


EXPLORATION OF RECOVERY FROM PTSD


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http://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf


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doi:10.1111/j.1755-5949.2008.00049.x

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EXPLORATION OF RECOVERY FROM PTSD

Appendix A

STUDY PARTICIPANTS NEEDED

Exploring the lived experience of recovery from service-Related Post Traumatic Stress Disorder in male Veterans of the Canadian Forces

I am a student in the Masters in Psychiatric Nursing Program at Brandon University conducting research to explore experiences of Canadian Forces Veterans who have been diagnosed with Post Traumatic Stress Disorder (PTSD) and have completed trauma treatment at the Winnipeg Operational Stress Injury Clinic (OSIC). I am interested in discussing your experiences of recovery to find out what factors, outside of or in addition to OSIC treatment have facilitated your healing and influenced your recovery journey. The aim is to provide an opportunity for Veterans to share their lived experience and, in turn, help others better understand factors that have been instrumental in this journey.

You may be eligible for the study if:

1. You are a male Canadian Force Veteran who has completed a course of one of the three evidence based trauma treatments at the OSIC and remains a client for supportive and/or adjunct services at the clinic.
2. You are currently not abusing any substances such as alcohol or illicit drugs and consider yourself to be stable and focused on recovery based initiatives
3. You are able and willing to participate in an interview that will be audio recorded for data collection purposes and will last approximately two hours.

A description of the study consent and confidently measures can be reviewed with the research coordinator. Your participation would be entirely voluntary and confidential. Your lived experience of recovery will be captured in the research without revealing your identity in any way. If you are interested in participating in this study or would like more information, please contact Amber Gilberto @ 204-831-3446 or at agilberto@deerlodge.mb.ca.
Title of Study: Exploration of the recovery journey of Canadian Forces veterans diagnosed and treated for service-related PTSD

Principal Investigator: Amber Gilberto RPN, BScPN
Deer Lodge Centre
2109 Portage Avenue
Winnipeg, Manitoba
R3J 0L3
agilberto@deerlodge.mb.ca
204-831-3446

Purpose of study:
This research study is part of a graduate degree requirement for a Master in Psychiatric Nursing program at Brandon University. The purpose of the study is to learn more about the lived experience of recovery of Canadian Forces veterans diagnosed with and treated for Posttraumatic Stress Disorder (PTSD).

You are invited to consider participation in the study if you have completed one of the three evidence based treatments for duty related PTSD:
- Prolonged Exposure, (PE),
- Cognitive Processing Therapy (CPT),
- Eye Movement or Desensitization Reprocessing (EMDR).

This study will not evaluate Operational Stress Injury (OSI) clinic treatment or services by OSI staff, is not being conducted on behalf of the OSI clinic, and will not release any information to the OSI clinic other than publications available to the public.

Volunteering to participate in this study will enhance the understanding of what factors, outside of trauma treatment protocols, facilitate recovery from PTSD by Canadian Forces veterans.

Goals of study:
- Explore how participants understand recovery from PTSD
- Determine what supports, practices, and factors in participants’ lives contribute to recovery
- Identify, from the viewpoint of participants, what factors may negatively affect recovery and/or what essential supports are lacking

Who can participate in study:
- Male Canadian Forces veteran
- Previously deployed on a combat mission
- Diagnosed with service related PTSD
EXPLORATION OF RECOVERY FROM PTSD

- Completed one of the following treatments at the OISC: Prolonged Exposure (PE); Cognitive Processing Therapy (CPT); Eye Movement; Desensitization Reprocessing (EMDR) trauma treatment protocols.
- Has been discharged from services at the OSI clinic

Who cannot participate in study:
- Individuals who have engaged in any clinical service with the principal investigator (Amber Gilberto) or members of the research team (C. Enns and Dr. S. Yaren) are not be eligible for participation in this research study.

Study Procedures:
Four veterans of the Canadian Forces will be interviewed separately on their experience of recovery from PTSD. If selected, you will be invited to engage in a two hour (maximum) interview focused on your lived experience of recovery from duty related PTSD. The interview will be a dialogue between you and the principal investigator using key questions. This means that the intent of the study will remain dedicated to qualitatively exploring how you have experienced recovery from duty related PTSD. You will be contacted by phone once the study is completed and offered access to a copy of the study findings.

Interviews will be audio recorded and transcribed, however, all identifying information (such as names) will be kept separate from the interview data. The professional transcriptionist hired for this study will sign a confidentiality agreement before handling and transcribing interview. Computer files with interview transcripts and audio recordings will be returned to the principal investigator for safe storage. Computer files of transcribed interviews will be held on a computer in a secure location, password protected, and accessed only by the principle investigator. Audio recordings and any notes pertaining to the interviews will be stored in a locked filing cabinet in a secure office accessible only by the principal investigator. All interview computer files, data, recordings, and notes will be destroyed at a suitable point following completion of the study.

Time Frame:
It is anticipated that interviews will begin February 2016 and will be completed by March 2016. Data analysis and compiling of the findings for the final research report will be completed by January 2017.

Confidentiality:
Your participation in this study will remain confidential. This means that no one, outside of the research team, will be able to identify you as participating or as having participated in the study. There are limited, specific conditions under which confidentiality may be broken: as required by law (e.g., interview discusses the commission of a crime); as required by a serious safety concern (e.g., you are intending to harm yourself or someone else).

Potential benefits of participating in the study:
There may be no direct benefits to you in sharing your experiences in the study; however, your experiences will contribute to an improved understanding of recovery from service-related PTSD that could, in turn, benefit others with service-related PTSD.
Potential risk of participating in the study:
While discussing traumatic events is not the intent of the study interviews, there is a potential risk of experiencing reminders of specific traumatic events, therefore, access to debriefing with psychiatrist Dr. S. Yaren will be available during or after the interview should it be needed.

Legal rights:
If you feel, at any time, psychological harm has occurred and/or your personal rights have been violated, you are encouraged to contact the Brandon University ethics committee and the Deer Lodge Centre ethics committee (information below). It is important to stress that as a participant, you have not waived any right to legal recourse if you feel that you have been harmed during the course of this study.

Costs Associated with the Research:
There is no cost to you in sharing this information. A two-hour interview is required to participate in this research, however, this interview can be conducted either by telehealth and/or phone should this make participation more feasible.

Freedom to withdraw from study:
Participation in this study is completely voluntary and you may withdraw with no negative consequences. Nonparticipation, participation, or withdrawal from participation in the study will have no bearing on future access to any type of services.

If you decide to withdraw from participation in the study, the information in your interview file and audiotape will be immediately destroyed however, once your information has been anonymously combined with other interviews into themes, it will not be possible to remove your information from the study. All information, including the decision to withdraw from the study, will be safeguarded and never used wrongfully by the researcher.

*** It is important to realize that you are under no obligation, for any reason, to participate in this study.***

Contact Information:
Thank you for taking the time to review and consider participation in this study. Any questions regarding participation in the study should be directed to Dr. Kristen Klassen, Research Coordinator at the Operational Stress Injury Clinic. Upon providing written consent to participate in the study, inquiries can then be directed to the principal investigator, Amber Gilberto at 204-831-3446. Other questions regarding general rights as a research participant or concerns about this study can be directed at any time to the Brandon University Ethics Committee (BUREC) 204-727-7445, or manager of DLC Ethics Committee at 204-831-3422.

Participant: I have read and understand the above information and agree to participate in the study entitled Exploration of the recovery journey of Canadian Forces veterans diagnosed and treated for service-related PTSD.
Certificate of Completion

This document certifies that

Amber Gilberto

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: 7 September, 2015
EXPLORATION OF RECOVERY FROM PTSD

Appendix D

Interview Questions:

1. Can you tell me about your individual experience of recovery from PTSD?  
   Sub question: How have you viewed recovery from PTSD, what has been your understanding of this concept?

2. What do you consider (services, people, other) missing from your recovery journey? Has there been anything that was unhelpful or detrimental to you that had impact on your journey?

3. When you reflect on your journey, do you consider yourself to be recovered or still in recovery?

4. How do you view the relationship between trauma focused treatment and the recovery process? Meaning, how has your treatment for trauma fit within your recovery experience and what things have helped you in recovery that falls outside of the treatment protocols: supports, practices, coping mechanisms.

Questions have been designed in order to meet research objectives which are as follows:

1. -explore how participants understand recovery from PTSD  
   determine what supports, practices, factors in their lives contribute to recovery

2. explore what behaviours, coping mechanisms contribute to recovery  
   identify what has perhaps negatively affected recovery or what may be lacking that participants view as essential to recovery
January 18, 2016

Ms. Amber Gilberto  
2 Citation Circle  
Winnipeg MB R3R 3B3

Dear Ms. Gilberto,


Thank you for submitting the requested information as per the letter from the Brandon University Research Ethics Committee (BUREC) dated December 7, 2015. I am pleased to report that the ethics application entitled “Lived Experience of Recovery from Post-Traumatic Stress Disorder in Veterans of the Canadian Forces” is now approved.

Enclosed is the Ethics Certificate for this project. Please note that the first Annual Progress Report is due January 18, 2017.

As per BUREC Policies and Procedures, Annual Progress Reports and a Final Report at the conclusion of the project are requirements for the continuing approval of ethics applications. In addition, ethics approval is granted for a maximum of five years. If this project is continuing beyond that time, a new application is required prior to the expiration date. For more information and for access to the Annual Progress and Final Report forms, please visit www.brandonu.ca/burec.

If you have any questions or concerns, please contact Mrs. Shannon Downey, Administrative Officer to the Vice-President (Academic & Provost) and Research Ethics Officer, at (204) 727-9712 or downeys@brandonu.ca.

I wish you success in your research endeavour.

Sincerely,

[Signature]

Dr. Phillip Goernert  
Interim Chair  
Brandon University Research Ethics Committee (BUREC)

smd

Enclosure

C

Ms. Karen Clements, Faculty of Health Studies (Psychiatric Nursing), Brandon University

270 18th Street, Brandon MB, Canada R7A 6A9
Appendix F

Brandon University Research Ethics Committee (BUREC)
For Research Involving Human Participants

ETHICS CERTIFICATE

The following ethics proposal has been approved by the BUREC. The approval is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. As per BUREC Policies and Procedures, section 6.0, "At a minimum, continuing ethics review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects. Failure to fulfill the continuing ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approve any new research ethics submissions, and/or others as outlined in Section 10.0."

Any changes made to the protocol should be reported to the BUREC prior to implementation. See BUREC Policies and Procedures for more details.

As per BUREC Policies and Procedures, section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the BUREC Policies and Procedures. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

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270 18th Street, Brandon MB, Canada R7A 6A9

BrandonLea
Appendix G

Winnipeg OSI Clinic Recovery Road Map

Author: A Gilberto RPN, BScPN OSIC Clinical Nurse Specialist

Welcome to the Winnipeg Operational Stress Injury Clinic (OSIC) program. The Winnipeg OSIC is part of a national network of clinics that have been set up across Canada. The OSIC is funded by Veterans Affairs and operates under the Winnipeg Regional Health Authority (WRHA). The OSIC mandate is to provide timely, accessible and specialized mental health care to members and Veterans of both the Canadian Armed Forces (CAF) and Royal Canadian Mounted Police (RCMP) who have sustained injuries during operational duties. You may be attending the OSIC as a spouse or family member of a member or veteran of the CAF or RCMP. It is not uncommon for the OSIC to receive referrals for both spouses and family members who have also been negatively affected by the effects of Operational Stress. As a result, many family members will also access services at the OSIC in order to obtain education, and support, as it is required.

Whatever your individual experience is, the OSIC has a range of service options for those who have been affected by Operational Stress and are part of the Military, RCMP and/or Veterans Affairs.

Recovery Philosophy

Recovery from any injury is a journey and for each person, this journey is unique. At the Winnipeg OSIC there have been great efforts made to recognize how individualized recovery is and recognize the factors that may have influence over an individual’s successful progression in this journey.
EXPLORATION OF RECOVERY FROM PTSD

If you are reading this document, you have already attended your first appointment at the OSIC. This appointment also known as the intake meeting has been scheduled in order to meet you in person and introduce you to the clinic. This appointment also serves as an opportunity to obtain pertinent information about your symptoms and allow you to provide a general overview of the key events or experiences that have perhaps led to your decision to accept or request a referral to the OSIC.

Weekly Team Meeting

Following the intake appointment, the information you have provided at this initial meeting will be shared with the OSIC team at the interdisciplinary team meeting. This meeting occurs once per week and is comprised of all mental health professionals who are part of the OSIC team. From this meeting, a proposed treatment plan and decision around the next steps to be taken in the clinic program will be shared with you and a follow up appointment with one of the mental health professionals will be offered at this point, or shortly thereafter.

Given our interdisciplinary approach to treatment and the diversity of programming available at the clinic, you may be involved with a few different professionals during your time in the program.

CBT-m Classes

For many individuals, therapy is a new area that has never been explored before. Because of this, the OSIC has developed a series of four Mindfulness based Cognitive Behavioral Therapy Classes (CBT-m) that are typically offered to individual and families who are new to the clinical program. These classes have been designed to orient people to the effects mental health conditions can have on people and what in turn helps to heal from these conditions. For many,
these classes have been a positive introduction to the clinic and a great introduction to
subsequent assessment and treatment, as it is indicated.

**Diagnostic Assessment**

Typically the next individual appointment you attend will be the diagnostic assessment. This appointment may be scheduled before, during, or after CBT-m classes. The diagnostic assessment will consist of a conversation with your therapist and may include some formal psychometric testing; this being part of the comprehensive assessment process. With the diagnostic information, we can ascertain whether there is a mental health diagnosis, and if so, we can carefully describe the most suitable treatments available to you and your family. At this point, we can work towards supporting you in your decisions around what modality or program seem to be most feasible for you at this particular point of your recovery journey.

**Treatment**

Following the M-CBT classes and/or the completion of the diagnostic assessment, individuals typically proceed onto **individual** or **group based treatment**. Again, the decision as to what treatment people will be offered or decide to engage in will be determined by a few key factors such as clients’ personal preference and program suitability. However, the OSIC maintains a client centered approach throughout the recovery journey therefore, at no point are any of the treatment decisions made without the clients input and agreement for participation.

**Adjunctive Services and Coordination of Care**

With each assessment, educational class and treatment component of the recovery journey, you will be contacted by an OSIC therapist who is responsible for your case or part of the treatment modality that you have consented to. We will work diligently at trying to maintain a steady flow of this process and make it as seamless as we can for you and your family.
EXPLORATION OF RECOVERY FROM PTSD

At certain points in the journey, you or your therapist may indicate additional services that could be of benefit to you throughout your recovery journey. This may include but is not limited to: medication consultation, assessment for the pain management course, emotion regulation and mindfulness course (DBT) or referral to for couples or family therapy; to name a few. Again, for each client, the recovery journey is highly individualized and as a result, there are no strict guidelines around certain service utilization both within and outside of our clinical programming.

**Individualized, client centered approach**

Though treatment protocols typically consist of a set number of sessions (12-16), there are a number of other factors and programs that can be of importance in your recovery. The clinicians at the OSIC will partner with you at the outset of your time at the clinic so that you and your family have a rough “road map” to refer to and hopefully ease some of the natural uncertainty that commonly arises when embarking on this journey.

**Systems Collaboration**

Should there be involvement with outside agencies such as other health care or community providers, we will try our best to coordinate care so that continuity between all parties involved in your recovery is maintained to the best of our ability. This communication with outside agencies will not occur without your consent as we try to ensure that decisions around your care within the larger system are not be made without your input.

Thank you for taking the time to read this introduction to the OSIC services. It is our hope this document helps to capture how individualized the recovery process is and explain some of the formal components provided by the OSIC team.
Attention: Brandon University Ethics Committee

RE: Brandon University Ethics Application- #21784

This letter serves as verification of my agreement to provide medical intervention should any participants involved in Amber Gilberto’s upcoming study indicate or are observed to require such service. I understand that individuals will be invited to participate in an interview where they will be asked to share details of their lived experiences of recovery from duty related Post Traumatic Stress Disorder. I will sign the required oath of confidentiality as part of the ethical requirements of this project and have requested that Amber ensure that all of the interviews arranged are on the days I am working at the Deer Lodge Centre site. I trust this letter will be sufficient documentation to verify my role and support of this upcoming project.

Sincerely,

Dr. S. Yaren MD, FRCPC
Associate Professor
Department of Psychiatry
University of Manitoba
September 3, 2015

Research Ethics Committee
Faculty of Health Studies
Brandon University

To whom it may concern:

Re: Master’s Thesis, Amber Gilberto

Amber Gilberto has notified DLC that she would like to pursue her thesis research, “An Exploration of Recovery from PTSD in Canadian Forces Veterans; a Phenomenological Approach” in pursuit of her Master’s degree.

I am in support of her doing so at our site, pending a standard review of the final research protocol. Once your institution has given ethics approval for her study, she may submit a copy of it along with a copy of the approved protocol to my attention (as manager of the research program) for review.

Sincerely,

Michael Kaan
Manager, OSI Clinic
Manager, Research Program
Brandon University Oath of Confidentiality

I, ________________________________________________ affirm that I will not disclose or make known any matter or thing related to the participants that comes to my knowledge during this research project.

______________________________
Research assistant _____________ Date___

______________________________ ____________________
Signature of Witness     Date