Battle on the Home Front: Post Traumatic Stress Disorder (PTSD) Medication Side Effects and the Quality of Life of Canadian Male Veterans

by

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Abstract

This thesis examines the experiences of Canadian male veterans and the impact that PTSD medication side effects have had on their quality of life. Using a narrative methodology, their stories of PTSD and the anti-anxiety and anti-depressant medication side effects revealed themes of fatigue and sexuality that were connected to the hegemonic masculinity of military culture, impacting the veterans’ everyday lives, relationships, and ultimately their sense of self. Deeper sub-themes of guilt and loss of identity emerged and require further investigation. This study illustrates the power of examining lived experiences from trauma and recommends the integration of narrative care into current treatment programs for veterans living with PTSD.
This thesis is dedicated to my grandfather:

James William Pickett “Grandpa”
March 22nd 1914 – September 16th 2004

Florence, Italy 1944
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Contextualizing the Study

In 2008, after witnessing a soldier fidgeting during dinner and later pacing in the lobby at a base function, I became interested in post-traumatic stress disorder (PTSD). The soldier in the lobby seemed to be tormented – wringing his hands nervously and glistening with sweat. He had recently returned from soldiering in Afghanistan and this social function was his first time in a crowd. My husband explained that soldiers, when on foreign soil, are trained to be on high alert – anyone could be a terrorist and even the teenager nearby could be a suicide-bomber. For some soldiers, feeling safe in a large crowd takes time. The look on this young soldier’s face was, in that moment, etched in my memory. That experience – my first encounter with PTSD – has led me on a journey of inquiry resulting in this graduate research study on PTSD and the subsequent quality of life challenges for these veterans.

Some months after my encounter with the young soldier, I met a Vietnam veteran at a mental health conference hosted by the Anxiety Disorders Association of America. He described his personal battle with PTSD, including the side effects of prescribed medication that compounded the intricacy of therapy, as well as his subsequent alcoholism, job loss, divorce, and periods of homelessness. Nearly every conference attendee I spoke with was a U.S veteran who suffered from PTSD. Tears flowed as I listened to their stories. Later that year I began Master’s course work with the intent of building a knowledge base and doing research on PTSD. Based on my background as an acute care nurse I was drawn to explore the influence of PTSD medication side effects. As a result, I wrote an article on PTSD medications (anti-
depressants and anti-anxiety medications) and their side effects, entitled “Pharmacological Treatment of Combat-Induced PTSD: A Literature Review” (Bastien, 2010). From this early inquiry, I questioned how the side effects of these medications influenced veterans’ lives (e.g., fatigue and sexual dysfunction) and work. As my interdisciplinary studies unfolded I came to understand that there were larger issues influencing PTSD such as masculinity, stigma, and militarism. These issues emerged as pivotal in shaping my understanding and desire to investigate veterans’ experiences of PTSD medication side effects in more depth.

Over the next few years, I attended and presented at international research conferences on PTSD. At one of these conferences – the Aftershock Conference (2010) on PTSD in the American military in Washington D. C. – I had discussions with two veterans from the Iraq war who spoke openly about their traumatic experiences and the anguish of ongoing recovery. Sam Console, one of the veterans, had written an autobiographical account of living with PTSD and traumatic brain injury (TBI). Through the publication of his book entitled Service and Sacrifice. Memories of Iraqi Freedom With a Veteran’s Mental Health and Resource Guide (Console, 2011), and his many public speaking engagements across the country, Console expressed a need for academics to do more qualitative research in this area. Notably, my own investigations had revealed that standardized surveys and checklists were primarily used in diagnosing PTSD at that time in North America. Although surveys and questionnaires have confirmed diagnosed cases of PTSD in returning veterans, face-to-face interviews, where veterans could share their experiences of trauma related to war and war-making, in a trusted researcher-participant relationship, were not generally used as a preliminary
tool to identify PTSD. Since this conference I have maintained an email relationship with Sam Console, and details from his book have informed this study. Jeff, the other veteran at the Aftershock conference whose story had an impact on my work, described emotional trauma that had led him to attempt suicide. While he is still enlisted in the U.S military, and a senior ranked officer, he deals with another anguish – that of training and sending young troops to war zones knowing that they too may face the risks of life altering and devastating emotional traumas.

Repeatedly, the stories the veterans with PTSD told were emotionally gripping and moving for me. Telling their stories and having someone listen non-judgementally to them seemed to provide the veterans with acknowledgement of their individual experiences and forms of healing. Each person’s experience was traumatic in different ways and worthy of recognition in itself rather than as a collective.

As I progressed with my course work I recognized the need for research methods that honoured the individual’s story. As a teaching assistant in a Canadian health care course I learned more about narrative inquiry as a teaching and research methodology. The professor, a seasoned narrative researcher, had a foundational impact on my learning about narrative. Graduate course work on research methodologies, especially a course on narrative inquiry, as well as attending and presenting for the first time at the Narrative Matters International and Interdisciplinary conference, hearing different stories about PTSD and combat experiences, and recalling my childhood visits where I listened to my grandfather’s stories of World War II, all played an important role in my decision to select narrative for my research project. In time, and with guidance, I began to discover my own personal story and how my past experiences have shaped me as a
woman, spouse, mother, and academic. My professional, academic, and personal experiences led me to select narrative inquiry as the most appropriate research method for exploring the veterans’ individual stories and their meanings along with the impact of the larger cultural stories of the military and mental health on their lives.

It is important at this point to explain the difference between story and narrative as they each relate to the narrative inquiry process. Polkinghorne (1988) defines narrative inquiry as the process whereby the stories, narrative, and context are examined. For Polkinghorn (1988), a story is what the interviewee tells the interviewer and the narrative is what is recounted by the interviewer, as it was told to her. Similarly, Clandinin and Connelly (2000) describe story as a communication tool, and the narrative process as the inquiry into that story(ries). Clandinin and Connelly (2006) write, “Story... is a portal through which a person enters the world and by which their experience of the world is rendered meaningful” (p. 375). For Clandinin (2007) “story is one if not the fundamental unit that accounts for human experience” (p. 4). Stories, whether autobiographical or biographical, allow us to communicate to and with others about personal experiences that are embedded in memory. Stories are representations of embodied knowledge shaped by significant encounters with the world. Stories cry out to be told and while two people may experience the same thing each will process it and recollect it with different meanings based on the values, beliefs, and the encoding of past experiences.

War stories are likely encoded through the lens of the military culture and gendered scripts of masculinity – strength, bravery, heroism, and victory, to name a few. While the overall account of war may be one of victory or defeat, each soldier who was
there recounts a different version of the events and how they unfolded. Upon return to civilian life, their stories of heroism may be honoured, at first. Yet, in time, they are likely to become buried, forgotten, or challenged. However, soldiers carrying the burden of psychological and emotional trauma may also encounter dismissal, and feelings of shame or fear in revealing their stories.

A narrative research methodology offers veterans suffering from PTSD, who may be self-censoring their stories and hiding their emotions due to cultural biases and stigma related to emotional and mental illnesses, the opportunity to tell and come to terms with their stories, and make sense of these experiences. As Connelly and Clandinin (1990) state, “[H]umans are storytelling organisms who, individually and socially, lead storied lives. The study of narrative therefore, is the study of the ways humans experience the world” (p. 2). However, it is also important for narrative researchers to create a culture of trust for PTSD veterans so that their stories can be told without judgement or labelling. This requires an ethic of care on behalf of the narrative researcher, and an understanding of the entwined nature of the researcher and participant’s stories and lived experiences that happen throughout the narrative research project (Clandinin & Connelly, 1988). Clandinin and Connelly also refer to not only a negotiation of entry and exit into and out of the inquiry, but to the ongoing negotiation that takes place as researcher and participants connect through the narrative inquiry process. They describe this coming together as “the negotiation of two people’s narrative unities” (p. 281). Later Clandinin and Connelly (2000) reiterated the importance of the relationship between researcher and participant stating that, “relationship is key to what it is that narrative inquirers do” (p. 189). For Clandinin and Connelly, the researcher-
participant relationship is based on a foundation of trust, and of mutual understanding of 
the other. Moreover, in the negotiation of the researcher-participant relationship there is 
a deep respect of the other, and their experience of, and their place in, the inquiry and 
the world. Through my experiences as a nurse following a professional code of ethics, 
and working with critically and often terminally ill patients, I have come to understand 
the sensitivity of this relationship and have learned to engage in a non-judgemental 
approach to care.

My initial encounter with the soldier with PTSD at the base function triggered an 
enduring question about PTSD. Following this, my discussions at conferences with 
PTSD sufferers about their quality of life and my academic studies into core narrative 
themes influencing PTSD have led me to a series of questions that shape this thesis:

1: What is known about PTSD?

2: What are the common PTSD medications and their side effects?

3: What are the social, cultural, and personal influences that interconnect with 
the PTSD medication side effects that veterans experience?

4: What are the factors that influence a veteran’s quality of life?

What is Known About PTSD?

Post-traumatic stress disorder (PTSD) is by no means a new phenomenon. On their 
website, The U.S. National Center for PTSD (2013) provides an overview of PTSD for 
the public:

After a trauma or life-threatening event, it is common to have reactions such as 
upsetting memories of the event, increased jumpiness, or trouble sleeping. If
these reactions do not go away or if they get worse, you may have Posttraumatic Stress Disorder (PTSD). (np)

PTSD has been documented as far back as the ancient Greeks, when Homer wrote about Achilles and Odysseus traumatic experiences following the Trojan War (Shay, 1994, 2002). It was not termed PTSD at the time, but the symptoms these leaders displayed upon returning home were described in detail as “crazed” or “berserk”, Achilles’ excesses “destabilize his community” (p. 1). Thus, while the fighting had ceased for these warriors, the war had continued in a different way. PTSD came into modern history following the American Civil War in the 1800s when soldiers referred to their cluster of symptoms as combat exhaustion. A civil war doctor later dubbed it “soldier’s heart”, implying that a combat veteran’s heart is tainted or filled with woe after war. A century later, World War I gave rise to the terms “shell shock” and “combat neurosis”, which were carried forward in World War II where they were joined under the diagnosis of “battle fatigue”. It wasn’t until after the Vietnam War in the 1960s that the cluster of symptoms became known as PTSD. After this war, media coverage of veterans suffering from PTSD led the US Veterans Affairs Department to fund research on this complex condition. Johnathan Shay, a psychiatrist who treated many Vietnam veterans, recognized similarities to the Vietnam veterans’ experiences with trauma and Homer’s account in the Iliad of Greek soldiers’ lives following war. The symptoms Homer had described were the same symptoms now named as post-traumatic stress disorder. In his books, Achilles in Vietnam (1994) and Odysseus in America (2002), Shay described what he had witnessed in veterans’ lives as their inability to come
“home” or to see an “end” to the war, but a long-road of suffering through the war that continued to rage in their memories and emotions.

Historically, PTSD has been referred to under a variety of terms stemming from the medical model: combat exhaustion or fatigue, combat neurosis, shell shock, Vietnam or Gulf War syndromes, or PTSD. The medicalized terms associated with PTSD – fatigue, neurosis, shock, syndrome, and disorder – create an impression of the veteran needing to be fixed or taken care of. Labelled and tainted with clinical terms, the veteran who served in war and peacekeeping is relegated to the role of needing to be taken care of, a dramatic contrast to the veteran’s previous assigned soldier role. According to Campbell’s (1991) review of Copps and MacAndrews (1990) book *Battle Exhaustion: Soldiers and psychiatrists in the Canadian Army 1939-1949*, even the Canadian Army commanders in WWII were stressed and concerned with the treatment of the numbers of soldiers experiencing the disability of PTSD: “Victims of battle exhaustion experienced confusion and shame in a system which was not well prepared to deal with them” (p.178).

In Canada, similar terms were used to describe veterans’ emotional trauma following World War I, World War II, and the Korean War. Following the Korean War, Canada’s military focused on UN peacekeeping efforts in Europe and Africa. In Afghanistan, the Canadian Forces role shifted from the traditional peacekeeping to one of active combat, and PTSD became a headline issue with Forces personnel, their families, and the Canadian public. Those serving in Kandahar, a combat intense zone in Afghanistan, are reporting higher rates of PTSD than those in Kabul, which was a more stable region. However, while combat soldiers were at high risk, many cases of PTSD
were reported by peacekeepers. Canadian UN Peacekeepers in Bosnia, during the 1990s, reported symptoms of PTSD after witnessing the horrific sight of the mass graves created by the ethnic cleansing of the Serbia, Croatia, and Bosnia religious war. Thus, both combat and peacekeeping soldiers alike experience PTSD as a result of war and/or the aftermath of crimes against humanity. These soldiers came home from combat exhibiting signs of PTSD, such as nightmares, flashbacks, or anxiety. For some soldiers these symptoms did not emerge immediately but months later. At the conference in Washington, D.C., mentioned previously, a veteran of the Iraq War recalled hearing a car backfire at the local supermarket. He described “waking up” nearly ten minutes later on his knees covering his head with his arms in an attempt to protect himself from the rain of missiles and gunfire. This incident occurred nearly three months after he returned from tour. “In that moment I was back in combat” (discussion with unknown veteran, 2010). Whenever symptoms present, pharmacological treatments, as well as behaviour modification therapies, have been used over the years to help veterans manage their symptoms.

**What are the Common PTSD Medications and Their Side Effects?**

In his book, *The Post-Traumatic Stress Disorder Sourcebook Second Edition* (2009), clinical and forensic psychologist, Dr. Glenn R. Schiraldi, lists symptoms and associated features of PTSD as: anxiety, arousal, hypervigilance, flashbacks, dissociation, impulsive behaviours, irritability or anger, self-destructive behaviours/addictions, mood disturbances, repetition compulsion, and bodily complaints (somatic complaints). While PTSD is a consequence of war that veterans cannot predict or prevent, a range of medical treatments is available. Ideally, veterans who seek help
for their PTSD symptoms may be involved in some form of psychological or psychiatric therapy, such as behaviour modification, and may not solely rely on the pharmacological treatment of symptoms. Different combinations and mixtures of medications, often referred to as “medication cocktails”, have varied over the years and must be tailored to the individual and the symptoms that individual exhibits. Many of these decisions are made by health care providers in collaboration with the veteran to optimize compliance and efficacy of the medications. In the literature review on the medications used to treat PTSD in veterans that I conducted in 2010, I examined two types of medications: anti-depressants and anxiolytics (anti-anxiety) medications.

**Medications.**

Many different medications and combinations of medications are used to treat the symptoms associated with PTSD. Two medications commonly prescribed by health professionals to treat and/or control such symptoms are: selective serotonin release inhibitors (SSRI), often referred to as anti-depressants, and benzodiazepines (BZD) that are referred to as anti-anxiety agents (Bastien, 2010; Marshall, Beebe, Oldman & Zanelli, 2001; Pary & Lewis, 2008). Asnis, Kohn, Henderson, and Brown (2004) report that SSRIs possess both anti-anxiety and anti-depressant properties and have a sedating effect. These authors suggest that some PTSD patients suffering from agitation and insomnia may benefit by this sedation. Some of the side effects of anti-depressants used to treat PTSD include vivid dreams, nightmares, insomnia, trembling, anxiety/depression, apathy, suicidal ideation (thoughts of committing suicide), and change in heart rate.
BZDs are also used to treat PTSD. Their side effects include drowsiness, lethargy, tremors, anxiety, depression, and hallucinations. Like some anti-depressants, some of the BZDs side effects mirror many of the symptoms of PTSD, such as tremors or anxiety. The health care provider needs to be hyper-vigilant when prescribing medications for the unique symptoms that each veteran exhibits in attempt to help the veteran control the PTSD symptoms and medication side effects. While a health professional may question the similarities between PTSD symptoms and the potential for PTSD medication side effects, and may conclude that medications may not be an optimal treatment, it is necessary for the caregiver to keep in mind that PTSD symptoms are a guarantee while medication side effects are only a possibility.

While the sedating effect of SSRIs and BZDs may be useful for those PTSD veterans suffering in a constant state of hyper-arousal (over-stimulated, hyperactivity), many veterans fall into a state of hypo-arousal (under-stimulated, lethargy), where they become withdrawn from their families and peers in an attempt to detach themselves from all that they associate as the trigger to their PTSD. Both SSRIs and BZDs may potentiate such negative behaviours. Military veterans, not only PTSD veterans, have also been identified as having high risks for addiction. With a high risk of dependence and addiction from BZDs, this family of medications is not a good fit for veterans. Since alcohol potentiates the effects of BZDs, the many veterans diagnosed with PTSD who ingest large quantities of alcohol are not candidates for BZD therapy.

The presence and severity of side effects differ amongst individuals. However, a constant factor is present during the treatment of veterans: whether enlisted, retired, or on active duty a soldier is immersed in the unique culture of militarism.
What are the Social, Cultural, and Personal Influences that Veterans Experience with the Side Effects of PTSD Medications?

Gaining an understanding of the uniqueness of military culture is essential in appreciating some of the roots of PTSD in the military. Following WWII, Selye’s theory of general adaptation syndrome guided the military’s interventions with veterans who experienced battle exhaustion in the US and Britain. For example, Lord Moran, Winston Churchill’s physician during and following WWII, referred to what was later called PTSD as “the exhaustion of nervous energy reserve” (Copp & McAndrew, 1990) or the extensive depletion of veterans’ emotional and psychological resources. It is also important in terms of appreciating the meaning of the medication side effects and how PTSD is influenced by the military culture. During a graduate course on gender and war, I was introduced to a new source of investigation, gender and militarism.

There are two key underpinnings of the military culture that need to be considered in relation to veterans with PTSD: masculinity and stigma (Connell, 2005, 2009; Harrison & Laliberté, 1994; Higate, 2003; Kimmel, 2006; Whitworth, 2006). Militarism, in terms of national and international security, may require the use of force, hence traditional constructs of masculinity (e.g., endurance, virility, fearlessness) are valued and encouraged. Military personnel who do not demonstrate an ability to meet the required standards, often described as hyper-masculine, may be subject to ridicule and stigmatization.

In examining the hyper-masculine culture of the military and the stigma directed toward those who do not meet the standards -- those who suffer from PTSD (often viewed by the military as having a lack of mental resilience) – face an even greater risk
of stigmatization. For a once high functioning, expert in multi-tasking, and highly efficient soldier, chronic fatigue and sexual dysfunction can be debilitating, furthering feelings of weakness and insufficiency (Connell 2005, 2009; Harrison & Laliberté, 1994; Whitworth, 2006).

In a military culture, hyper-masculinity and heterosexuality are integral components. The behaviours and values instilled in soldiers during socialization into the military culture create a myriad of implications for the holistic treatment of PTSD. Hall (2011) discusses how helping professionals can assist military personnel coping with PTSD so they can have a more productive daily life. However, first it is necessary to discuss PTSD and how it intertwines with the military culture in the development of model soldiers; thus introducing potential stigma (Connell, 2005, 2009; Iversen, van Staden, Hughes, Greenberg, Hotopf, Rona, Thornicroft, Wessely & Fear, 2011; Kimmel, 2006; Whitworth, 2006). This can exacerbate issues for soldiers with PTSD taking antidepressants; soldiers who may already be dealing with fatigue, sexual dysfunction, and decreased libido.

Masculinity in Western society and its emphasis in military culture has been a topic in studies on gender by Kimmel (2006) and Connell (2005, 2009) that examine the correlation between hyper-masculinity and stigmatization. As Nagel (2005) writes, "Classical history is replete with linking strength and valor on the battlefield with masculine sexual virility" (p. 402). Consequently, PTSD sufferers may feel “flawed” as they cope with the sexual side effects of medications, stated previously, and may begin to question their legitimacy as soldiers. Non-disclosure may offer a safe haven for a period of time. However, when a soldier comes forward with symptoms of PTSD his
psychological integrity and reliability may be questioned. In a hyper-masculine culture, a mental illness is likely to be viewed as mental inferiority, or as lacking in soldier-like qualities (Nagel, 2005). This loss of face in the military culture leaves soldiers with PTSD not only at risk of stigmatization by their peers but also of self-stigmatization.

According to the Mayo Foundation for Medical Education and Research website, stigma is defined as a mark of disgrace or shame. It has four components: 1) labelling someone with a condition, 2) stereotyping people with that condition, 3) creating a division — a superior "us" group and a devalued "them" group, resulting in loss of status in the community, and 4) discriminating against someone on the basis of their label (MFMER, 2005). The military culture prides itself on creating strong, fearless warriors who march into and out of battle unscathed. Thus, a physical injury from battle may be viewed as a result of a heroic and selfless act while a psychological injury may be viewed as cowardly and selfish (Alvarez & Eckholm, 2009).

PTSD can affect any soldier of any rank at any time in war and peacekeeping. For example, in the 1990s following the genocide that took place in Rwanda and the world’s abandonment of the people and the soldiers’ pleas for assistance, General Romeo Dallaire, who had led the Canadian UN Forces stationed in Rwanda, suffered seriously from PTSD. His autobiography, *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (2003), reveals his experience with PTSD following the crisis. Dallaire’s book provided a breakthrough in openly discussing PTSD within the military culture and opened the doors for soldiers of different ranks to discuss publically their personal stories of living with PTSD. To date, there are a number of books, conferences, websites, blogs, and films that provide public access to this hidden and stigmatized
illness. Books by General Dallaire (2003), and Lieutenant Console (2011), a young American National Guard member who served in Afghanistan, have provided insight into the daily experience of war and the emotional trauma that follows for veterans. Testimonies of soldiers with PTSD are also available on the Internet where veterans with PTSD discuss their individual and personal experiences with the illness, its medications and their side effects, as well as their experiences of stigmatization, alienation, and marginalization.

In a scan of Internet sites on PTSD, I reviewed a blog site called *PTSD: A Soldier’s Perspective*. One entry read:

The battle never leaves [a veteran] — we return from conflict every day of our lives. This is my story and struggle with PTSD; it affects every aspect of my life. I want people to know what a combat veteran goes through after the media and people forget. (2008, np)

Another entry on the same site discusses the suicide of veteran Orrin McClellan. The blogger talks about the event, with a sense of loss and alienation:

There is no “purple heart” for PTSD. There is no “war memorial” that lists those who died by suicide from PTSD, even when combat was the most likely explanation. And maybe there should be... But in the meantime, all we can do is try to reconstruct what we can find about who Orrin McClellan was in the 25 short years he was here. (2008, np)

These two poignant blog entries introduce the realities of veterans returning home from war as well as the loss of meaning, recognition, and place in their country’s story of heroism.
As with any international incident, the media, including social media, plays a role in educating the public about war — who is involved, its repercussions, and morbidity and mortality rates. However, in an attempt to provide the public with selected and tailored information to suit the media’s organizational mandates, these may be edited. Nevertheless, many hours and dollars have been allocated by the media to socialize the public to the horrors and heroics of war, and raw footage of the wounded have become commonplace in our living rooms. With the increasingly graphic nature in which media currently portrays war and violence, desensitization of the public reaction can result (Bushman & Anderson 2001; Bushman & Cantor, 2003; Cantor, 2002; Fahmy & Johnson, 2007; Menning, 2007; Parry, 2010; Robinson, Brown, Goddard & Parry, 2005).

A Pulitzer Prize winning photograph, taken in Saigon by journalist photographer Eddie Adams (1968) following the Vietnam bombing with Napom, seems to have been one of the first instances of graphic and gripping media coverage of war. Debates also ignited over a photograph of Vietnam police chief, Lt. Colonel Nguyen Ngoc Loan, executing a Vietcong prisoner on February 1, 1968. Allegedly, Adams later stated, “I got what I came to Vietnam for” (Faas, 2004, np). Deep rooted emotional responses to such images and terms such as MIA (Missing in Action), POW (Prisoner of War), PTSD (Post Traumatic Stress Disorder), and IED (Improvised Explosive Device) have become desensitized and compromised. Rather than educating the public on the social and human injustices of war, the media has been criticized for sensationalizing scenes, shocking viewers with ill-explained, gory portraits of everyday atrocities (Sontag, 2003). Viewers see the scripted side of the combat as reporters and specialists select scenes of
terror for “sound-byte” moments and visuals. For US veteran Sam Console (2011) no-one can capture the raw emotion of the lived experience of war and its horrors like those who were there and who now live the fallout every day. The following quote from the UK *Aftermath PTSD* homepage, acknowledges the individual and psychological sacrifice of war:

> Our society has been continuously at war since 1939, the start of WWII. Each and every day, for the last 72 years, war has been News – taking seconds to report the loss of life, and a lifetime to suffer the resulting trauma.

(http://aftermathptsd.co.uk, np)

It seems that many of us are, at some level, affected by the human sacrifice of war, both physical and psychological. Whether by a direct connection to the military, a professional and/or personal interest in history and conquest, mental illness, and/or political science, we are impacted by the media’s portrayal of war and its political dynamics. Canadian media coverage of the war in Afghanistan, for example, has provided Western society with an upfront and personal look into combat and the lives of soldiers, both during and after war, and the challenges they face. The families of soldiers that are deployed, injured, or deceased, have also been in the spotlight. Media headlines bombard us with mortality rates, rebel activity, and the responses of NATO troops. Sometimes the sensationalism of headlines, borders on exploitation. For example, on February 16, 2011, InsideTV’s show *Voice of Reason*, showing service members and their families’ reunions, was criticized for the exploitation of service members and their families’ experiences for the sake of TV ratings. Two days later, commenting on the show, blogger Suzanne wrote:
My husband was on active duty for six years and I’ve been through two deployments and countless workups. My husband and I were talking about this show and we both believe that it’s exploitative. The parents of these children are trying to do a really wonderful thing by surprising them but I think that Lifetime is using their moments to jack up ratings…. Maybe [the television station] could use some of their airtime to compel people to actually DO SOMETHING to assist service members and their families whether it be with adjusting to life after active duty or fighting for the rights of service members to keep the benefits they’ve been promised and deserve. (np)

Similar to autobiographies, conference discussions, and blog sites of personal experiences with combat-induced PTSD, American films attempt to capture gripping emotional struggles of war and its aftermath via portrayals of fictionalized or non-fictionalized characters and events. For example, Warners Independent Pictures’ film, *In the Valley of Elah* (2007), portrays the Iraq war, PTSD, and the treatment of prisoners through the story of a father’s search for his son’s murderer. Whereas, following the Vietnam War, and Hollywood produced films such as *Deer Hunter* and *Platoon*, it has yet to address some of the vital social and health issues caused by recent wars. Although there are recent documentaries — *Wartime Experience* (2007); *This Is War: Memories of Iraq* (2007); *Restrepo* (2010); and *Inside the Afghan War* (2012) — these are all American independent films and documentaries produced for those with a particular interest in the subject matter rather than for a mass audience. And, unlike Hollywood films, Canadian independent filmmakers do not have multi-million dollar budgets and
large sponsorships, resulting in fewer movies capturing veterans’ experiences with PTSD within the Canadian culture.

**What are the Factors that Influence a Veteran’s Quality of Life?**

While the media may provide the public with a snapshot of life with PTSD, the complexity of the illness faced by each individual needs to be examined biographically and autobiographically in order to better understand how veterans perceive PTSD and how it affects their quality of life and the quality of life of their families. The definition of quality of life has been debated and examined from philosophical, societal, psychological, and medical points of view (Atchley, 1991; Easterlin, 2004; Kane, 2003; Lawton; 1997). Kane (2003), for example, focuses on global issues stating that quality of life is often used as a summary term regarding the measurement of the various multi-dimensional aspects of one’s life. Lawton (1997), on the other hand, claims that the temporal nature of quality of life involves reflection on the past, aspirations for the future, and appraisal of the present. For Lawton, a person’s quality of life may be perceived as one way before illness and another way after; and even different again following treatment with medication. Addington and Kalra (2001) argue that professionals’ perceptions may differ from patients’ perceptions and that the key to the therapeutic process for PTSD sufferers is acknowledging this potential tension.

Quality of life, therefore, has two key similarities to narrative inquiry: a) the temporal nature of experience when reflecting on and addressing the meaning of past, present, and future experiences; b) the method designed to value the participants’ biographical accounts of their experiences. Both quality of life and narrative are based
on the participants’ meanings embodied in their stories of experience along with the telling of their stories as they intend them to be heard.

Relevance of the Research

For the first time since World War II Canadian troops have been actively engaged in combat (in Afghanistan and in bombing missions in Iraq). Veterans Affairs Canada and health professionals across the country are now witnessing both the physical and psychological atrocities of war that were previously primarily known only by the veterans with PTSD, their families, and communities.

Since observing the incident with the veteran suffering from PTSD at a base function, I have met veterans in a variety of social, academic, and professional contexts. Listening to their trauma stories has led me to this journey of inquiry into PTSD and veterans’ quality of life. I have also joined the association Psychosocial Rehabilitation Canada and this has linked me to services and programs offered at a number of Military Family Resource Centers across Canada. I have read from my book *My Daddy is a Soldier* (Bastien, 2012) to the local Cub Scout troop on Veteran’s Day 2012, and to others, and donated copies to Military Resource Centers across the country. Also, as a result of my own post-partum depression and experiences with anti-depressant medication, I have become involved in related activities, such as volunteering with MOMS link (a mentoring program for mothers with post-partum depression).

In the final stages of writing this thesis, I have come to understand how my childhood memories of military stories told to me by my grandfather, a WWII veteran, and recently my uncle’s retelling of those war stories to me, have helped me recognize that my interest in the military and PTSD goes back a long way in my life. This research
process has enabled me to reflect on my own experiences, not only as a new mother medicated for post-partum depression, or as a military wife whose husband has been deployed to war zones in Europe and the Middle East, but as a child listening to stories from WWII from my grandfather.

As a child sitting on my Grandpa Pickett’s knee I recall hearing stories of bravery and struggle during WWII that were no doubt softened versions for a child. My grandfather spoke of his troops starving in the Sahara Desert where the only food left was the tiny crumbs that remained embedded in the ridges of the empty tin cans. The soldiers used the tips of their knives and saliva to loosen the remnants of food trapped by the can’s ridges. Every soldier shared the cans, ensuring that all had the chance to survive and none succumbed to starvation.

During my early adult years my grandfather passed away. However, recently my uncle shared stories that my grandfather told him during their many conversations. Although these stories were told by a soldier to another man, they are vivid in my memory. Through them I have come to learn and appreciate the challenges and suffering the soldiers endured, and, for the first time, to hear them as they were meant to be heard. My grandfather was under Montgomery’s command in the Sahara and spent years apart from his newlywed wife, Nanny Primrose Pickett (Brooks). When talking to my uncle over Christmas 2012, he quoted my grandfather’s telling of Christmas 1942 encamped in the Western desert when there was a lull in the fighting. My grandfather spoke to his experience, “We each had two bottles of beer and a packet of Sweet Caporal cigarettes.” He heard recorded music coming from the American soldiers’ camp nearby. Following his curiosity, he made his way in the direction of the music and, for the first time in his
life heard the song "White Christmas." For the rest of his life “White Christmas” was my grandfather’s favourite song. Now, many years later, I understand why.

My Grandpa and I also shared other memories like my decision to become a nurse. My grandfather had triple-bypass heart surgery at eighty years of age and while he was in the intensive care unit before discharge home, I looked at him and decided as soon as I saw him attached to the high-tech equipment that I would be a nurse. During the Christmas season there were only a few scheduled nursing visits, so my mother and I cared for him – his surgical sites, incisions and convalescence. Indeed, my grandpa’s surgery and the care he required also led me to conduct research on veterans’ experiences with PTSD. He used to say that his old heart was the reason I became a nurse. Looking over at me with pride and a smile under his thin grey-white moustache he told me this fondly.

Initially, during the US Civil War, PTSD was known as “Soldier’s Heart”. So from my grandfather’s soldier’s heart to the wounded heart of the young man at the base dinner in 2008, I have taken a journey of professional and personal discovery learning about PTSD and bringing it home to myself through the veterans’ stories. Grandpa’s voice, though he passed away many years ago, lives on in my uncle’s telling of his war stories, and in my research with veteran’s experiencing PTSD. However, his audience is no longer a fragile, young child sitting on his knee, but an adult with that same wonder about the effects of war on veterans, their stories and their lives as a whole.

Chapter 1 has outlined the context for this study on PTSD, PTSD medication side effects, and veterans’ quality of life. I have introduced PTSD as an illness, described the key PTSD medications and their side effects for veterans, examined the
multi-dimensional experiences of veterans suffering from PTSD, and discussed the core quality of life issues veterans with PTSD experience. In Chapter 2, I examine literature focused on PTSD, the medication side effects, and quality of life. Key factors that influence PTSD are discussed – militarism as a culture, masculinity as a driving force within the military, and stigmatization as a result of combat-induced PTSD. PTSD may be a diagnostic term, but for those who suffer from its terrors in their lives, it is a multi-layered complex story of contradictions and traumas that they live with constantly and try to cope with and heal. PTSD is an unresolved and unpredictable narrative. In Chapter 3 narrative as a research methodology is discussed along with its relevance to the research topic of PTSD and PTSD medication side effects. As a narrative researcher, nurse, wife of a Forces member, and mother of three boys who may find themselves in the military as young adults, my personal reflections inform this study and I endeavour to examine their influence as issues arise throughout the thesis. Since narrative research is biographical and autobiographical in nature, I present in Chapter 4 brief biographies of the research participants and the core themes and sub-themes that emerged from the interviews with these veterans who courageously shared their emotional trauma with me during this study. While the research focuses on the experiences of veterans living with PTSD, conducting research involves a social contract to share the knowledge gleaned in the study with the public so others – veterans with PTSD, their families, other Forces personnel, the general public, and political authorities – have the opportunity of reading the study and shape their own insights into PTSD in the military. Chapter 5 also offers ways in which this study’s findings may influence future research on PTSD, PTSD
medication side effects, and the quality of life of veterans, and offers recommendations for future practices (professional, personal and public).
Chapter 2: Reconnaissance

Searching the Literature

Before beginning this study, I conducted a literature review for an article on medications prescribed to treat combat-induced PTSD. Conducting this early focused literature review led me to question the drugs used for PTSD and their side effects, as well as the impact these drugs may have on veterans’ lives. Also, around the same time, I was taking a graduate course on gender and war and was introduced to the topic of masculinity as well as its relationship to the military and PTSD, and my interest in issues related to PTSD in the military grew. I engaged in an examination of literature on militarism as a culture and the stigmas associated with PTSD amongst military personnel. As the influences of these research themes emerged, I reviewed scholarly, peer-reviewed articles from a variety of article databases (e.g., CINAHL, PubMed, Academic Search Premier, and PsychINFO) using key words for searches that applied directly to this research study (e.g., PTSD medications, masculinity, military, quality of life, narrative inquiry, and stigma). While I was not yet aware of it, my study had begun in these early graduate courses. I went on to explore references and resources from the Royal Military College, the Canadian Institute for Military and Veteran Health Research (CIMVHR), and the National Defense and Canadian Forces (DND/CF). In addition, I expanded my literature inquiry into relevant articles from specific disciplines such as nursing, psychology, gender studies (masculinity studies), sociology, and military/war studies. From these literature reviews, I gained insights into the impact a PTSD diagnosis and PTSD medication side effects had on veterans and their quality of life, which led me to identify gaps in the qualitative literature on veterans’ quality of life after
a PTSD diagnosis. The gaps that became evident revealed that there was a limited focus on fatigue and sexual dysfunction as primary side effects of PTSD medications. Though this inquiry was significant, it did not identify the implications of such side effects on the military population.

In this chapter I discuss literature related to the key themes that emerged during the research project on PTSD medication side effects and the quality of life of Canadian male veterans. Key topics discussed include: PTSD, PTSD medications, medication side effects (fatigue, sexual dysfunction), quality of life, military culture, masculinity, conformity, and stigma.

With my research questions focused on understanding the implications of PTSD medication side effects on veterans’ lives, I first introduce these core concepts and discuss their relevance to the study. Following this, a basic orientation to the key concepts of PTSD, medications, and medication side effects, is provided before transitioning into the more complex themes and sub-themes that arose from the research interviews with the veterans.

**Post-Traumatic Stress Disorder (PTSD)**

Veterans Affairs Canada (2021) defines PTSD as:

Posttraumatic Stress Disorder (PTSD) is characterized by the onset of psychiatric symptoms after exposure to a traumatic event. The individual's response to the traumatic event must involve intense fear, helplessness or horror. The characteristic symptoms of PTSD develop in three domains: reexperiencing the traumatic event, avoidance of stimuli associated with the traumatic event and increased arousal. (np)
The American Psychological Association’s *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (2013) outlines the following diagnostic criteria for PTSD: presence of a stressor, intrusive recollection, avoidant/numbing behaviour, hyper-arousal, duration of symptoms, and functional significance on the individual. The U.S. National Center for PTSD (2013) elaborates on these diagnostic criteria, stating:

Diabetic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning. (np)

A variety of treatments currently exist in the care of individuals with PTSD, such as psychotherapy. However, medication therapy is often used in conjunction with different therapies to help manage PTSD symptoms.

### PTSD Medications

In my early article on PTSD medications, I examined two groups of medications used to treat veterans with PTSD: anti-depressants and anti-anxiety (anxiolytic) medications (Bastien, 2010). The following is a summary of this review published in *The British Journal of Nursing*, which has granted me permission to use this content in my thesis.

Veterans suffering from PTSD as a result of combat are often treated with psychological and psychiatric interventions as well pharmacological therapies. Oftentimes medications are prescribed to gain a degree of control over PTSD symptoms while the veteran begins and/or continues to engage in some form of psychiatric,
psychological or behaviour modification therapy. The use of anti-depressant and anti-anxiety (anxiolytics) (Marshall, Beebe, Oldman, & Zanelli, 2001; Pary & Lewis, 2008) medications has become common practice among medical professionals involved in treating war veterans whose memories have continued to haunt them after returning home (Hoffman & Matthew, 2008; Lamberg, 2004). As the number of returning veterans diagnosed with PTSD increases (Iversen, van Staden, Hughes, Browne, Hull, Hall, Greenberg, Rona, Hotopf, Wessely, & Fear, 2009; Litz, 2011), research into the efficacy of standard treatments has become more prevalent. Medical and nursing literature resources support the use of anti-depressants and anti-anxiety agents but they do not address the optimal pharmacological treatment for veterans with combat induced PTSD.

**Anti-depressants.**

Anti-depressants are medications prescribed to treat symptoms of depression, which may include feelings of sadness, fatigue, worthlessness, isolation, and/or suicidal ideation. The main concern with the use of anti-depressants in the treatment of PTSD is that it may take up to six weeks to reach the therapeutic blood level where clients’ symptoms are well managed. This long wait is a major cause of participants withdrawing from clinical trials. It is during this long wait time that many sufferers may turn to alcohol, drugs or even suicide in attempt to numb the agoraphobia (fear of crowded spaces), depression, and nightmares that accompany PTSD. However, once the client’s PTSD symptoms are controlled, anti-depressants are often the medication of choice for PTSD as they treat the anxiety and the often co-morbid depression (Bastien, 2010).
Most research studies for anti-depressants run between 4-12 weeks and address mainly the initial, acute phase of PTSD. A longer study would be more favourable to pass the acute phase, or onset of symptoms, but this would require ongoing compliance by the research participants, which tends to wane over time. Researchers determined that a longer time frame could provide more opportunity for those who do not respond to treatment initially to respond after a 12 week period (Brady et al, 2001; Davidson et al, 2001).

**Anti-anxiety medication (anxiolytics).**

Anti-anxiety or anxiolytics belong to a family of medications called benzodiazepines (BZD) and are often prescribed to control symptoms of anxiety such as nervousness, restlessness, hyperactivity, and/or trembling or shaking. Some anti-anxiety agents do have one main advantage over the use of other medications in the treatment of anxiety associated with PTSD: Because of their rapid onset, anti-anxiety medications can be prescribed and taken as needed while a client waits for symptom control from their anti-depressant(s) (Hoffman & Matthew, 2008).

There is still much to learn in the use of anxiolytics in PTSD. Since 1960 they have been one of the primary medications prescribed for anxiety, and since the late 1980s, they have been prescribed adjunctively with anti-depressants to treat anxiety related illnesses. The main drawback of anti-anxiety medications is that they can be addictive and veterans already suffering with an addiction are not ideal candidates for treatment:

Because benzodiazepines are cross-tolerant with alcohol, patients with a history of alcohol dependence are at an increased risk for addiction. Benzodiazepines...
are not recommended as monotherapy (the sole therapy) for patients with PTSD. [But] there are times when a benzodiazepine is the drug of choice. [For example, in the case of a veteran] with a longstanding PTSD that is poorly responsive to anti-depressants. (Pary & Lewis 2008, np)

Finally, a study on the neurobiological impact of BZDs and the benzodiazepine receptors in the brain revealed that the relationship between the two have to be further investigated to determine the efficacy of treating anxiety disorders such as PTSD. Perhaps BZDs could be the primary treatment for PTSD at some level.

With the therapeutic wait time of up to six weeks for anti-depressants and the risk of addiction with anti-anxiety medications there does not seem to be an ideal pharmacological treatment for combat induced PTSD in veterans. There is certainly no miracle treatment. At the present time, pharmacological intervention along with other forms of medical intervention such as psychological, psychiatric, and/or behavioural therapy would be most successful in treating PTSD holistically. In the case of pharmacological intervention, the use of a combination of anti-depressants and anti-anxiety medications produce favourable outcomes since the medications can be used simultaneously and/or conjunctively depending on the client case. Prescribing both types of medications may also be beneficial as there is often a co-morbid (additional) depression that exists in the family of anxiety disorders, where PTSD fits (Bastien, 2010).

Anxiolytics would be indicated for acute panic-type episodes and symptom management until the anti-depressants’ blood concentration level is achieved. Once a therapeutic anti-depressant dose can be maintained, this would minimize and ideally
eliminate the use of anxiolytics, thereby minimizing the risk for addiction. A combination of medications is not to be solely relied upon, but used as an introductory therapy in the treatment of PTSD. When acute symptoms are pharmacologically controlled, then psychiatric or psychological treatment may be initiated. Health professionals need to collaborate to investigate which medication combination, in conjunction with select other treatments, yields the highest number of effectively managed cases of combat induced PTSD. Each case of PTSD is unique to the individual and to his or her life experiences and narrative. Therefore, symptoms will vary from one individual to another, as will the medications prescribed and their side effects that will effect the veteran’s quality of life.

**Prominent Side Effects**

The two medication side effects discussed in this section include sexual dysfunction and fatigue. While health care professionals place safety above all else when giving medications, there must be a consideration for what the individual may view as a troublesome side effect. Pharmaceutical manufacturers of these types of drugs list impotence and difficulty with sexual functioning as relatively rare side effects; however, some studies discuss that participants commonly report sexual dysfunction (Balwin, 1995; Davis-Berman & Pestello, 2005). In a study, conducted by Davis-Berman and Pestello (2005), of civilian individuals’ sense of self while medicated with psychiatric medications, the authors concluded that sexual side effects impact non-compliance with the medication regime as a result of suffering from the sexual side effects thereby creating feelings of inadequacy. Constructs of masculinity may play a part in a veteran feeling frustrated with his decreased sex drive, and admitting to a decreased libido or
erectile difficulties. The hyper-masculinity constructs within the military culture could fuel this response.

PTSD has the potential of precipitating types of sexual dysfunction. Letourneau, Schewe, and Frueh’s (1997) research reported that 80% of combat veterans had experienced some form of sexual dysfunction as a result of PTSD, and with the majority of veterans complaining of erectile problems. Sexual dysfunction can be further exacerbated by PTSD medication side effects. The connection between sexuality and masculinity is examined in a study by Webb and Daniluk (1999) in a qualitative research study which Don Sabo (2005), a leader in the social, psychological and sexual dimensions of gender, describes as, “one of the few studies” (p. 337) of its kind. Webb and Daniluk (1999) compared the experiences of men who had never biologically fathered a child with men who were infertile. Participants in their study described feelings of overall loss (depression, exclusion, and isolation) with a focus on their loss of masculinity. Decreased sense of masculinity strongly correlated with sexual dysfunction, and participants reported "a tremendous blow to their masculine identities" (p. 21) due to sexual dysfunction. Don Sabo (2005) adds to Webb and Daniluk’s (1999) study by saying that infertile men also experience "profound grief and loss, loss of control, personal inadequacy, isolation, a sense of foreboding, and desire to overcome and survive" (p. 337). All three authors claim that, no matter the cause or the result (e.g., unable to father a child, erectile dysfunction, decreased libido related to medications, etc.), men who report suffering from sexual dysfunction have a negative self-perception. For these men, compassionate, sensitive and ethical care, as well as follow up is needed. Thus, if sexual dysfunction results in loss of self for the
average male in society, it can be hypothesized that hypermasculine military males living with PTSD may encounter more intense degrees and side effects of this phenomenon. A decrease in the physical aspects of sexuality may be a direct result of prescribed medications. To compound the sexual medication side effects, fatigue is another unfavorable side effect caused by anti-depressants (Asnis, Kohn, Henderson, & Brown, 2004; Bastien, 2010). The impact of fatigue on sexuality may not only be due to the physiological implications of drugs but from the larger concern of chronic fatigue that impairs the desire and energy levels of the sufferer.

Though the initial fatigue caused by the nightmares and flashbacks associated with PTSD and resulting insomnia may be in the past, a ‘new’ fatigue may emerge related to the medication side effects. While the source may be different, fatigue is a common result of both. For a once high-functioning expert in multi-tasking, and a highly efficient soldier, chronic fatigue can become debilitating, furthering those feelings of weakness and insufficiency created by the PTSD and the accompanying stigmatization.

A “cookie-cutter” approach (similar or identical treatment regimes for same diagnoses), to treatment of any kind, such as current pharmacological treatment for PTSD, cannot possibly meet the individualized needs of veterans diagnosed with PTSD. Each soldier may interpret similar symptoms and/or side effects differently, and internalize the effects individually. Though assumptions are made, it is only by learning of the context of each soldier’s life and by hearing the stories of those living with PTSD and PTSD medication side effects that we as health professionals can gain an understanding of core issues and hidden meanings affecting a veteran’s quality of life.
Quality of Life

Quality of life (QOL) can be affected when PTSD and PTSD medication side effects alter a veteran’s career path, family life, and sense of self. Coming home can be like entering a foreign territory when the soldier copes with PTSD side effects, psychological/psychiatric/behavioural therapies, daily medications and a myriad of potential side effects. Life as it was before war may not exist anymore; a new kind of war looms over the soldier’s life — one that cannot be fought with weapons and machines.

While existing QOL measurement scales may examine both subjective and objective measures of QOL, Conceicao and Bandura’s (2011) work introduces wellness as a parallel term to QOL. For Easterlin (2004) wellness equals happiness and life satisfaction. While for McGillivary (2007) however, the concept of wellbeing is multidimensional and encompasses all aspects of human life. He acknowledges that there is complexity in assigning boundaries to the term wellness or QOL. Literature sources outline both objective and subjective QOL and wellness definitions. The objective form refers to measurement tools and the subjective form refers to self-reported happiness and life satisfaction. In this narrative study, the focus of QOL is the subjective form or the wellness or happiness as described by each veteran regarding his lived experience. Thus, the working definition of QOL is what the veteran describes it to be. QOL, as wellness, self-perception, and life satisfaction, shapes my research interview question: How have PTSD medication side effects affected your quality of life?
Whereas there is no universally accepted definition of QOL, for PTSD sufferers QOL is influenced by many factors, especially medication side effects. Svensson (1991) describes the process by which each individual evaluates their QOL as a process engaging in an autobiographical reflection on what was experienced and the meaning these experiences had in shaping life events. Narrative researchers examine life experience through the use of stories of experience that are essentially autobiographical and biographical. For example, Atchley (1991) focuses on the individual’s sense of the present in creating an understanding of QOL, whereas Svensson (1991) and Atchley (1991) discuss ownership of stories as they are told by the individual. Thus, QOL for Svensson and Atchley is defined by the storyteller – or is subjective and autobiographical. Lawton’s (1991) proposed model of QOL is multidimensional and identifies factors that help define an individual’s QOL as behavioural competence and psychological wellbeing. In their work on stigma and mental health, Marcussen, Ritter, and Munetz (2010) reveal that there is a strong relationship between stigma and a perceived decrease in quality of life. These authors recommend that self-perception, stigma, and QOL are factors to consider when working with persons with mental illness. Warshaw et al. (1993) argue that little research has been done on the QOL of patients with a history of trauma or PTSD. In comparing a variety of scenarios, both historical and mental illness specific, they recognized a gap in research on QOL with PTSD patients. A gap was also evident on these issues within the military culture in my search of academic, peer-reviewed databases (e.g., CINAHL, Academic Search Premier, PubMed) using key words military, PTSD, and quality of life.
Through my investigations and literature searches into the side effects of PTSD medications for veterans, a more comprehensive view of military culture, PTSD, and the influence of medication side effects on veterans emerged. In this study, I examine the meaning of these factors on each veteran’s quality of life, as each described them. Moreover, this study addresses themes identified by the veterans and how these themes related to themselves as persons, their families, their peers, and the military culture in which they lived and worked.

Military Culture

Fenell (2008) describes the military culture as one unto itself, with several important values such as:

- Always maintaining physical fitness; training hard before deployment to reduce casualties; never abandoning fellow warriors in combat; making sure the mission and the unit always come before the individual; and never showing weakness to fellow warriors or the enemy. (p. 9)

While these values are often applied in preparation for a mission, they are also embodied in the everyday culture of the military. Klare (as cited in Eibee & Thee, 1990) lists military values as: “centralization of authority, hierarchisation, discipline and conformity, combativeness and xenophobia” (p. 36). Despite the diversity of ethnicity, religious practices, and gender there is the common cultural bond of militarism amongst soldiers. Militarism is defined by Klare as “the tendency of a nation’s military apparatus (which includes the armed forces and associated paramilitary, intelligence and bureaucratic agencies) to assume ever-increasing control over the lives and behaviour of
“its citizens…” (p. 36). He further describes military goals as: “preparation for war, acquisition of weaponry, [and] development of military industry” (p. 36).

Why do young people join the military? What are the drawing factors? Are there differences between countries and cultures? Four reasons why an individual joins the military according to American author Hall (2011), who draws on work by Wertsch (1991), are: family tradition, benefits, identification with the warrior mentality, and as an escape. Family tradition shows that families who have had generations of soldiers may join because they are accustomed to the military culture. However, Hall (2011) warns that this extreme sense of dedication to the military, to warrior mentality, and to fostered conformity has the potential to disrupt family functioning and relationships rather than further it. Despite the reasons for enlisting, soldiers within the military culture are expected to share the same values of fighting an enemy and protecting their society against threats. In so doing they share a common identity of objectifying an enemy.

In militarism, objectification of an enemy is a significant and perhaps necessary response. Grossman (1995) describes how, in basic training, the instinctual response of fight or flight is pared down to one reaction – fight. In his book, On Killing (1995), Lt. Colonel Dave Grossman, also an American, describes the military’s practices of transferring the human moral instinct not to kill to creating warriors capable of waging war and killing their fellow human beings:

On the training bases of the major armies of the world, nations struggle to turn teenagers into killers. The “struggle” for the mind of the soldier is a lopsided one: armies have had thousands of years to develop their craft, and their subjects have had fewer than two decades of life experience…. [The soldier] generally
tries to cooperate by “playing the game” and constraining his or her own individuality and adolescent enthusiasm, and the army systematically wields the resources and technology of a nation to empower and equip the soldier to kill and survive on the battlefield. (p. 217)

Captain Jung (2008) provides us with insight into how this process can be done more easily. In his online article, “Can the Canadian Forces reflect Canadian society?” (2008), Jung identifies demographic data of Canadian soldiers that show how the process can begin:

The recruitment pool for the CF [Canadian Forces] traditionally has been fit young men between the ages of 17 and 24, coming from rural areas or from urban areas with a population of less than 100,000. Recruits generally have been white males with previous familial CF ties, possessing a high school education or less. (p. 28)

The values and beliefs instilled by parents, society and the church from birth are challenged as these young soldiers complete basic training and are to kill the enemy they face. Thus, soldiers enter the battlefield with not only the fight with the physical enemy ahead of them, but an internal battle of moral conflict. This begs the question of whether soldiers shoot to kill or struggle to miss in order to protect their sense of humanity and family values. Contradictory evidence exists. Initially, S. L. A Marshall in *Men Against Fire: The Problem of Battle Command in Future War* (1968) states that,
It is … reasonable to believe that the average and normally healthy individual – the man who can endure the mental and physical stresses of combat – still has such an inner and unusually unrealized resistance toward killing a fellow man that he will not of his own volition take life if it is possible to turn away from that responsibility. (p. 79)

Marshall (1968) also theorized that their reluctance to kill or fire, … Was more fundamental to the human condition, and in particular to the American national condition, since civilization had cultivated in most people a “fear of aggression” so strongly absorbed that it became “part of the normal man’s make-up.” (p. 16)

However, in the 1980’s Spiller challenged Marshall’s arguments and his evidence. Spiller in Engen (2009) critiques Marshall’s research as having little data collection and lacking statistics from the interviews he conducted. Marshall’s ‘systematic collection of data’ “appears to have been an invention” (p. 20). Marshall’s service in WWI and credibility as a researcher has come into question to a point where Spiller stated that” it may just be that Samuel Lyman Marshall made the whole thing up” (p. 20).

However, the process of othering the enemy has been used for centuries to motivate killing and minimize remorse (Grossman, 1995). Objectification of the enemy is used to reduce the enemy to an inhuman status. Othering socializes soldiers into rendering the other as inferior, evil, morally wrong, culturally and/or biologically bad.
While physical distance from the enemy is not always possible for infantry soldiers engaged on the frontlines of heavy combat, the emotional rather than the physical distance that soldiers are expected to maintain during war is significant. Therefore, othering is intended to create emotional distance.

**Masculinity.**

Characteristics of the military and the values held by soldiers are foundational in comprehending the complex nature of PTSD, especially the impact that PTSD medication side effects have on the quality of life of Canadian male veterans. Socialization theory suggests that from birth we are groomed to fit socially defined gender roles and to accept gender defined behaviours (Harris, 1995; Oetting & Donnermeyer, 1998). Gender roles are introduced to children in Western society by a variety of means and as a child transitions to adulthood can become embodied and more distinctly defined. In general terms, Western society creates a social distinction between the characteristics of what it is to be a boy and what it is to be a girl, for example pink and blue colours of clothes, selections of toys, assigned roles, and more. For boys, toys often include toy guns and soldiers, tanks, war-planes (Dawson, 1994) and small sized fatigues clothing or Superman T-shirts.

Masculinity has been examined by researchers from a variety of perspectives (Connell, 2005, 2009; Grossman, 1995; Iversen, van Staden, Hughes, Greenberg, Hotopf, Rona, Thornicroft, Wessely, & Fear, 2011; Kimmel, 2006; Whitworth, 2006). Social biases shape views that attributes deemed feminine minimize a young man’s masculinity (Connell, 2005, 2009; Goldstein, 2001; Higate, 2003; Kimmel, 2006; Whitworth, 2006). In military culture the binary of femininity and masculinity is
amplified. Soldiers are socialized to conform to acceptable masculine behaviours. Carver (2008) in his work on masculinity describes the social perspective of un-masculine behaviours: “[m]asculinity is...not weakness, emotionality, irrationality, softness, passivity, etc. – qualities typically associated with femininity” (p. 71).

Along with Carver (2008), Freud (1925), Kimmel (2006), and Connell (2005, 2009) have influenced current understandings of masculinity and gender studies. Freud’s controversial theories surrounding female hysteria, penis envy and terror of castration supported the dichotomy of masculine and feminine characteristics: women are emotional and irrational while men are deemed unemotional and rational. Carver (2008) argues that this gendered binary is carried forward from society into the military culture where manhood and all that masculinity encompasses are emphasized.

Authors Connell and Wesserschmidt (2005), Dimetriou (2001), Higate and Hopton (2005), and McCready (1994) examine a form of masculinity often attributed to the military culture described as hegemonic masculinity – a form of masculinity that "boys and men are generally encouraged to aspire to" (Higate & Hopton, 2005, p. 433). Higate and Hopton (2005) note that this type of masculinity is characterized by "the interrelationship of stoicism, phallocentricity, and the domination of weaker individuals, competitiveness and heroic achievement" (p. 433). Connell and Messerschmidt (2005) describe hegemonic masculinity as “[embodying] the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men” (p. 832). Demetriou (2001) defines hegemonic masculinity as "an essentially white, Western, rational, calculative, individualist, violent, and heterosexual configuration of practice
that is never infected by nonhegemonic elements” (p. 347). Finally, McCreary (1994) simply states that it is an attempt to distance oneself from everything feminine. Indeed, the military has been depicted as an overly masculinized institution that personifies hegemonic masculinity (Barrett, 1996; Green, Emslie, O’Neill, Hunt, & Steven, 2010).

Military constructs and discourses surrounding masculinity and its qualities are relevant in providing a foundation for the examination of PTSD medication side effects. Risks for soldiers associated with non-conformity to the over-masculinized or hyper-masculine norms and the stigmatizations that arise with such deviations are relevant in understanding the meaning of quality of life for soldiers suffering from PTSD. PTSD is defined as a mental illness by the DSM-IV psychiatric diagnostic manual. Stigma and the hypo-masculinity resulting from this diagnosis create additional stress for those who live with PTSD.

From basic training, recruits are programmed to conform to expectations of masculinity demanded by the military. Goldstein (2001) argues that “cultures mould males into warriors by attaching to ‘manhood’ or ‘masculinity’ those qualities that make good warriors” (p. 252). In the military culture, where patriarchal norms dominate, qualities defined as feminine are considered undesirable amongst the male ranks resulting in labels of inferiority isolating and alienating them from the hyper-masculine soldier norm (Carver, 2008). For example PTSD, as a result of combat and war, could be viewed as a psychological or emotional inferiority. Veterans who return from the atrocities of war may be haunted by the events and memories that accompany their experiences. With an inability to heal the wounds of war, some soldiers suffer from
PTSD and must live in a world of unpredictable emotionality and irrationality — a world foreign to the demanded and accepted gendered code of practice in the military. Similarities exist between gendered expectations of masculinity and the military’s vigilance in demonstrating masculine power in the creation and maintenance of fearless combatants:

> Power lies in the language of male sexual identity. The soldier’s world is characterized by a stereotypical masculinity.... His professed sexuality [is] crude and direct; his maleness is his armour, the measure of his competence, capability and confidence of himself. (Marlowe, 1983, p. 191-2)

Deviation from hyper-masculinity is deemed a weakness that may result in unfavourable career implications and marginalization (Whitworth, 2006). Soldiers who suffer from PTSD are often viewed as deviants, as “lesser than” the model soldiers who show no physical or emotional vulnerability.

**Conformity.**

According to Canadian author, Winslow (1999) in his article, *Rites of passage and group bonding in the Canadian airborne*, the pressure to conform is present both on and off the base. Members of the military are expected to fit into a fiercely unique culture according to American authors Hall (2011) and Sabo (2005). Hall states that having been immersed in this culture since basic training, soldiers may not recognize what society at large views as behaviour bordering on dysfunctional or as unfathomable. Sabo claims that, "warriors [are] taught to conform to a type of hegemonic masculinity that embodies violence-proneness, toughness, and obedience to male authority" (p. 335). Recruits are expected to bond with each other during their eight weeks of basic training...
and secure similar such bonds with their platoons, so that they are unbreakable in the threat of war or battle.

In their book, *No Life Like It: Military Wives in Canada*, Harrison and Laliberté (1994) write:

The unique structure of military life — its isolation from civilian life, its self-sufficiency, its distinct uniform, traditions, rules, and values — facilitates a closeness and bonding amongst its members during peacetime that only requires intensifying during war….Unit cohesion often means slavish conformity – being with the group even when you would rather be elsewhere. Conformity is the natural outcome of intense bonding. (p. 27 & 30)

Harrison and Laliberté (1994) further argue that “[b]asic training is the recruits’ initiation into the total institution of the military’s preoccupation with bringing and keeping its members under control” (p. 21). In recounting the narratives of active duty soldiers, retired military members, their wives, and other professionals, such as social workers, who have had contact with the military, they state:

Army combat units especially take pride in their ability to produce “rough, tough, mean sons of bitches”, who drink, fight, screw, break things, and otherwise show themselves to be the kinds of “real men” who can wage wars. (p. 44)

Thus, from the time of enlistment soldiers are groomed to be psychologically impenetrable and physically dominant in comparison to their civilian counterparts. Male soldiers who do not conform to the expectations of hegemonic masculinity may experience stigmatization. While this stigma is perpetrated by peers in the military
through labelling and marginalization, a side effect that may be even more harmful is the subsequent self-stigmatization that the veteran with PTSD experiences or takes on under the pressure of alienation, discrimination, or othering.

**Stigma.**

The links between masculinity, militarism, and stigma can be traced back to Waller (1944), who, in line with Freud, suggested that veterans’ breakdowns are due to a “pre-existing weakness in the personality” (p. 166). He claimed that psychological traumas “would not have harmed the ordinary man” (p. 166), but would traumatize a man with a pre-existing weakness. A few decades later, Hartman (1978) argued that it was possible for the military to normalize and re-masculinize such veterans. As a result, both Waller and Hartman’s claims created a foundation for “othering” and stigma to occur.

Wilson and Freer (2010) report that mental resilience is still seen as a military strength, and soldiers who display or admit to failure may fear stigmatization. Consequently, soldiers who see themselves as weak or ill-equipped to be valid members of the Forces often do not come forward with their PTSD symptoms. Nash et al. (2009) concur, stating that “mental health stigma causes individuals suffering from mental disorders to lose respect for themselves, whether or not they receive treatment” (p. 789). Lamberg (2004) notes that some soldiers will not report their symptoms in fear of stigmatization; they exist alone and isolated in their suffering within a tight-knit core of hyper-masculine comrades. In examining an internal Canadian Forces document, Harrison and Laliberté (1994) emphasize that: “these members [suffering with PTSD] are often harassed and branded as “wimps” (p. 93). Nagel (2005) agrees with Harrison
and Laliberté’s assessment and asked soldiers: What is the worst name you could be called? The majority of those interviewed responded, “wimp” or “coward” or “pussy”; only cowards shirk the call of duty; real men are not cowards” (p. 402). A male soldier longing to conform to his own and his comrades’ gendered expectations may shy away from revealing that he suffers from PTSD. By admitting that he “was not man enough” to cope with the side effects of the disorder on his own and that he is taking medications to manage symptoms, the soldier may feel that he is a disgrace to his unit.

In the military, mental injury is stigmatized as “real men” are deemed not to be psychologically weak, particularly hyper-masculine military men (Higate, 2003; Whitworth, 2006). In a New York Times article entitled, “Purple Heart is Ruled Out for Traumatic Stress” (Alvarez & Eckholm, 2009), Pentagon spokeswoman, Eileen Lainez is quoted as saying, “historically, the Purple Heart has never been awarded for mental disorders or psychological conditions resulting from witnessing or experiencing traumatic combat events” (p. A-1). Later in the same article, a veteran responded by saying:

For some soldiers suffering from the disorder, the historical distinction between blood and no blood, in an injury fails to recognize the depth of mental scars. A modern war – one fought without safe havens and the benefit of improved armour – calls for a new definition of injuries. (p. A-1)

To identify those at risk, the Canadian Forces and Veterans Affairs Canada have developed screening tools, i.e., questionnaires and surveys, for those who are already experiencing emotional traumas, such as PTSD:
All soldiers who have been away for more than 60 days have to complete a detailed [mental health] questionnaire... [but] some are falling through the cracks. Out of about 4,800 people who had returned from Afghanistan and were required to have the screening, 2,900 were still due for it and only 1,257 had completed the questionnaire. (www.ctv.ca, July 23, 2007, np)

Questions arise as to whether or not the soldiers completing the questionnaires were too busy with their next military assignment to complete the questionnaires or too fearful of the repercussions to answer the questionnaires truthfully. Soldiers in such dire need may be reluctant to seek help or to reveal their real health status, due to the stigma attached to the military’s cultural biases about masculinity and weakness.

Why would anyone in the military, conditioned to conform, disclose that they have a mental illness? Because military members must continually brace themselves for the ultimate — the sacrifice of their lives — the combat readiness imperative requires that they be “tough” (Harrison & Laliberté, 1994, p. 20). Nash, Silva and Litz (2009) agree that individuals with mental illness can lose respect for themselves, which worsens social isolation and depressive symptoms as the individuals develop a sense of shame from the stigma associated with mental illness. The cycle of shame and stigma results in non-compliance and eventually these veterans drop out of treatment (if indeed they had decided to enter treatment in the first place).

In this chapter, I examined the themes and subthemes that have arisen in the American and Canadian literature search, including militarism and the unique experience of combat-induced PTSD. I have also discussed anti-depressant and anti-anxiety medication side effects and evidence of their implications on the quality of life
of a specific cohort of men – veterans of the Canadian Forces. The literature demonstrates how masculinity and stigmatization play significant roles in the social, cultural, and personal implications of, and the deep-rooted perceptions of PTSD, PTSD medication side effects, and veterans’ quality of life.

In Chapter 3, I describe the narrative qualitative research methodology used in this study. I identify and discuss the key features of narrative inquiry, the theoretical underpinnings of narrative, and the methods and tools used by a narrative researcher. I examine the suitability of narrative as a methodology in this inquiry into veterans’ quality of life while experiencing PTSD and PTSD medication side effects. Chapter 3 also explores how the different features and methods of narrative have guided me in examining how my own life and career experiences have informed this thesis.
Chapter 3: Strategy

Conceptualizing Narrative Inquiry

In this chapter I outline the qualitative narrative research method used in this study. Connelly and Clandinin’s (1988) conceptualization of narrative inquiry, which arises from a Deweyian notion that “thinking is inquiry, inquiry is life, and life is education” (p. 10), guides my research into the impact PTSD medication side effects have on the quality of life of two Canadian male veterans diagnosed with PTSD and treated with medications. Through a narrative research approach, participants share stories of their experiences living with PTSD and medication side effects. One participant in this study is on extended medical leave and the other is a retired veteran from the Canadian Forces. The veterans have served an average of fifteen years with peacekeeping and combat missions in Africa, Afghanistan, and Bosnia. Connelly and Clandinin (1990) describe narrative inquiry as an adaptable and applicable research approach for a variety of disciplines in the social and biological sciences. This includes disciplines relevant to this study such as nursing, masculinity studies, sociology, military studies, and psychiatry. The veterans were invited to tell their personal stories in a context outside of their general military and medical environments. In a narrative methodology veterans’ lived experiences can be examined more deeply by drawing on their stories of life before and following a PTSD diagnosis.

This chapter identifies key features of narrative inquiry – story, temporality, continuity, reflexivity (participant-researcher relationship), verisimilitude (truth), and plausibility. These key features enable the participant and narrative researcher to reflect on their stories of lived experience as told and retold, and how these stories evolve over
time. Narrative reflections help the storyteller and researcher make sense of particular experiences in relation to the life lived; storying such reflections can provide new and deeper insights into life as a whole and the challenges their life experiences have brought. A reflexive participant-researcher relationship fosters a mutual understanding of life stories by encouraging a dialectic relationship, which involves mutually examining stories and their meanings to bring them from the “either-or” to a “both-and” perspective. In addition, the narrative research tools of voice, audience, and signature are examined in terms of their significance to participants and the telling to the researcher. Voice changes in narrative structures in relation to a participant’s emotions and reflections at the time and in relation to the listener’s narrative, relationship, and responses to the stories heard. The implications of this process will be explored in terms of the veterans’ and the researcher’s experiences. Metaphors and dreams are tools that are helpful in understanding the implicit meanings of PTSD experiences and the side effects of PTSD medications. Dreams and metaphors may be a subconscious way of telling stories that the study participants cannot yet put into words. Journaling in narrative research gives both participants and researchers a time and a place to reflect on insights, memories, and meanings following the interview process. A journal may make stories visible and provide a safe place for both to be alone with their thoughts, ideas, and reflections. I had invited the veterans who took part in this study to keep and share journal notes, but none were submitted. However, the participants did report having reflected on the interviews and the themes that surfaced. At the end of the chapter I also discuss ethical considerations of protecting the veterans’ identities and ensuring confidentiality of the data.
Story, Temporality, Reflexivity, Verisimilitude, and Plausibility

Story and narrative.

As introduced earlier, Polkinghorne (1988) differentiates between story and narrative. He describes the story as what is told by the participant, whereas narrative is the researcher’s recounting of the story that has been told. Narrative inquiry follows with an analysis of the stories and the overall context of the individual experience. Clandinin and Connelly (2000) describe story as a communication tool, and inquiry into the story as the narrative process. This narrative process, according to Charmaz (1983), provides evidence and insight into the everyday lived experiences of the storytellers. In this case the storytellers are the participants and the researcher. In terms of this research project, “story” refers to the method of data collection or the communication tool (Clandinin & Connelly, 2000).

Data collection in this study involved participant experiences collected from individual interviews; each participant was interviewed once face-to-face, followed by a brief telephone interview/follow up and the invitation to participate in a second face-to-face interview. The interviews involved the use of open-ended questions inviting the participants to speak about their experiences with PTSD diagnosis and medication side effects. Once the first interview had been transcribed each participant was given a copy of the transcript and invited to reflect and/or journal on the accuracy of the transcript and to add any additional information they would like to have included. Following this, I invited each participant to meet with me to discuss their reflections, to bring forth other stories that might have been triggered by the interview or the reflection on the interview, and to talk about the interview experience itself. Offering the option of a second
interview, provided participants with a second opportunity to clarify earlier statements, share underlying stories, and deal with some of the emotions that might have been triggered in the first interview. Unfortunately, neither veteran met for a second face-to-face interview. However, one veteran did state at the end of his interview that: “It’s therapeutic to talk about it.” Shay (1994), an American psychiatrist, used narratives of experience to help veterans work through their Vietnam War traumas. He also taught other health care personnel by using a variety of veterans’ narratives to illustrate how to draw on veterans’ PTSD stories in order “to understand what it is that generates Post-Traumatic Stress Disorder” (p. 1). Blucher (2003), in reviewing Shay’s book, Achilles in Vietnam and Odysseus in America, writes:

Narrative is a key concept in Shay’s therapeutic work and in his writings. Part of the healing process has involved helping the vets to construct a personal narrative of their experiences and to grieve for their fallen comrades and for their own lost youth. (p. 160)

Story.

In keeping with Dewey’s (1934) conceptualization of inquiry, life, and experience, the veterans were invited to reflect on their lives before and after their PTSD diagnosis in order to provide a sense of narrative continuity (meaning of stories through the past, present, and future). Recounting stories offered each veteran an opportunity to make sense of his previous experiences of war, the PTSD event, the challenges of living with PTSD, and the current situation of facing each day with the help of medications. Telling stories of trauma experiences can be difficult and risky. As a nurse who had worked in critical care situations, I was prepared to support the veterans through this
painful process and to refer them to appropriate resource persons should something untoward happen. As a military wife, I also was aware of the local resources within the military that would provide support if needed. While this self-reflective process or re-entering the trauma can be difficult, recounting traumatic experiences can also be useful and even helpful. Entering into the experiences once more, to see these experiences differently, to reflect on their meanings and to develop insights in terms of the continuity within their overall life story, created an opportunity to make sense of who they are now as persons living and coping with PTSD and PTSD medications. Drawing on Dewey’s (1934) work, Hedy Bach, in *The Handbook of Narrative Inquiry: The Mapping of a Methodology* (2007) states:

> Human beings are not ‘subjects’ or ‘isolated individuals’ who have to build bridges to go over to the other human beings or to things of nature; human beings are originally and continually tied to their environment, organically related to it, changing it as it changes them. (p. 284)

> Our life stories are constructed and reconstructed over time depending on the experiences in between and the meaning made from these experiences. Each person’s life story differs from another’s. For example, each veteran in this study has responded differently to combat induced trauma and to the medications prescribed for PTSD symptoms. The veterans’ responses to interactions may be related to individual life experiences and military experiences.

Connelly and Clandinin (2000) state that the role of narrative is to “avoid strategies, tactics, rules, and techniques that flow out of other theoretical orientations” because “experience is our concern” (p. 188). The focus of narrative research is to gain
knowledge of the complexities of human lived experience and its meaning (Clandinin & Connelly, 2000; Pinniger & Daynes, 2007). Humans have told stories throughout history – metaphorically and verbally – through a variety of means in attempts to convey the meaning of events in their lives to another person and to seek understanding about the mysteries they encounter. Narrative researchers “hold in common...the study of stories or narratives or descriptions of a series of events. These researchers usually embrace the assumption that story is one if not the fundamental unit that accounts for human experience” (Clandinin, 2007, p. 4).

Recognizing recurring themes within their storytelling can help interviewees find ways to initiate a healing process from the inside where the core story dwells. Studies by Connolly, Baker & Mazza, (2004) and Sakalys (2003) have examined illness and traumatic events with respect to how the interviewees’ storying of events provides them with a sense of meaning and healing. Pennebaker (2000) also explains how stories can foster healing from traumatic experiences:

In an ideal world, upsetting experiences are transformed into stories that are shared with others. This process helps us to understand the events and, at the same time, alerts our friends to our emotional and psychological state. Such storytelling ultimately helps us maintain a stable social and emotional life. In our less-than-ideal existence, however, we often keep important personal experiences to ourselves. (p. 15)

Pennebaker explains that we keep stories of personal experiences in a more protected space within ourselves. We search to:
[Translate] personally upsetting experiences into language in a story format, even when the story is written rather than spoken, may accomplish for us what oral storytelling must have accomplished for our ancestors — improvements in physical and mental health as well as the development of closer social bonds. (p. 15)

A narrative inquiry methodology offers veterans an opportunity to recount stories of how life was before PTSD, during and following the trauma and after treatment with medications. Veterans can gain insight into their lives as a whole. As these difficult stories begin to make sense, a healing process begins (Coulehan, 1991). Thus, as Clandinin and Connolly (2000) explain, narrative can have a therapeutic effect.

**Narrative unity.**

No matter our geographical location, culture, upbringing, and self-perception can all influence the creation, interpretation, and understanding of our life stories, and the evolution of our narrative unity. Narrative unity can be described as an embodied story that weaves through the sense of self and different dimensions of self. It is how we see ourselves in the world around us. Narrative unity will affect our choices and the way we live within the choices we make, and it shapes our personal philosophy. All of these affect our identity and our sense of wholeness in the world (Clandinin & Connolly, 1986; Freeman, 2007).

Connelly and Clandinin (1986) discuss the term “personal philosophy” (p. 306), along with narrative unity, as a lens of continuity through which we imagine ourselves in a new situation or experience: “[P]ersonal philosophy contains the notion of beliefs and values but goes beneath their surface manifestations to their experiential narrative
origins” (p. 306). Connelly and Clandinin further discuss narrative unity as going beyond an individual’s way of thinking to how this thinking informs an overall understanding woven through different experiences. To build on this idea, they also discuss how individuals base their everyday lives, decisions, and choices on past experiences and the meaning drawn, implicitly or explicitly, from them.

In narrative research, consistent with the reflexive participant-researcher relationship, the narrative unities or personal philosophies, recurring in the experiences of both the participants and researchers, are considered. What is observed and reflected upon arises from recurring meanings made from these experiences or the narrative unities. They inform a person’s interpretations and reactions, and could influence the process and meanings made from constructing and reconstructing the stories shared. Meanings of stories are embodied and encoded based on how we have made sense of past experiences as well as how our beliefs shape an imagined future (Connelly & Clandinin, 1986).

Veterans’ past experiences, prior to enlistment and military life, are fundamental in shaping their personal values, beliefs and reactions to life experiences. However, military culture also has a significant impact on a soldier’s identity as well as on how he finds meaning in these experiences. Over time, childhood values and memories may be altered by the military way of being, but when PTSD assaults a veteran’s identity he may revert to a previous way of knowing, or struggle to cope by developing and constructing a new story or identity. The intertwining of time and experience can create either confusion or comprehension, depending on the encoding of previous experiences.
Temporality.

Two key narrative inquiry qualities as described by Connelly and Clandinin (1994) are voice and temporality. While voice will be discussed in coming pages, temporality is inherent in the telling and retelling of stories and shows a kind of back and forthness as memories are triggered and reflections on these memories bring forward different meanings. As American novelist Ursula K. LeGuin (1989) states, “Narrative is a language used to connect events in time” (p. 38), and the narrative feature of temporality plays a significant role in story creation and understanding. As we reflect on stories and experiences, insights surface and new meanings are made in an effort to foster and ensure continuity of the self. New experiences build upon meanings constructed from past experiences while past experiences inform meanings made from recent ones (back and forthness). In her writings on the topic of past stories, Rashotte (2005), a nurse researcher at the University of Alberta noted, “A story makes a journey. It locates itself in the past in order to allow itself to move forward into the present” (p. 36). LeGuin (1989) also considered how stories endure throughout this ongoing temporal process, when asserting, “only by locating itself in the past is the story free to move toward the future, the present” (p. 38). Reflection occurs throughout and meanings change to incorporate changes in perspective.

Temporality influences the researcher-participant relationship and how one person responds to the other’s experience. In narrative, trust and respect in a researcher-participant relationship develops over time, depending on the quality of their collaboration. The journey unfolds over time as participants and researchers construct a relationship in which participants share their personal stories. As the researcher-
participant relationship grows, personal memories of experiences stir reflections that
both inform the discussion and the interpretations. The trust fostered in a quality
relationship may empower the participant to share deeper, more personal stories of
experiences and discover new meanings as encounters develop with respect and
meaning. According to Hogan (1988, 1995), this is described as a reflexive relationship:

Empowering relationships [that] develop over time and … [it] take[s] time for
participants to recognize the value that the relationship holds. Empowering
relationships involve feelings of ‘connectedness’ that are developed in
situations of equality, caring and mutual purpose and intention. (1995, p. 12)

The connectedness between the researcher and participant creates a foundation for many
ways of knowing: the discovery of insights, the creation of new meaning, a sense of
healing, and a release from the strain of embedded painful memories. As the stories
buried deep within are freed and shared with another who acknowledges and respects
those stories of lived experience, memories can be re-storied and reconstructed into a
new narrative unity. This sharing of stories allows for both the participant and researcher
to reflect, alone and together, on the meanings assigned to the lived experiences and to
examine emotional (conscious and subconscious) responses that may have been
triggered by the telling and retelling of difficult stories that did not feel “whole”.

Reflection and reflexivity.

In narrative research, there is a key difference between reflection and reflexivity.
While both are fundamental to a narrative research project, their distinction is important.
For Cunliffe and Easterby-Smith (2004), “Reflection encompasses learning by reflecting
on experience … [and is] generally characterized as a cognitive activity” (p. 31).
Reflection involves giving order to situations, and is, therefore, a means of clarifying the information available to us at that time. For Dewey (1934), reflective experience is giving a situation a tentative interpretation or hypothesis, whereas for Swan and Bailey (2004) reflection is “variously defined as a competence, a process of problem solving and a means of personal and social emancipation” (p. 105). In narrative inquiry, participants and researchers keep reflective journals to record stories and insights following interviews or for other relevant memories. This reconstruction process can unfold in a journey toward wholeness with insights that help the author make sense of fragmented, difficult or traumatic experiences. For persons with PTSD, memories may remain fragmented hindering the development of insights into the past, while reflective interventions can move them forward in a dialectical manner revealing deeper and more integrated meanings.

Throughout the narrative inquiry process, researchers look for clarification or for elaboration of the participants’ assigned meanings. As described by nurse researcher Sandelowski (1993), narrative researchers interpret the evolution of data collected through interviews and observations to inform interpretations, create new knowledge, and inform future practice. Reflecting on comments spoken, gestures of relevance, and intonations in voice during and following interactions with participants can guide the researcher with her examination of the key concerns and problematic issues emerging from the participants’ stories and their interpretations rather than relying on her own beliefs and feelings. By keeping field notes and journal reflections the researcher can track her own responses and insights into the participants’ stories to help her raise questions and prompt participant reflections along with underlying and unformed stories.
In this study, as mentioned above, participants were encouraged to journal about their PTSD and its influence on their quality of life and to keep notes on their feelings regarding the interviews. However, no journals were forthcoming, which may have been due to the fact that these participants were males and/or military veterans trained in physical action rather than reflective engagement. However, my own journal reflections helped me to inquire into some of the concerns I felt following the veterans’ interviews, but also to understand subtle ways in which their stories touched my own or triggered personal memories. These journal notes cued me to relevant emotional responses such as sadness when recalling my own memories of personal experiences with anxiety and post-partum depression and frustration with the challenges and stigma that veterans with mental illness continue to face alone. My personal story had to be told before I could continue with the research process so that meanings assigned to the veterans’ stories were legitimately theirs and not influenced by my experiences. Russell and Gregory (2003) claim that a researcher’s continuous reflections during the research project, foster transparency related to the evidence gathered and interpreted. In being more aware of the participants’ troubling statements and my emotional responses to these, I learned to be more open to and more understanding of the participants’ perspectives. In Clandinin’s *Handbook of Narrative Inquiry* (2007), Ruthellen Josselson (2007) also addressed this issue in relation to narrative research and stated that, “narrative research consists of obtaining and then reflecting on people’s lived experience and, unlike objectifying and aggregating forms of research, is inherently a relational endeavor” (p. 537).

The relational nature of narrative research also necessitates an examination of the concept of reflexivity. Josselson (2007) defines reflexivity as the researcher’s knowledge
of self (biases, fantasies, and understandings), entering the research process, and their potential effect on the research project. At times I found myself drawn to my own experiences and risked missing the meanings of the veterans’ stories and assigned meaning. This awareness allowed me to re-focus on the research question and research process and to better understand my autobiographical journey. This reflexive process enabled me to engage in the veterans’ stories as told from their perspectives, and to gain insight in the themes that presented in their lived experiences of combat induced PTSD.

Self-reflection is necessary to differentiate between the researcher’s personal reactions and the participant’s reactions to their story and experiences, and how, in my research study, PTSD medication side effects have affected their quality of life.

Reflexivity in the narrative research process can be a complex endeavour, in that, it encourages the participants and the researcher to search inside themselves, and consider how personal experiences and intentions influence the story telling or the research. Sandelowski and Barroso (2002) explain that:

Reflexivity is a hallmark of excellent qualitative research and it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share. (p. 222)

For Connelly and Clandinin (1990) relationship builds when the researcher and participant come to understand their own stories and each other’s. The narrative research
process involves having the participant and the researcher reflecting individually on the interviews and transcripts and then coming together to reflect collectively on the whole process:

Narrative inquiry is [...] a process of collaboration involving mutual storytelling and restory-ing as the research proceeds. In the process of beginning to live the shared story of narrative inquiry, the researcher needs to be aware of constructing a relationship in which both voices are heard. (p. 5)

In the process of beginning to live the shared story of narrative inquiry, the researcher needs to be aware of constructing a relationship in which the researcher and participants reflect separately and then together, and in sharing their insights both participants and researcher came to a common place in understanding PTSD and the meaning of QOL.

Reflexivity can foster personal and mutual growth that results in common understandings of both stories — shifting from an “either-or” to a “both-and” (dialectic) stance. Gaining insight from the other may foster narrative unity and a stronger sense of self for both the participant and the researcher. Discovery of new meanings from experiences may also allow for some improvement in the quality of life of the participant as difficult stories that had once remained buried in the participant’s memory emerge in consciousness and language.

In her narrative research on eating disorders, Martin-MacDonald (1999), discusses reflexivity in relation to congruency, coherence, and completeness. Congruency ensures the intended interpretation of the story is conveyed, by describing the meaning of the story in the participant’s terms – how she intends it to be heard. Completeness is achieved when the participant acknowledges that the final narrative
clearly reflects the participant’s experience (Martin-MacDonald, 1999). Thus, the process of creating a text with congruency, coherence, and completeness is dependent on a reflexive relationship between the researcher and participant in which reflections are shared and meanings are understood. During the research process, the retelling of similar events, themes and emotions creates a sense of coherence in the stories (Bruner, 1987; Martin-MacDonald, 1999).

During the interviews, both participant and researcher reflect on relevant memories and come to terms with meanings by reflecting on the impact each has had on their lives. For Clandinin and Connelly (1990):

Merely listening, recording, and fostering participant story telling was both impossible and unsatisfying. We learned that we, too, needed to tell our stories. Scribes we were not; story tellers and story livers we were. And in our storytelling, the stories of our participants merged with our own to create new stories, ones that we have labelled collaborative stories. The thing finally written on paper (or perhaps on film, tape, or canvas), the research paper or book, is a collaborative document; a mutually constructed story created out of the lives of both the researcher and participant. (p. 12)

Temporality (time) and reflexivity (insight and meaning) are interrelated — one is based on the other. The same storyteller may tell a specific story differently at different times in different social contexts. Stories evolve over time as individuals change and interact with their worlds. The storyteller gains insight through reflecting on meanings emerging from situations. In narrative, temporality speaks to the movement of stories through time and informs us of the continuity of the stories’ themes over time. As
a story is revisited, new details may be added, changed, or deleted depending on the current context of discussion, the audience, the meanings, as well as the storyteller’s sense of self in that moment. At times a story can be used as a lesson to be followed, a fond memory, a turning point, or a dilemma left unresolved. Participants’ stories, in research narratives, change as memories from the past are reframed for the present and for an anticipated future (Cunliffe, Luhman, & Boje, 2004). Though stories may change over time and contexts, core themes remain consistent in the telling and re-telling of the lived experiences.

Temporality is not measured by time on a clock but rather by how stories emerge over time and travel through time. Stories do not occur and are not told necessarily in a linear fashion but in a back and forth movement, entwined in time (Clandinin & Connolly, 2000). The telling of stories through time allows for participants’ and researchers’ stories of past, present and future to enter into the reflexive relationship, which results in a legitimization of their individual and collective stories.

**Verisimilitude and plausibility.**

Verisimilitude describes the lived experiences that give a sense of truthfulness, plausibility, or realness to stories. When readers relate to stories as believable, they perceive them as more plausible and meaningful. When narratives appear plausible to a reader, in terms of their own experiences, a sense of authenticity is established (Atkinson, 1990). Narrative plausibility is likened to “rigour” in quantitative research, or to research stories that “ring true” for qualitative researchers (Bruner, 1987; Martin-MacDonald, 1999).
Todorov (1977) describes verisimilitude simply as something “able to occur in reality” (p. 82), whereas for Denzin and Lincoln (1994) it is a text’s relationship to reality. Stories that “ring true” can be more informative and useful. Martin-MacDonald (1999) describes this as inter-subjectivity, which happens when individuals make links between their own and another’s experiences. She describes subjectivity as the way people make sense of their experiences. Munhall (2007) and Peshkin (1988) argue that it is important for the narrative researcher to maintain a mutual understanding with the participants’ stories, to avoid misinterpretations, and to ensure that the participants’ stories and meanings are described accurately.

The veterans in this study did not know each other and had lived different lives prior to, during, and after PTSD, and they were interviewed separately. Yet, their stories of PTSD and the impact the PTSD medications had on their quality of life connected on many levels, such as their: civilian backgrounds, military training, combat and peacekeeping experiences, their PTSD experiences and treatments, and medications prescribed for their PTSD.

Etherington (2007) describes narrative research as an interpretive process whereby personal experience is studied by gathering and analyzing stories. With each individual’s unique lived experiences and the uniqueness of each recounting of those experiences, narrative researchers examine the meaning from the participant’s perspective and its philosophical underpinnings. Constructivism is a core component of narrative inquiry, and is based on the assumption that we are able to understand the meaning of a given phenomenon through the eyes and stories of the people who have experienced it firsthand (Cohen, 2006).
A story resonates with the audience, touching a personal story within them. For Conle (2011) resonance is how an audience “connect[s] specific items in current or past experiences to a narrative of their own or someone else’s experience. In this process, listeners or readers subconsciously create metaphorical correspondences between two sets of narrativized experiences” (abstract, p. 297). The story that is told and understood is plausible, striking a chord with the listener.

As I listened to the veterans’ stories and reflected on the issues related to their personal experiences with PTSD medication side effects, I was surprised by their concerns regarding problematic symptoms from the medications prescribed. Fatigue and sexual dysfunction (medication side effects) emerged as core themes, while guilt, family dysfunction and loss of identity emerged as sub-themes. These concerns went far beyond the diagnosis and medication side effects into a deeper story of insights into how deeply their quality of life was affected by the PTSD experience as a whole.

**Audience, voice, and signature.**

Voice changes as a story is told and retold, and changes as the relationships change. Stories may also be heard differently from listener to listener or told differently from storyteller to storyteller. Voice may also change depending on the teller’s or listener’s connection to memories of the experience. For example, a veteran’s story of PTSD medication side effects may be told differently to me as a researcher than to a peer in the military, to a spouse or a doctor, or to a child. Details of the story or of the actual traumatic events may be omitted to protect a child, whereas those same details may be shared differently with an adult, or a comrade who was there and who understands the context. However, emotions may be hidden from a military peer because
of the culture of hyper-masculinity fostered in the Forces, or declared openly to a health professional who counsels the veteran to express emotions. As the storyteller incorporates insights from such encounters, the story is expected to evolve and change with each telling as a storyteller comes to terms with his experiences, leading to further reflective examination in the current context of the veteran’s life. When stories do not change, the veteran may need more in-depth guidance or intervention.

Narrative researchers need to be aware of their own voice in writing a narrative research text. Bruner (1987) warns that while the author’s voice exists within the text, it must not dominate. If the author’s voice dominates, then the research text becomes more personal and egocentric rather than representing the participants’ experiences and the research findings.

During my inquiry process into veteran’s experiences with PTSD medications, I became keenly aware of this risk during my journal reflections. I recognized that my voice was, on occasion, overshadowing the veterans’ voices. As I reflected more closely into my own experiences, I realized that my experiences with postpartum depression were in some ways similar to the veterans’ experiences with PTSD. As a new mother living away from my family and with a husband posted overseas with the military, I was overwhelmed with the care of a new-born on my own. I suffered post-partum depression and felt alone in my struggle to gain my previous sense of confidence back. I had worked as a nurse in critical care areas and in highly stressful situations and had no difficulty delivering intensive care to several seriously ill patients. However, now I was faced with the care of only one person – my newborn son – on my own and had lost my sense of competence and confidence in the process. The emotions that I had felt during
this painful time were sometimes paralysing and I was prescribed anti-depressant medications. Now, years later, as I read and reflected on the veterans’ experiences, emotions and tensions related to PTSD and PTSD medication side effects, those post-partum emotions were entering into my research writing. At these times, I was not the researcher, but the new mother, alone and exhausted, feeling sad and ill and having side effects to the medications that I had been prescribed. I was awakened to the risks a narrative researcher experiences, and I was glad that I had the opportunity to study my own responses in a journal and to become aware throughout the study of times when these personal stories were at risk of influencing the study’s integrity. I became acutely aware of the role my own voice played in the study and worked to be vigilant with questions raised by my own thesis committee relating to my voice in the writing. I worked hard to get in touch with my own story and to gain insight into its connections to the participants’ stories as the writing process unfolded. Researchers are human beings with difficult life experiences as well, and it is impossible to separate the researcher’s story from the participants without great care for both so that the differences emerge along the way and the researcher is attentive to their influence on the study.

A narrative researcher’s signature is an individual representation of her personhood that is implicitly embodied in the writing, in the expressions used and the choices made within the text. When the researcher becomes explicitly aware of her voice coming through the writing, she can mediate its influence so that the voices of the participants and their particular meanings become the focus. In this way, the author’s signature is in the written research document and the participants’ signatures are in their individual interview accounts.
With changing voice and audience in storytelling, continuity exists in the researcher’s signature, but the researcher needs to also be aware of the participants’ voices so that the study itself strengthens their voices throughout. Indicators of signature in the text include such things as the way a point is argued, the choice of words used, and the style of writing. Each can point to the author’s voice and intention. For example, if we were to read one of Shakespeare’s plays, without having been told who the playwright is, we would likely recognize the style of writing to be Shakespeare’s through the use of language, description, context, dialogue and characters. In Denzin and Lincoln’s (1994) *Handbook of Qualitative Research*, Clandinin and Connelly (1994) claim that a researcher’s signature, as the author of a text, is their “stamp” on the work – it is different from other authors.

Clandinin and Connelly (2000) go on to explain that signature is important in research texts where participants are speaking. The signature of the text certainly belongs to the author, but the signature of the participants is equally important. For example, a text needs to reflect the persons involved and how they would like to be perceived through the reading of their stories; participants also need to see themselves represented with respect and care. Personal stories, and especially ones dealing with trauma, need to be cared for with compassion, respect and dignity so that participants’ stories are honoured and not judged. The researcher’s signature is present and can be used as an accompaniment or comparison to those of the interviewees. “Too vivid a signature runs the risk of obscuring the field and its participants; too subtle a signature runs the risk of the deception that the research text speaks from the point of view of the participant” (Clandinin & Connelly, 2000, p. 148). Hence, there should be a balance
between the story, the interpretation, and subsequent reporting of findings (e.g., themes) to validate the narrative research process.

In creating a research text the researcher attempts to capture relevant meaning from the lived experiences of the participants. As stories move through time and are shared, a participant-researcher relationship develops, leading the storytellers to risk sharing deeper and more personal and intimate stories. Josselson, in Clandinin’s *Handbook of Narrative Inquiry* (2007), states that:

People will often take the opportunity to articulate the most sensitive areas of their lives, the matters about which they are doubtful or ashamed. It is not uncommon for people to tell [narrative researchers] things they have never told anyone else. (p. 546)

**Sacred story.**

As the veterans in this study recounted and reflected on their stories, and developed trust in themselves and the researcher, deeper stories and insights surfaced. These deeper accounts went beyond experiences with the medication side effects of sexual dysfunction and fatigue to ones of examining the extent to which these side effects affected their families and their sense of self. Crites (1971) describes this process as developing insight beyond an everyday social story to a deeper, more personal (or even sacred) story. The everyday story, which Crites (1971) refers to as the mundane story, is one that is socially acceptable and does not evoke a reaction from the listener or reader. We may often hear the mundane story, a cover story that is presented and acceptable to peers and to the world, a story that changes based on time and context. Crites explains that while the mundane story and the sacred story are distinct, “mundane
stories are implicit in [the] sacred story, and every mundane story takes soundings in the sacred story” (p. 296). A deeper or sacred story is one that is private, protected, personal, and rarely told unless to a person who is trusted.

There is no set agenda for researchers to probe for participants’ sacred stories. Such deeply held personal accounts may emerge naturally as trust develops between the participant and researcher, and between the participant and their trust in themselves. Research is enriched when a participant trusts themselves and the researcher to the point of sharing secret and even sacred experiences. In Crites (1971) terms, such stories live deeply and silently within the heart and soul of the person, awaiting expression: “The sacred story is altogether alive, transforming itself in the depths” (p. 297). Discovering the deep meanings of sacred stories, as they rise to the surface and are told, can render an unexpected appreciation of the depth and breadth the impact of PTSD has had on the veteran’s quality of life and identity. Along with Crites’ writing on sharing sacred stories is the profound work of philosopher, Martin Buber (1958), who examines the concepts and construct of the I and Thou. In Buber’s I and Thou, individuals can meet each other or the self as a Thou or as something sacred.

Buber describes an individual’s relationship with the world as an I-It or an I-Thou. The I-It relationship indicates an objective impersonal relationship between an individual and the other – a person, self, or life. For example, in a relationship between a soldier and the enemy – the enemy is an other – an it, disconnected from the soldier in an attempt to ease emotional and moral responses to killing or destroying the enemy. It is a relationship that is limited but implies distance from something experienced. “An It for [an] I [is] an object of perception and experience without real connexion” (Buber,
1958, p. 41). This relationship may be interpreted as one where there is primal knowledge of the other, or as one of having chosen to keep the other – the ‘object’ – at a distance. The *It* may not yet be truly understood or the person may have chosen, consciously or subconsciously, to keep the relationship distant and objectified as an *I-It*. Considering the sacred story of veterans and the impact that PTSD and medication side effects have had on their identity the veterans may feel a loss of self from the traumas they have witnessed or taken part in and objectify themselves as *I-Its*. A process of self-stigmatization may occur as a result an alienation from their sacred self and their collegial bonds with their military peers. Veterans may view themselves as less than or unable to meet life’s demands for work and for family. Their loss of self as a *Thou* leaves in its wake a saddened sense of alienation within themselves – an *It* separate from the *I* they once knew, trusted and relied upon to navigate through life.

Buber’s *I-Thou*, however, can also be understood as the *I* maturing in wisdom and possessing a deeper wisdom and sense of meaning, leading to becoming one with the *It* and transforming the *It* to a *Thou* — a transformation that evolves as shared meaning and a sense of community with the other evolves. The *Thou* is kept safely hidden until ready to be revealed – the sacred story perhaps.

While individuals may share many traits and experiences, each person is integrally separate from the other. For philosopher Lani Roberts (1997), the person is a whole being who needs to be recognized as greater than the sum of his or her parts. Lenn (2011) agrees with Roberts (1997) that each individual is distinctive and while some
may share a similar background and everyday story, each has a unique and personal experiential story, or sacred story, as Crites (1971) names it. Buber’s (1958) I-It can be reflected in our everyday stories told to protect sensitive feelings and memories that guard a deeply personal sacred story. Crites (1971) claims that the sacred story is a creation story – one that cannot be named: “the story itself creates a world of consciousness and the self that is oriented to it” (p. 296). Similarly, Buber describes the notion of Thou as not existing in “an organized, continuous sequence, but …whose purely intensive dimension is definable only in terms of itself” (p. 41). Recognizing a personal Thou may happen as an individual reflects on and draws meaning from their personal experiences, memories, and stories. Both Buber’s Thou and Crites’ sacred stories are related to one another, to the world, and to ourselves. Both authors also examine the flux that exists in deep relationships with the self and with others. For Buber, a flux unfolds over time and with experience, between the two Is (I-It and I-Thou) as they engage one to the other. For Crites (1971) a flux is evident between mundane and sacred stories in that insight into the meaning drawn from one may allow the emergence of a richer meaning for the other. New experiences may bring light to old stories that may not have been fully understood or may have been misunderstood. Reflection on past experiences may influence interpretations of current experiences leading to changes in these life stories. Both Buber and Crites describe the “back and forthness” of the everyday self to the sacred self – a form of temporality and reflexivity.

In reflecting on Buber (1958) and Crites’ (1971) work the notion of othering emerges. Crites (1971) explains that our telling of an everyday story rather than a cherished sacred story to different audiences involves a decision regarding the other’s
relationship to ourselves, as well as the context involved along with the degree of trust and safety we feel at the time. We see others in terms of how we see ourselves. In a trusted, mutually respectful relationship, a sense of freedom to share deeply personal stories with another is more likely. A wounded veteran may find peace in hearing the narrative of another veteran’s story of trauma and may hold these stories as sacred, secret, and safe. The other veteran storyteller evolves from being an other, a stranger, as the interaction transforms into a personal, relational, valued and perhaps even hallowed encounter through the power of sharing a deeply painful experience, sometimes in silence with only the dialogue of presence.

As a hidden, possibly painful memory surfaces there may be no words to describe the depth of the emotion associated with the experience. Crites (1971) explains that some stories are “too deep in the consciousness of a people to be directly told” (p. 294). If a deeply held or traumatic sacred story has never been shared, the storyteller may rely on metaphors to share the experience with another person; disclosing an experience that they alone may understand by mere cues and military terms, an experience shared deeply due to the trauma that defies words and exists only in the raw emotions of embodied memories of the event.

Metaphors

Metaphors enrich the interpretation of stories by providing a commonplace image for quick comprehension of intended meanings. Lakoff and Johnson (1980), authors of *Metaphors We Live By*, state that, “metaphor is one of our most important tools for trying to comprehend partially what cannot be comprehended totally: our
feelings, aesthetic experiences, moral practices, and spiritual awareness” (p. 193). Levitt, Korman and Angus (2000) add:

Using metaphoric expressions opens up possibilities for richly textured communication. Metaphors convey visual and tactual imagery [which] adds a more vivid level of understanding. Due also to the different layers of sensory and informational meanings, metaphors are more likely to evoke an experiential response in the listener than the relaying of an adjective alone. At times, metaphors can more accurately capture the quality of an emotion than an adjective or an emotional label. (p. 23)

In narrative research, participants’ experiential accounts are generally full of metaphors expressing a range of emotions that are difficult to put into words. An examination of metaphors in a story can reveal an essential meaning of the experience. As Levitt et al. (2000) emphasize, metaphors within a story may not only “evoke an experiential response” (p. 23) for the listener, but also “capture the quality of an emotion” (p. 23) that the storyteller may be subconsciously experiencing. A metaphor may: cue and provide clues to deeper meaning; provide the speaker with an entry into the experience that is not explicitly but somatically remembered; give the teller a safe and unemotional means of conveying how the experience felt; and evolve as retelling happens into actual stories when the implicit language describing the experience emerges in consciousness.

**Dreams.**

Dreams are often metaphorical images representing life experiences and are significant narrative resources to draw on for deeper meaning related to participants’
stories (Maggiolini, Cagnin, Crippa, Persico, & Rizzi, 2010). A dream may be a series of metaphors or a key metaphor that points to painful experiences not ready to be named. Dreams harbour implicit meanings, feelings, responses, and emotional triggers that the person is working through but has not yet made sense of in relation to a difficult or traumatic experience. In Maggiolini et al.’s (2010) study of dreams, there is no difference between the storyteller’s perceptions of characters or social interactions in reality and in the dream state. Revonsuo (2000), a cognitive neuroscientist, psychologist, and philosopher, notes that threatening scenarios in dreams are but a simulation meant to train and/or prepare the dreamer for situations to be faced in real life or that dreams are metaphors of experiences not yet understood in language form.

Hoss (2010), author of *Dream Language* and former President of the International Association for the Study of Dreams, describes dreaming as a process of self-maintenance whereby the dreamer may discover hidden emotions and use dreaming as a process of problem solving and psychological growth, a sort of progress report. Drawing on Jung’s (1973) work on dreams, Hoss (1973) explains a dream as a “symbolic image” of rational thought and claims that “the unconscious meaning of a conscious experience is revealed in dreams” (p. 30). Veterans who hold painful memories of trauma from war and live daily and silently with the emotional impact may be prone to working through these emotions while dreaming. Examining themes and metaphors from metaphors in dreams can cue the veteran, their caregiver or a researcher to the deeper ongoing suffering and its assault on the veteran’s everyday existence, relationships, and overall quality of life.
A researcher’s reflections on a participant’s dreams can lead to a shift in questions to ones that gently probe for meanings and the participant’s insights into their message. They can be helpful in understanding the encoding process used by the veteran to deal with the trauma and its long-lasting encoded somatic pain and the PTSD process. Many other narrative tools help a narrative researcher enter into the participant’s world of implicit experience.

Methods

According to Connelly and Clandinin (1990), a narrative researcher has access to and may utilize several tools in striving to understand participants’ stories. Narrative research tools include: field notes, journal records, interviews, storytelling, letter writing, and autobiographical and biographical writing. Narrative tools used in this study on quality of life for veterans living with the side effects of medication for PTSD are outlined below, under three headings: interviewing, journaling, and autobiographical or biographical writing.

Interviewing.

In this study, the interviews with veterans living with PTSD were a means of inviting their individual stories of how medication side effects impacted their quality of life. I followed narrative researchers Connelly and Clandinin (1990), who wrote, “interviews are conducted between researcher and participant, transcripts are made, the meetings are made available for further discussion, and they become part of the ongoing narrative record” (p. 5).

An initial meeting and introductions, an open ended, face to face interview, and a follow up telephone interview were conducted with each veteran for the study. The
initial meetings were scheduled and held at a location chosen by each veteran. These meetings provided an opportunity for introductions between the researcher and the participant, as well as for information exchanges regarding the study and its purpose, and volunteer signatures of the consent forms. Each face to face, open ended interview was audiotaped, and each took place shortly after the initial meeting at a place, time, and date selected by each veteran. A second, telephone interview was conducted after the veterans had an opportunity to reflect on the first interview and review transcripts. In a narrative study, participants are invited to talk about their experiences, but the researcher may use scripted interview questions. Open-ended questions are encouraged in order to negotiate entry into the relationship and the study. This negotiation of entry is important in narrative research in that it offers an opportunity for the researcher and the participant to find a comfortable approach to the research interview. It sets a foundation for the researcher to pose broad questions that invite core stories, related stories and deeper stories from participants. The interviews in this study began with the open ended question: “How have PTSD medication side effects impacted your quality of life?” In response, the veterans began to share the stories of their personal experiences with medication side effects. The veterans’ required little cueing or prompting during their storytelling as their stories peeled away layers of emotion and experience with PTSD medication side effects and the impact they have had on their personal quality of life as well as the lives of their families. Anderson and Jack (1991) explain that the non-structured nature of an interview involves “shifting from information gathering where the focus is on the right questions, to interaction, where the focus is on the process” (p. 23). For Connelly and Clandinin (1994) these “[i]nterviews can be turned into written
field texts through transcription, note taking, and/or the selective use of interview segments” (p. 421). In this study on medication side effects for veterans living with PTSD, interviews were conducted, transcribed, and returned to the participants for changes or corrections to the text or to add new stories that were prompted by reviewing the transcript. Interview segments were selected for inclusion in chapters 4 and 5 of this thesis.

**Journaling.**

In narrative inquiry, participants and/or researchers use journals as a means of data collection (Connelly & Clandinin, 1990). Journaling provides an opportunity to acknowledge personal responses to what is heard, and to document insights into the storied experiences. While the veterans in this study were invited to journal, they did not forward journal reflections, which may be understandable considering the difficulty PTSD sufferers experience when trying to shape traumatic memories into words. However, in the interviews, significant and painful dreams and reflections emerged and gave evidence to the deeper silent suffering the veterans endured and were trying to make sense of in their everyday lives. Having been moved and challenged by some of the stories and dream images recounted by the participants, I felt a need to journal my reflections on their troubling narratives and agonizing dreams, which stirred responses to, and insights into, my own stories and dream images.

While the veterans in this study did not journal, the process of journaling after having been interviewed can be helpful to a participant in working through the emotional impact of recounting painful memories. Journals may also help the researcher gain insight into the meaning participants hold regarding their experiences through
examining recurring stories, themes or metaphorical representations in different forms. In addition, journaling guides the researcher in understanding his or her own emotional responses that participants’ stories stir within the interviewer’s life. Journals may also help the researcher work through assumptions and personal experiences that relate to the research topic or themes embedded in the participants’ stories. For example, in my journaling, I reflected on my personal experiences with the military culture and recalled my childhood moments listening to my grandfather tell painful stories of war, and later I became aware of a deeper and more personal link to the veterans’ experiences of being treated for PTSD with anti-depressants. This led me to examine my history of post-partum depression and treatment with anti-depressant medications. Journaling revealed inner tensions for me that needed to be worked through prior to proceeding with data analysis and the writing of the research text. In the initial drafts of my thesis writing, this proved to be a challenge, as I tried to focus on the veterans’ stories separately while also processing my own. At times my own story overtook my reflections and writing, leading me to keep a separate journal of my experiences with PPD and medication side-effects, and to be vigilant in the interpretation and writing process of the thesis to stay true to each veteran’s narrative intentions, accounts and interpretations. A risk in narrative research is that the researcher’s story is enmeshed with the participants’ stories, which may be mis-read through the biased personal views of the researcher. It is the researcher’s responsibility then to ensure that the integrity of the participants’ voices is maintained throughout the research process. By being continuously vigilant to keeping the participants’ voices true to their interviews and narratives, I hoped to ensure that the research analysis accurately represented the meaning of their experiences. This involved
reading and re-reading the veterans’ transcripts, examining their narrative accounts for recurring core stories and themes, and reflecting more deeply on the encoding of core meanings hidden in the veterans’ metaphors and dreams. My intent was to stretch my insights beyond my own experience in order to hear the others’ – the veterans’ stories in the ways they themselves had intended them to be heard. Unexpectedly, I learned from this process of listening and reading for the veterans’ own voices and intentions in their accounts, that I, in turn, gained more insight into my own. Thus, in learning to understand the other in this research relationship, I engaged in a process of self-discovery. My journaling allowed me to recognize the tensions I had kept silent for many years while raising my children on my own away from family and at times when my husband and their father was deployed overseas for many months. This reflective inquiry into my own experiences helped me to see that many of us may live with PTSD from other traumas – post-partum depression, a life-threatening illness, a deep loneliness from spousal caregiving for a loved one with dementia, a displacement in a refugee camp for a family displaced by war, and many more.

For some of us who are treated with medications, there can be an added, unexpected and unwelcomed dimension of living with the side effects of anti-depressants or anti-anxiety medications, but for others it may be the side effects of emotional isolation, poor nutrition, or continuous displacement from home. In this study, each veteran conveyed that he felt he had been heard, and telling his story as a whole helped him appreciate the breadth and depth of the trauma, the devastating consequences of the medication on himself and his family members, and the long-term impact on their
lives. They both informed me that this was the first time they had been able to talk about their experiences as a whole, and in relation to their entire lives.

**Biographical and autobiographical writing.**

Narrative creates a space for both the biographical and autobiographical, and the professional and personal to be examined. As part of the data collection process in narrative inquiry, the researcher examines both the participants’ biographical accounts and their autobiographical influences. In this study, the veterans spoke about their experiences before and after the trauma, along with their diagnosis and its impact on their careers and lives, as well as on their positive and negative effects from PTSD medications. Veterans living with PTSD may or may not share their experiences with other veterans due to the stigma within the military culture. Yet, they may feel a sense of unity with other veterans who cope daily with PTSD and its secret existence within the military culture. For the autobiographical researcher story related to PSTD and medication side effects, I also engaged in an examination of past experiences in my life and the stigma with post-partum depression. My journey, like that of the veterans with PTSD, has taken years of recovery step-by-step while searching for meaning, unity and wholeness in life and within the self once more. It is a long and arduous journey that is not for the faint-of-heart. Freeman (2007) describes it well in the *Handbook of Narrative Inquiry: Mapping a Methodology*, when he states that with autobiographical writing “there is a search for ‘unity’, the resultant product being an expression of the innermost dimensions of self” (p. 130). Within this study, creating meaning from my life narrative helped me understand my position and my power within the research context, and to be vigilant of the use of both with the participants and their stories.
Participants.

The participants in this study were two retired male, English speaking Canadian Forces army veterans of different ranks. The recruitment of participants – veterans – was informal, relying on the word of mouth of military families and fellow graduate students. During an initial interview both veterans described their military history and the PTSD challenges they faced with their illnesses and treatments. Each interview offered relevant details related to their PTSD experiences and provided a context for their stories. Other information included their rank, corps, leadership roles and responsibilities, and their overseas deployment experiences, as well as the time span from the onset of PTSD to the present.

The veterans openly shared their accounts of events in regard to PTSD and the medication side effects on their quality of life. Each veteran began with a description of how the trauma had occurred, his PTSD experiences and symptoms, the medications he was prescribed, and the medication side effects. Their recounting of their experiences pointed to the colossal impact that PTSD symptoms and PTSD medication side effects had on each soldier as well as on their families, careers, and quality of life.

The research process involved seeking consent to a face-to-face and a follow up telephone interview. Since both agreed to be interviewed, face-to-face interviews were scheduled, and written consents were given. The interview consisted of a series of open-ended questions followed by probing cues and questions for further or deeper responses. Once the interview transcripts were typed, each veteran was given a copy of his interview transcript and asked to review and edit it, or add to it as he saw fit. During this time each had the opportunity to correct, change, or omit any part of the text. At their
request, I sent the transcripts to the veterans via email. These emails were password protected with the password relayed to the veterans by telephone. After the second interview the veterans were reminded of the steps I, as the researcher, and the transcriber, had taken to secure the confidentiality of the content shared. In our final telephone discussions, each veteran, without request or prompting, offered to share his story for any other research projects regarding PTSD. This reflexive process of reading their own transcripts, reflecting and clarifying meanings, enabled the veterans and researcher to develop a common understanding of, and the meanings embedded in, their personal stories and experiences. Both interviewees offered their medical records and whatever else I, as a researcher, needed to bring to light the impact PTSD and treatment with medications has had on their quality of life. PTSD and the medication side effects have been devastating to many aspects of the veterans’ lives.

As this study focuses on traumatic experiences and the effects of prescribed medications, I was aware of the risks to veterans should their emotional responses become too stressful. As a nurse, I have the educational and clinical background knowledge and expertise to deal with emotional responses and support the individual involved. In addition, I am aware of the drugs prescribed, their potential side effects and their risks in terms of emotional stress. Each veteran was also made aware that he could stop the session and the recording at any time if he felt concerned, or that I would stop the session and recording if, as a nurse, I felt that signs of distress were being exhibited. I also allotted a debriefing time after each session to allow for some “off the record” discussion and time to decompress from the intensity of talking about PTSD and their treatment experiences.
The taped interviews lasted between one and two hours. Following the first interview, considering the emotional stress involved in a reflective interview regarding personal experiences with PTSD and its treatments, I took time with each participant to debrief. This allowed each veteran to have a reflective space to process the interview experience, to make sense of the traumatic experiences discussed, to raise issues of concern to them, to give me a sense of how their were doing and to intervene if needed, and particularly for them to return to their everyday lives with their families and colleagues. As a registered nurse, I was careful to assess their body language and dialogue throughout and following the interviews for any signs of emotional distress when revisiting traumatic memories, unexpected medication side effects, and the fallout of PTSD in their lives.

During the transcript review process, I noticed there were pauses indicating unfinished thoughts or a searching for the right combination of words. Each interviewee clarified that the pauses were nothing more than a moment to catch his breath, or to gather his thoughts for the next statement. The second, telephone interview with each veteran lasted from fifteen to forty minutes and took place a few weeks after the first, allowing the veterans time to receive, reflect on, and revise the first transcripts. The second interview provided an opportunity to clarify details from each veteran’s review of the transcripts and to ensure that my interpretations of the stories, metaphors, dreams, and sub-themes reflected their intent. In short, the second interviews allowed for a clearer understanding and a validation of stories and interpretations.
Ethical Considerations

In planning this research, ethical protection of human subjects was requested, reviewed, and approved by the University of New Brunswick Research Ethics Board (REB). With PTSD, traumatic memories can become “trapped” in memory and, when discussed or brought to the surface, may trigger distress. During the initial meeting with each veteran, I sought confirmation from them of their readiness and willingness to discuss these PTSD experiences with me. Also, prior to the first interview with each veteran, I discussed the potential for re-traumatization. The veterans acknowledged their awareness of this potential for harm. Each veteran confirmed that he was currently being followed by the health care professional who had prescribed his PTSD medications, and each provided me with the professional caregiver’s name.

Confidentiality is a significant issue in mental health and in research with human participants, as personal and private information may be communicated (Martindale, Chambers, & Thompson, 2009). Confidentiality and anonymity require vigilance in the reflexive researcher-participant relationship and in the management of qualitative information and the writing of the study. Wiles, Crow, Heath, and Charles (2007) explain confidentiality as not disclosing any personal identifying information (e.g., name) that is revealed in and/or outside of the interview and research process. Anonymity means ensuring an individual cannot be publicly identifiable. Researchers ensure that both confidentiality and anonymity are maintained throughout the research.

All interviews were conducted mid-morning. In our initial meetings each participant felt that the university was a neutral, “safe” place to conduct the interviews. I obtained parking passes for each participant, and we met in the parking lot nearest the
interview site. Each interview took place in an empty room in a low traffic area of the building. Doors to the room remained locked. Throughout the study, research data (i.e., transcripts, consent forms, and recordings) were secured in a locked cabinet; this information will be destroyed one year after thesis approval. All identifying information was removed prior to transcription. Final transcripts were sent from the transcriber to the researcher via email and were password protected. Transcripts were shared only with the thesis supervisors. All identifying factors (veterans’ ranks, trades, postings) were removed from the text to maintain anonymity. Pseudonyms were assigned to the veterans and have been used throughout all texts and will be used in subsequent research presentations and publications.

As discussed by Jeffreys, Leibowitz, Finley, and Arar (2010) in their qualitative study of trauma victims’ decision to disclose, there is often fear and shame associated with a veteran’s disclosure of PTSD, including fears of being locked up or labelled as “crazy,” thus jeopardizing their careers. Those veterans who do come forward, disclose feelings that PTSD symptoms, such as avoidance and anxiety decreased and they began to socialize and connect with others. Thus, the disclosure enabled them to gain a better understanding of their trauma. These authors also point out that the most traumatized participants disclosed that they would like to be asked about, and invited to share, their experiences.

Jeffreys et al. (2010) also recognized the fears experienced by those veterans who chose not to disclose, and remarked that their fears were related to others thinking less of them, and a lack of trust in the care provider. This study identifies that it is worthwhile for health professionals to consider the responses of veterans in regard to
their overall choice in disclosing traumatic personal life experience(s). This qualitative study was only one of few examining the topic of disclosure of veterans to health providers. Bolton, Glenn, Orsillo, Roemer and Litz (2003), who also studied disclosure, stated that the disclosure of a traumatic event enables the teller to verbalize feelings and memories into a narrative structure. This organized structure facilitates the process of working through emotions associated with events that were previously buried and unexplored. In the following chapters, the personal accounts of the veterans who participated in this study on PTSD in the military, medication side effects and quality of life for veterans will be examined in detail.

Chapter 4 includes brief biographies of veterans Steven and Mark (pseudonyms used to protect their identity) and includes excerpts from the transcripts of the interviews with only minor editorial changes to ensure the texts are cohesive and comprehensive. The transcripts honor the veterans’ stories, so that, as stated by Sandelowski (1994), “the images, feelings, desires, thoughts, and meanings known to the person whose life it is” (p. 26) can be heard.
Chapter 4: Call to Arms

Discovering Meaning Through Story

Introductions

Mark.

Off work and on medical leave as a result of a PTSD diagnosis, Mark, a husband and father, spent many years on a variety of PTSD medication cocktails (combinations of anti-depressant and anti-anxiety medications) accompanied by unfavourable side effects. Mark enlisted young as a non-commissioned officer (NCO) in the Forces and spent time overseas both on peacekeeping and combat missions. He spoke of peacekeeping and a combat tour where the savagery of war became devastating. In the interview, Mark reflects on the changes in himself as well as failed relationships as a result of PTSD, compounded by medication side effects.

In his interview, Mark recalled his "zombie like" state when on high doses of medications, and he also spoke of concerns with unmanaged PTSD symptoms. He spoke of his struggles with experiences of being "unable to turn off" when doses were too low. Mark’s life with PTSD, before medications, was wrought with symptoms of hyper-vigilance and various degrees of sensory overload; the disorder became inescapable. He was prescribed anti-depressant and anti-anxiety medications in an attempt to manage his PTSD symptoms.

After years of pharmacological intervention, Mark was fed up with the constant side effect of being in a zombie-like stupor and stopped taking his medications. At the time of the interview, he had not been on the medications for six months, but was continuing to attend therapy sessions.
Steven.

Steven is a retired veteran who served over two decades in the military, mostly in senior ranks. For Steven, his PTSD resulted from mental exhaustion and traumatic experiences related to multiple peacekeeping and combat deployments. Retirement became inevitable as a result of uncontrolled PTSD symptoms dominating his daily personal and professional lives. Though the diagnosis only came recently, PTSD has been an issue for Steven for nearly a decade. His words and facial expression revealed deep emotion as he recalled tours of combat and personal struggles. After only a year of therapy, Veterans Affairs informed Steven that he had the tools to cope and was released from scheduled therapy sessions. He was given an emergency contact number in case of relapse. For Steven, some wounds remain open and unexplored despite the termination of his therapy sessions.

Steven, a husband and father, has been taking medications for PTSD. His daily routine involves spending the morning getting his children ready for school and daily chores. Oftentimes, he ends up back in bed, after having succumbed to the exhaustion precipitated by his anti-depressant medication or at times from the “hung-over” feeling left by the benzodiazepines taken at bedtime the night before to help him sleep.

As evidenced in their introductions, Mark and Steven are two people with different PTSD medication regimes and different quality of life narratives. Yet, both have risked telling their deeply difficult and painful stories to help others who may also be dealing with PTSD or taking anti-depressants. Their hope was to help others find their way back to a meaningful life again, as they are trying to do. Despite the
differences in Mark’s and Steven’s personal and professional lives, common threads are evident in both that linked their stories of experience.

Mark and Steven held different ranks in the Forces and have had unique experiences both in peacekeeping and combat tours of duty. Each experienced a variety of other life events that may have contributed to their emotional trauma(s), PTSD, and quality of life responses to medications. The stories told by each participant confirmed the need for individualized care for veterans diagnosed with PTSD. Each veteran had undergone a complex myriad of events, not only in their lives but also in military training, rank and level of responsibility, their tours overseas, and the side effects manifested by the very medications prescribed to help them live with PTSD.

In the remaining pages of this chapter significant themes from both Mark’s and Steven’s stories are analyzed for narrative meaning. The veterans’ individual meanings are examined through their statements, concerns, stories, metaphors, dreams, intentions and actions. Similarities and differences that exist between the participants, their lived experience in the military, and their experiences with PTSD are also examined. Key themes that emerged from content in the transcripts related to PTSD medications included: stigma, sexual dysfunction, and fatigue. Sub-themes of guilt, problem solving, and identity were also evident and were examined. These themes and sub-themes provide glimpses into the lives of veterans experiencing the side effects of PTSD medications and the impact these have on their quality of life. In this chapter, I also discuss the metaphors each used, and the ways the veterans worked against all odds to render their lives whole again through changes such as leaving the military, stopping
medications, getting more involved in caring for their families, and searching to create new narratives to bring fragmented stories together meaningfully.

Themes

Analysis of the interview transcripts showed several common and significant themes. Core themes regarding PTSD medication side effects and quality of life included stigma, sexuality, and fatigue. In the following pages, I discuss these three themes, based on the veterans’ statements and concerns as well as the subthemes of guilt, family and identity that came through.

Stigma.

For Steven, “Even though the military says there is no stigma attached, there is a stigma attached... that's rubbish”. In the military culture, where heterosexual hegemonic masculinity is the accepted norm, individuals may not challenge the culture or seek help for mental health issues or stress due to stigma (Harrison & Laliberté, 1994; Higate, 2003). Research into military personnel and their views on PTSD showed that less stigma is associated with reporting a physical health problem than a psychological health problem (Britt, 2000; Langston, Greenberg, Fear, Iversen, French & Wessely, 2010). Steven also addressed this concern of under reporting health problems:

By the time I was willing to accept the fact that I needed help, I was probably very close to the point of no return... in my mind anyway. So, when I did go... when I did seek help and they did help immediately, they hadn’t diagnosed me yet, but they had immediately realized that I had, as they called it, operational stress injury symptoms... that’s the tag they gave me before they
officially diagnosed me about two weeks later with PTSD after seeing [the doctor].

Steven discussed at length his hesitancy to come forward with his symptoms of PTSD and the weight such a claim potentially posed on his career:

*If I had identified myself as a potential operational stress injury case while I was still serving, I would have been removed from my job... I would have been placed into a sort of cuckoo unit holding cell on base.*

In the second interview, Steven clarified that the “cuckoo unit” is a term used by base soldiers who are familiar with the psychological diagnoses of PTSD, for example, for the Joint Personnel Support Unit (JPSU) where soldiers may be placed on restricted workloads while unable to perform regular duties. Steven felt that his boss was aware of some undisclosed issues with him, but chose not to address them:

*Clearly my boss probably watched me a number of times and listened to me a number of times, as I would either be teaching or running exercises and stuff like that, and I think he was just happy to let me carry on as opposed to confronting the fact that, “listen, I think you may have issues”.*

In Steven’s interviews he expressed resentment regarding his boss not recognizing his illness or denying his illness, despite some clear signs. Steven states:

*Honestly, just working in a military environment and being surrounded by an organization that I felt would rather me just hide the fact as opposed to coming clean with it, you know, knowing that it would affect my career.*

Stigmatization as a result of coming forward would not only affect his career, but would threaten the bond with his peers. Steven felt that to prevent such a risk, his boss
overlooked Steven’s PTSD symptoms as the best choice available to keep a good soldier on the job and moving up the ranks. Camaraderie in the military is paramount (as discussed in Chapter 2) and there are some unbreakable bonds formed between soldiers who are responsible for their own safety and the safety of those soldiers who stand beside them (Harrison & Laliberté, 1994). Stigmatization from such a close-knit peer group could be devastating. Steven’s final statements from our first interview identified a devastating feeling of betrayal – he lacked the support of the military when he needed it most:

_I gave 25 years of my life to that organization and... you know... that’s all I ever wanted to be in my life when I was a kid was to join the military and either be a soldier or a pilot or something... And when I truly needed them to be there for me, they weren’t._

The above statement led me to ask Steven about his experiences with camaraderie and feeling distanced from his peer group with his PTSD diagnosis. In his second interview he elaborated and indicated that soldiers may feel obliged to march alongside the troop with an “if they can do it, I can do it too” mentality. He described a heartfelt responsibility that exists between soldiers, and he smiled as he paused and recalled this camaraderie. Steven had good insight into the negative impact of isolating a soldier from his peers when he is unwell:

_You know you are almost held in isolation in a way... from the rest of the military environment... so that you supposedly can get better. To me, that is like the complete opposite of getting better. Now, if you are going to get better, you stay with the people you work with -- the people you know and stuff like that --_
not go into a holding cell with a bunch of other cuckoos. Because everybody has different experiences so sometimes you can relate to the other people but most of the time you really don’t because every individual is different.

Although Mark did not speak so directly about stigma, he spoke about the reactions of others in regards to his tiredness as a result of medication side effects. The expectation to be ready for action or physically active and able can no longer be met. He stated, “[it] frustrates a lot of people too. They are like why are you always so tired? They don’t understand that it’s not a voluntary choice to be tired... You are lazy.” Mark also discussed stigma more so as it related to his daughter and her frustration with a father experiencing PTSD medication side effects. Mark described how his daughter pushed him away as a result of his fatigue:

It’s more frustrating to the kids because my daughter would tell me that she was just annoyed that I didn’t have the energy to do stuff. It does make you feel bad because they don’t understand it really, she doesn’t understand exactly how it works. She knows that I do have it. She doesn’t understand the principles or the medicines behind it. All I know is that she is frustrated that this has affected her life.

Both Mark and Steven were third generation Armed Forces members, and followed in their fathers’ and grandfathers’ footsteps. Gegax and Thomas (2005) argue that a son’s decision to join the military is not generally based on familial trends but on the rights of passage into manhood. Nash (2007) supports Gegax and Thomas (2005) by saying, “the psychology of war is a test of manhood and rite of initiation in many cultures” (p. 17). Hall (2008) confirms Nash’s position by stating, “throughout the
history of warfare, combat is often seen as a test of manhood” (p. 39). In the instance of when a son joins the military, as part of a family tradition, Gegax and Thomas (2005) argue, “there is no better way to win a father’s respect than to defy death just the way he did” (p. 26). The authors describe the expectations of not only peers, but family, rest on the assumption that man is a war machine and that combat soldiers are “real men”. Those veterans who can no longer meet such requirements risk stigmatization from those who fit that military mould. As third generation soldiers, both Mark and Steven may also feel the pressure of family and perhaps the perceptions that they are no longer honoring family tradition. A sense of ousting or judgment by family may lead the veterans to withdraw from family gatherings, i.e., self-stigmatizing.

For Hall (2011) the authoritarian structure of the military leads to many problematic factors that relate to stigma: isolation and alienation of members from civilians and their civilian life; class system in regard to the rank system; absence of parents; importance of the mission; and preparation for disaster. In the military culture there is an expectation that you hold the military above all else. “The great paradox of the military is that its members, the self-appointed front line guardians of our cherished... democratic values, do not live in a democracy themselves” (Wertsch, 1991, p. 15). There is an othering that is inherent in training for warfare that involves objectifying the “enemy”. Othering can be transferred, implicitly, to different groups within a soldier’s world. It can also exist between soldiers and civilians who belong to the military institution itself – between ranks, commission/non-commissioned soldiers, and soldiers who have PTSD and those who do not. As a result, soldiers with PTSD can be stigmatized by their comrades.
Whatever the soldier’s reason for joining the military, all members of the military are dominated by the culture of authoritarian structures that essentially control many aspects of their lives, inside and outside of the military (Wertsch, 1991). Beyond the military community, a soldier’s family may become a potential source of conflict, as Hall (2011) argues happens when the “military family” is perceived to take precedence over the soldier’s biological family. Exclusion, as a result of PTSD, from the military family is a reality that a diagnosed veteran fears should he disclose that he suffers from PTSD. Literature sources from Connell (2005), Higate (2003), and Kimmel (2003) suggest that there is a deep-rooted sense of respect and guardianship in the military culture. The veterans interviewed in this study acknowledged the pressure they experienced to remain part of that group, and in Mark’s case, part of his family, and the way they felt when not given due respect for their contribution to the causes. Having become accustomed to the camaraderie in the Forces and the bond between family members, the veterans discussed the reactions of what they consider to be their support groups and the feelings of stigmatization they provoke.

Sexuality.

Individuals diagnosed with emotional illnesses and who are prescribed anti-depressants are generally cautioned by physicians and pharmacists regarding the sexual side effects of decreased libido and erectile dysfunction. Mark described how medication side effects impacted his libido, also referred to as “sex drive”:

[Anti-depressants] change your whole lifestyle... it will mess up any intimacy you have with your wife or partner because you have no drive or desire to do
They always tell you that medicines will always affect your sex drive, it affects any drive actually, not just sex drive.

Both participants in this study raised concerns about their individual sexual disturbances as a result of the PTSD medications. Steven stated, “There is no masturbation... no desire... nothing....it hit me like right away and it’s been that way for two years.” To counteract the anti-depressant side effects of decreased libido, another medication, Viagra, was prescribed to Steven. Steven was troubled with his use of this drug and wanted to stop it in an attempt to regain some intimacy with his spouse:

My heart was just literally pounding out of my chest... and I was getting... feeling really hot. It certainly wasn’t making me want to... I mean ...was it having the boner effect? Sure... the mechanical part was there, but all I could think of was, Holy Christ! Let’s get this over with.

Despite the discomfort, there seemed to have been a desire to perform sexually. Reflecting on his experiences with Viagra, Steven stated: “I didn’t like it... I tried it a couple of times, and I told my wife how it was making me feel and she just said, “Stop using the drug.” Mark states, “The passion is not there. You are there doing your thing...It’s done... It’s not what it was before...” Both veterans spoke about intimacy and sexuality, and identified a desire to please their spouses sexually, but had this desire thwarted by the drugs. Both participants discussed the impact that fatigue had on their sex drive. In the first interview, Steven named his concern: “my libido has gone to pretty much zero.” For Steven, even if he had wanted to, he says “it was just so exhausting” and he doesn’t “need to be any more tired than I already am.” Mark referred to his
wife’s feelings on the matter, “It [is] like having sex with a stranger because ‘you’ are not there.”

While my conversation during one interview with Steven focused on erectile dysfunction and the use of Viagra, the issue of sexuality seemed to have been much deeper than the physical act of intercourse. For Steven the act itself seemed to have been a story in need of telling in order to move beyond the issue and experience passion and intimacy with a spouse.

While for both veterans the symptoms of fatigue weighed heavily on their lives, Mark’s comment on how medications caused problems with “any drive” is significant. The exhaustion associated with medication side effects had a debilitating impact on the lives of both veterans, indicating that its importance stretched beyond the individual to their partners and families. This indicated that medication side effects have a strong correlation with the experiences of fatigue and its influence on sex drive, among other drives.

**Fatigue.**

Both veterans described experiencing complete and utter exhaustion while on medications and this interfered with the expected level of physicality in the military. Physical endurance is paramount in preparing soldiers for duty or for war. Every day, for example, there is an expectation to take part in group physical activity (Higate, 2003), such as physical training, ruck-sack marches (where a soldier marches a designated distance in full combat gear with a weapon and loaded back pack), as well as marches and runs organized to maintain a fit corps. The crippling fatigue PTSD sufferers experience can result in a drastic change in lifestyle when a medication regime is
initiated. Steven spoke of his attempts following medication treatments to start a training regime at home as a civilian:

*I’ve tried to set goals for myself to get a routine back but I have failed miserably at it because I just feel tired, and when I feel tired like that I would just rather lie down on the couch. And I know as I’m doing it I should get my ass up and I should go for a walk or go for a run or something like that, but I don’t.*

Mark concurred, stating:

*You are a zombie.... The whole focal point was trying to keep busy and there are times when you would be so... I don’t know what the word is... I don’t know if the word is mentally exhausted, but you are so just burnt out and fatigued out from being on the medicines, and also from what’s going on inside your brain [...] you are always so tired, the medications always make you tired*

In describing their initial feelings when first taking PTSD medications, the veterans used such terms as: being “numbed out”, feeling “a euphoria” or like having “smoked a joint”, “floating”. Mark used the word “lazy” to describe his fatigue:

*I would have slept in until twelve in the afternoon and went to bed at six at night, almost like you have mono without the side effects of mono. Get up to eat, you still keep your same grooming habits but you are lazy.*

Steven spoke about having little rest: “*I hadn’t slept in almost three years. I wanted to. It was almost like my body was telling me, finally, catch up on this sleep.*” Steven also described troubling dreams due to a sleep-aid that was also prescribed:
Weird ass dreams...They were almost like, to be honest with you, they were kind of like demon, monster-type dreams. I actually remember one dream where a dog was attacking me from behind and eating into my back.

In our second interview, I asked Steven to clarify the meaning and concerns he had regarding his dreams. After reflecting on these, he stated that he felt pain from the dog attack in his lower left back, in the same spot where he had been shot on one occasion and bayoneted on another. Steven also stated: “It was almost like my body was telling me, finally, catch up on this sleep.” Steven had been living in a state of hyper-vigilance for some time and was always on the move:

*Even when I would go away on a holiday or something like that, I knew that two or three days after I got home from the holiday, it was time to start packing to go off for the next training mission or training exercise in order to get ready for the next deployment, or go on the... Yeah, and so even though it’s meant to be a relaxing time on the beach with, it never really (is).*

Steven also spoke about the challenge of falling asleep and staying asleep:

*I couldn’t switch my brain off! Okay, so eight hours, so trying to sleep for eight hours or six hours a night was exhausting. I could not physically...I wouldn’t say I woke up in the morning, I just got up in the morning just feeling, just ugh.*

Sleep disturbances for veterans are assumed to be due to flashbacks, thrashing in sleep (as a result of nightmares), and recurrent awakenings (Lavie, 2001; Nolan, 1995). The sleep disturbances that the veterans described in their stories are not usually attributed to the side effects of PTSD medications. As Steven described his dream, it gave me the feeling that it was recent and quite vivid to him even in a waking moment.
Listening to Steven’s description of his nightmares, and watching him point to his lower back while observing a quick trace of fear on his face and tension in his body, was chilling for me. Steven’s dream is discussed in more detail later in this chapter.

The lack of drive to do anything at all is also linked to fatigue. Mark outlined his experience while on medications:

*You are a zombie... You are not the same person as before your issues started... Your whole focal point was to get up, have breakfast, take your medicine, scratch your head and wonder what you are doing for the day... You are off in your own little world.*

Medications seemed to have inhibited Mark’s ability to focus or take things seriously. He identified how he responded to them:

*You are very forgetful, too relaxed to the point where you don’t take priorities seriously; I found with myself. You tend to not be able to address things the way you did before so if something does truly bother you, rather than addressing what should be addressed, it’s basically shrugged off.*

Mark spent time talking about feeling “dopey” and feeling that others perceived him as being “lazy”. Not caring is something that seemed most bothersome to him as he discussed his “*clouded state*” while on PTSD medications and how that clouded feeling led him to think and act uncharacteristically. He referred briefly to incidences of having debt and buying things to fill the void: “*Before you know it you are in debt, but you are on medication, so it’s okay*” (because you don’t care).

Mark conveyed a sense of personal ownership of his behaviour in his first interview discussion regarding taking medications and the affect these medications had
on his emotions. While at the time of the interview Mark was not taking medications, he admitted that: “I think going on medicines the last two, three years now... the last two years ... was more to keep family members... to keep my wife happy.” He later described in depth the emotional toll PTSD medications took on his life and how medications interfered with his emotions:

> You are so not caring... Things that would normally make you sad, you don’t care about, and it is important to be aware that you can’t be disrespectful with people in the way that you are just going to just revolve around your own little world.

Mark used metaphors to paint the picture of the back and forthness - feeling stuck in an unending cycle. He also used the metaphor of a bumper car: “you are like a bumper car bumping off walls... Boom, boom, boom, you back up you smash something else, who cares?” Fatigue hinders every aspect of life. No energy. No drive. No cares.

**Additional Themes**

In examining the core themes of stigma, sexuality, and fatigue, four additional themes became evident in the participants’ stories: family, guilt, discovering meaning and identity. From the discussion on spousal and parental relationships the subtheme of guilt was significant. The subtheme of discovering meaning is also introduced as a problem solving process that differs between the participants. Finally, the subtheme of identity is examined briefly since both veterans acknowledged the loss of self in their lived experience of PTSD medication side effects.
Family.

Schiraldi (2009), a researcher in stress management at the International Critical Incident Stress Foundation at the Pentagon, who also sits on the board of directors of the Depression and Related Affective Disorders Association, wrote a guidebook entitled, The Post-Traumatic Stress Disorder Sourcebook (2nd ed.). In this resource he discusses the impact that PTSD may have on the veteran’s family. The guidebook states that “when a combat vet returns home, the emotional numbing and avoidance caused by PTSD might leave the spouse wondering what she has done wrong or frustrated that she cannot help him or feel as close as they used to” (p. 309), which is also an issue that the veterans in this study discussed. The initial interviews in this narrative research study proved to be filled with emotion regarding family and not meeting their needs, which gave me an appreciation of the depth of suffering the veterans experienced from the medication side effects. Both participants spoke freely of the challenges they faced every day while on PTSD medications. Steven noted: “I knew if I stuck around I was not... I was not giving [the children] a happy home environment. ... I mean who the hell would want to be around me?” Both participants also emphasized a common metaphor that emerged after taking the PTSD medications – the metaphor of "the stranger". For Mark the experience was one of dissociation with himself, “Just because you are there doesn’t mean you are actually there”, “You are not the same person as before your issues started”, “You are a zombie.” Both veterans told similar stories regarding the impact of medication side effects on their families. Schiraldi (2009) described anger as “something we experience as we try to control our world and avoid pain. Some people [with PTSD] are troubled by their difficulty in managing anger better” (p. 120). At times the anger is
directed at family members, perhaps their children. Schiraldi (2009) states that children of PTSD sufferers “might feel fearful, resentful, and neglected by their emotionally wounded parent” (p. 209). Evidence of child resentment appears in Mark’s story as he described his daughter’s reaction to his incessant fatigue. Steven provided a poignant example of how his children reacted to having knocked over a glass of milk at the dinner table:

_They are not even looking at the cup now, to see it spill, they are turning around and they are looking at me with fear in their eyes because they are waiting for the screaming. So, I said when I went on the medication... if the milk for example got spilled, or something happened at the dinner table or whatever, you know because we eat as a family... the kids would look at me...I was almost... because I was taking the medication... you know there was almost like that little pause. It was like, yeah, it’s just milk. Yeah, don’t worry about it....I would right away realize, alright, get up, get a cloth, clean it up, don’t add to it like I would have in the past._

This quotation by Steven, about his children’s reactions to spilled milk, spoke to the fear that Schiraldi described. Steven discussed how medications improved his relationship with his family and had a calming effect on him. He also described himself as a volatile and angry person before having taken medications. Medications helped Steven to calm down and to pause before shouting and frightening the children.

Steven recalled being angry during what he felt were his children’s formative years. However, he now harbours guilt about the family’s quality of life before he was treated with PTSD medications. His discussion gave the form of a plea for support or
studies regarding family members’ experiences living with a veteran with PTSD and the impact the PTSD medications had on the lives of spouses and children. Schrialdi (2009) concurred, stating: “Parents might feel helpless and guilty for failing to protect a traumatized child; they might transmit their own excessive anxiety, rather than needed comfort and support, to the child” (p. 309).

While Mark stated that he was there, physically, he described an emotional absenteeism, which could have been considered similar to the "absent father" who is overseas on tour for six months. Contrary to Steven’s response in that the medications had improved his quick temper, Mark felt that the calming effect had been too extreme and hindered his relationship with his daughter:

It’s more frustrating to the kids because my daughter would tell me that she was just annoyed that I didn’t have the energy to do stuff, and it does make you feel bad because they don’t understand it really. She doesn’t understand exactly how it works. She knows that I do have it [PTSD]; she doesn’t understand the principles or the medicines....All I know is that she is frustrated that this has affected her life. But, she is a child, they are self-centred. They don’t understand that it’s not, to them it’s so....Just because you are there doesn’t mean you are there.

Guilt.

Guilt is addressed by the participants in response to the fatigue they both felt when on medications and the lack of energy when they had to take part in parenting and active play with their children. This guilt was also present in their acknowledgement of the children’s experiences of living with a father with PTSD and the negative impact on
their relationships with their children. McFarlane and Bookless (2001) stated that traumatic stress is often a precursor to drastic changes in interpersonal relationships. These changes may lead to a sense of guilt as the veteran is unable to be present in the relationships with family and friends. Drastic changes may include isolation, separation, divorce, end of a friendship etc.

Guilt emerges as the veterans described how their lives as fathers have been affected by PTSD, and by the medication side effects. The guilt expressed by the veterans can be understood in terms of Donaldson-Pressman and Pressman’s (1997) studies of an inverted parenting model, where a family system reveals a child being forced to adapt in order to gain attention, acceptance, and approval, since the parent is incapable of adapting in order to meet the child’s needs. Starman (2006) discusses extreme cases of “inverted parenting” (p. 329), where there is a shift of responsibility from parent to child -- where the child is forced to meet their own emotional needs and perhaps those of the parent.

Attachment theory in regard to the father-child relationship is relevant in terms of the parental guilt (Grossman, Grossmann, Fremmer-Bombik, Kindler, Scheurerer-Englisch & Zimmerman, 2002; Newland & Coyl, 2010). The veterans described guilt resulting from their children having been denied the father’s presence throughout childhood as a result of PTSD. Mark described himself as being physically there but “not really there.” Like Steven, he was too tired to take part in the interactive play that the children required of him in order to foster a healthy father-child relationship. Newland and Coyl (2010) elaborate:
Fathers’ sensitive and appropriate involvement with children would have a great degree of positive impact in their adult life as that of mothers. Conversely, one could see why fathers’ emotional unavailability, separation or loss could have a similar degree of negative impact as would the emotional unavailability, separation or loss of mothers, but in different ways and for different reasons. (p. 28)

Veterans described a sense of emotional and physical unavailability – a feeling that they were not there for their children. This was an ongoing struggle as the veterans sought to emotionally engage in their father-child relationships. As a result of fatigue, there were times when the veterans were unable to be physically present, the fatigue and the need to rest calling louder than a child’s voice for parenting. This absence in their role as fathers resulted in deep feelings of regret and of guilt.

**Discovering meaning.**

Another significant theme is how each participant approaches the process of discovering the meaning of his experiences. The ability or the methods used to discover meaning could be attributed to the age when the veteran enlisted. Since the target age for recruits in the military is between the ages of 17 and 24 years (Jung, 2008), there exists a potential for limited life experience for those who enlist at age 17 or 18. With fewer challenging life experiences, there may be less experiential knowledge for the individual to draw on in managing the demands and tensions that traumatic experiences in the field may bring. While the age of enlistment was not discussed with the veterans, both veterans referred to the different qualities they possessed in relation to discovering meaning and their PTSD.
Mark described himself as a pragmatist, who tried to manage the challenging feelings and experiences presented by PTSD and the medications in his life. For Mark, the solution to his undesirable side effects was to discontinue his medication. As he described, he did not like how the medications made him feel. Time and energy were spent educating himself as to the best way to taper off medications:

*I read a bit about it before doing it to make sure I did it properly because, apparently, it can make you very manic-depressed instantly if you don’t do it properly, from what I understand…it’s just the internet...from a medical site; it’s what I read.*

In the first interview, Mark identified the issues he dealt with involving medication side effects, how to best address them (discontinue use), and how to move forward in treating his PTSD (therapy). Mark used a matter-of-fact approach to solving the problem; he described himself as a “doer”. “*I did it!*” There is a task to be completed and it needs to be done. “*I didn’t tell the doctor I was off until he asked how it was going, and I said actually, to tell you the truth, I am off the medicines.*”

Acknowledging the ongoing emotional trauma and challenges, rather than dealing with each separately, has allowed Steven to adjust to life with PTSD. He acknowledged, “*I could see how the little things affected my entire life.*” Steven described looking to the future and to how he was going to get there. A difference in problem solving approaches are evident between Mark’s and Steven’s stories, or rather there was a difference in how each faced and worked through the obstacles associated with PTSD and PTSD medication side effects. Each veteran was at a different point in his journey and, as mentioned earlier, their coping mechanisms and/or problem solving
approaches could have also been influenced by their military careers and levels of responsibility within the Forces. Regardless, these differences are as unique to each individual as are their personal stories.

**Identity.**

Identity is a theme that surfaced during both initial research interviews with the veterans, although it manifested in different ways. Identity is a complex topic; however, there is a distinct connection between each veteran in who they believe themselves to have been before and after medication treatments for PTSD. The veterans described their sense of identity before PTSD and its pharmacological treatments in two distinct timeframes. Steven discussed his volatile behaviour and his peers’ responses to his demeanor following PTSD but prior to medication interventions:

*I think that it was probably [due to] the fact that there was a level of acceptance on their part. [They had] “Angry Steven” around because “Angry Steven” still got the job done.” “Angry Steven” was the volatile soldier who was known as the guy who got the job done. “Angry Steven” was accepted based on his ability to perform a task and was seeking eventual promotion.*

In our second interview, Steven revisited the notion of getting the job done but in a different respect by speaking of the potential for mentoring a younger soldier who mirrored symptoms of his PTSD. Steven realized that, if reported, the young soldier would likely be removed from his job and sent to the “cuckoo unit.” For Steven, an inner battle ensued as to what was best for the soldier— carry on with his assigned duties while being “monitored” by a fellow PTSD sufferer with whom he could discuss issues and concerns, or be reported to his superiors. Career implications for this young soldier...
could have been permanent. However, Mark talked about his own experience with colleagues more lightly. He stated:

*When I was on medication, a lot of people would joke and say, “Jeez it looks like you are on Ritalin”, because I am a pretty active person. Right there is a hint that something’s not right. I’m a very busy person but there is, not to confuse it, but pros to medication, it calms you down so that might be a good thing for certain people and some people but for myself the cons that went along with the being calmed down definitely didn’t benefit—the pros of being calmed down didn’t benefit the cons of what I felt I was getting throughout the whole bigger picture.*

Mark continued by using metaphors indicating the weight he felt from the PTSD experience, the medication side effects and their impact on his life, and from having weaned himself off the medications. “*It’s like someone’s lifted bricks off your shoulders.*” For Mark, therapy became something he had to make serious decisions about in order to improve his symptoms. Having phased out his dependence on medications, he has now regained a sense of clarity: “*While I was off the medication, the doctor helped me to address things.*” Later in the first interview, he stated: “*you are no longer numb to what you are being told [and] are able to understand and take things in.*” In this case medications were not the solution for Mark, and through much self-discovery, he moved forward in his journey through PTSD. Mark stated that he is now “himself” again after stopping all medication: “*I just got fed up of living in a clouded state.*”
One of the items that came into question for me while analysing the interviews was the participants’ usage of pronouns to refer to themselves. It is noticeable that both veterans used different pronouns at different times when describing the different PTSD experiences and how they saw themselves within these experiences. At times they spoke in the first person (I) but shifted to the third person (You) when speaking of negative experiences with PTSD and with the medications. This shift in pronouns may be akin to Buber’s *I-THOU* (first person) and *I-IT* (third person). There was a shift from first to third person when describing themselves during difficult moments when they identified not being in control or disconnected from their emotions and responses. For example, Steven referred to himself as “Angry Steven” or in the third person as “you”, the *It*. However, when he felt like himself again and his symptoms were managed well, he referred to himself in the first person – a person of agency in control of his life and emotions. Mark’s descriptions of this change in self and identity are similar. He refers to the effect of medication as “*it calms you down*” but when he stopped taking the medicines he felt like “himself” again. There is a familiarity and ownership in the return to self – the *I-Thou*.

**Use of Metaphors**

When conveying their concerns regarding the themes of family, sexuality, fatigue, and identity, the veterans often used metaphors. Metaphors enrich the interpretation of stories by providing the reader with a distinct image that sums up the meaning being communicated implicitly or conveys the experience more directly. “Metaphor is one of our most important tools for trying to comprehend partially what
cannot be comprehended totally: our feelings, aesthetic experiences, moral practices, and spiritual awareness” (Lakoff & Johnson, 1980, p. 193).

Mark and Steven used different metaphors throughout their stories, such as noise metaphors "boom, boom, boom", which indicate sounds of war and combat. Levitt, Korman, and Angus (2000) explain this use of metaphors in relation to meaning:

Using metaphoric expressions opens up possibilities for richly textured communication. Metaphors convey visual and tactile imagery [which] adds a more vivid level of understanding. Due also to the different layers of sensory and informational meanings, metaphors are more likely to evoke an experiential response in the listener than simply using an adjective. At times, metaphors can more accurately capture the quality of an emotion than an adjective or an emotional label. (p. 23)

From my examination of the literature and the transcripts, and by listening to the tapes of each interview repeatedly until I gained a deeper understanding of each story, a more subtle use of words and metaphors became apparent. Mark provided examples of cars and motorcycles to explain the meaning of the experience to him, while Steven used metaphors that related to war and animals.

The Western masculine/feminine depiction or gender stereotype was evident in Mark’s choice of metaphors. In his discussions, he used the term “things”, such as vehicles and houses, to illustrate his meaning. In describing how he believed he was not himself when on medications, he said:

I guess if you drove a sports bike, and you enjoyed driving a sports bike but all of a sudden someone downgraded you to a scooter, you would drive it but you
wouldn’t really enjoy it as much as you used to and you wouldn’t be as in to it, you wouldn’t be as proud of it. It would just be there.

Mark also described the feeling of being “not yourself” in terms of living in a different house:

_Having a really nice house that you are proud of, you lose your job and all of a sudden you are living in a house you would have never considered to live in before. You live in it. You go and close the door, you lock the door every night but it doesn’t mean you enjoy living there._

Mark’s examples indicate a before and after process, both in his use of metaphors and in recounting his life experiences before and after PTSD medications. He compares himself to a sports bike before and downgrading to a scooter after, and later as a nice house before the experience to a house that he was not proud of after a job loss. He makes a clear distinction between both time periods (before and after medications) and their value or meaning to his life and sense of self. For example, there is a strong sense of self before with a macho image and pride as having a sports bike versus a lesser sense of self having to settle for or be embarrassed by downgrading to a scooter. Also, a nice house provides comfort and a sense of worth, ownership and status, while a lesser house meets basic need but lacks the same comfort and sense of fulfillment. If these metaphors were to be interpreted in terms of their quality of life before and after PTSD and medications, a clear difference is evident in the veteran’s personal sense of satisfaction with themselves and their lives, with their pride and self-worth, with their identity and loss of self, and with their sense of pleasure and contentment in their lives.
Loss of choice is implied in the choices of metaphors and analogies the veteran’s made. Mark referred to living in a “house you would have never considered to live in before.” He emphasized that it was “all of a sudden” and that he needed to be protective since the risks of living in this house were much greater – “you go and close the door, you lock the door.” Since the PTSD trauma may have been experienced suddenly, and the PTSD symptoms and medication side effects in the same way – the veterans may have been left feeling like strangers in a world where they previously were integrated into their lives and work and felt a sense of belonging and self-worth. Suddenly, everything was different, unsettling, confusing and perhaps dangerous. Locking a door may represent self-protection in a world that is unfamiliar, uncharted, unmanageable, and unsafe. It is unclear what the metaphor means to the veteran using this comparison. The ritual of locking the doors is a means of caring for self in a world that brings unpredictable risks. Military personnel are highly trained to plan for combat, to map the territory being covered, to prepare for the risks. However, PTSD and its medications create an uncharted territory that military training did not prepare them to “fight” through and which their PTSD treatments did not address. Yet, they draw on their military training to “fight” this “war” within, though the PTSD war requires different training and different tools.

Both veterans refer to being "fixed" or to having their brains "rewired". They described themselves as military robots - programmed to fight and to feel no emotional response to soldiering and war making. However, a robot that is unable to function is flawed, in need of rewiring and a machine that can compromise the safety of the team.
One of the questions that arose for me when considering the metaphor of robots needing to be "fixed" was it referring to individuals now having disabilities and in need of repair.

In a graduate course on research as critical praxis, our class examined the deficit model of not fitting into societal norms, a model generally determined by powerful groups in society. In relating this academic discussion on deficit models to the military culture, similar power dynamics emerged. For example, soldiers who have not experienced PTSD and its medication regimen could be defined as a dominant “able” group, relegating those with PTSD to the “disabled” group in need of “fixing”. Divisive and exclusive labelling processes can lead to stigmatization and marginalization of persons with PTSD, and can further result in self-stigmatization by the PTSD sufferer.

**Dreams as metaphors.**

After the first interview, Steven described a recurring dream that he had had over the years. This dream revealed a significant health issue related to PTSD medications of sleep disturbances and their side effects on veterans’ lives. When I reflected on Steven’s account, I wrote in my journal: “I sleep well and cherish my sleep. One bad night throws me off for days. I can’t imagine not sleeping for months or years at a time.” As a result, I followed up with Steven in the second interview and discussed this dream and details about the effects of sleep deprivation on his life and work.

Steven stated that, once asleep, the dream of the gnarling and vicious dog appears, chasing him and knocking him to the ground. He described the dog as “ripping and eating” his back, tearing away at his flesh, but there is no one around to help him. The dream occurs when he takes his medication too late in the day. Studies on dreams and dream analysis by psychologist Maggiolini et al. (2010) and neuroscientist
Revonsuo (2000) shed light on the aggressive nature of Steven’s dream as well as the potential link between the characters in his dream and the social interactions surrounding his PTSD. For these authors, emotions can be subconsciously transferred from an individual’s review of current troubling events and appear in his dreams.

In Steven’s recounting of his dream when the dog attacked and bit at his right lower back, pain erupted in the same area where he had been bayoneted while on a tour of duty to a war zone. While the dream indicates physical injury to his body, a social assault, evident in a commonly used expression of being “stabbed in the back”, can also apply in this situation. Indeed, Steven described feelings of being betrayed by his peers, and the sense of neglect he felt when he informed his superiors that he had PTSD. They acknowledged that they were already aware of his PTSD diagnosis, but had not acted to help him. He described earlier how he always wanted to be a soldier to defend those who needed to be protected and when he needed protection and compassion, he was abandoned by those whom he thought “had his back”. Steven’s dreams seemed to be a combination of metaphorical significance representing actual memory and perceptions. Regardless of the cause, the experience of having horrific dreams of being attacked and the continuous loss of sleep are real concerns for Steven who required follow-up treatment for PTSD.

During one interview Steven mentioned feeling alone with PTSD. His dream revealed that sense of aloneness when under attack by something he could not control—the attacking, vicious and uncontrollable dog – perhaps a metaphor as well for PTSD and the side effects of the prescribed medications. Steven had spoken earlier in his first interview about feeling alone in his battle with PTSD; when he needed the military
support the most, no one was there. Examining the meanings of this metaphor revealed the mental anguish suffered by soldiers who live and suffer undefined trauma following PTSD. Even a veteran’s subconscious is burdened, so that sleep and rest may not provide refuge.

Throughout our interviews the uniqueness of each veteran’s past, present, and future paths was clear: there is no miracle drug without side effects. Steven and Mark each deal with many more compounding traumas in their daily life, from the illness, the medications, and the continuous assault on their identity through stigmatization, alienation and isolation. While this perspective is evident in the literature, the veteran’s narratives give it poignant and personal meaning beyond what has generally been written in research studies that do not take the veterans’ stories into consideration.

A narrative approach can provide veterans living with PTSD, like the Vietnam veterans, the Korean Veterans, and the Afghan war veterans, like those who participated in this study, with a voice with which to share their experiences and to accentuate the individuality of their lives and lived experiences with PTSD medication side effects. A narrative method in conjunction with medications may provide valuable care for veterans with PTSD. By offering plans of care and medications that are tailored to their individual narratives and the meanings these hold in maintaining their quality of life, veterans with PTSD may be supported in their profound struggle to find their way home to themselves. As Steven said, “It’s therapeutic to talk about it.”
Chapter 5: Forward March

Recommendations and Future Research Possibilities

This final chapter summarizes the research with two male veterans with PTSD in the Canadian military and the implications that PTSD medications have had on their quality of life. My intention in this chapter is to provide a deeper insight into the veterans’ stories and the meanings they conveyed – into what Crites (1971) might describe as a sacred implicit journey of trauma, personal self-discovery and identity. Indeed, through writing this thesis, I have come to understand that all trauma is a sacred story – one in which the sense of personhood of the individual had been injured and othered by the self, which for the veterans in this study, was re-traumatized by the metanarratives of the military culture, cultures of stigmatization, and cultures of alienation in society at large. Restorying the self from trauma to wholeness was unlike anything the veterans had encountered in military training – one that lies hidden within each veteran and within society’s metanarrative of “fixing” a health problem with powerful medications that re-traumatized him in new and unimaginable ways.

What started out as a question about the quality of life of Canadian male veterans who were prescribed antidepressants and/anti-anxiety medications eventually led me to encounters with their stories and issues of quality of life to a profound insight that I was bearing witness to a complex myriad of themes woven together into a profound narrative journey. Having started this research with a literature review on the PTSD medications and their predominant side effects, I shifted to a literary search for an understanding of military culture and then to an exploration of PTSD from a soldier’s perspective, rather than from my own experience as a military wife. Making the connection between the
medication side effects, namely fatigue and sexual dysfunction, and the construct of hypermasculinity in militarism, I realized that I was implicitly shaping my research questions. As a reader of military history and a military film enthusiast, I reflected on the books and films that spoke to the quality of life challenges following PTSD that were key themes featured onscreen. As a nurse and a young mother who was prescribed anti-depressant medication for post-partum depression and anxiety my thoughts turned to the impact the side effects of these medications had on veterans with PTSD taking similar medications. In the literature on quality of life for patients with chronic diseases who experience numerous medication side effects and who choose not to comply with treatment protocols, author Charmaz (1983) identified the “aha” moment when the patients finally made connections between the medications and their ill effects on their lives. I also recall this type of response when a patient in my care as a nurse made similar connections, and when I myself realized the impact on my role as a new mother.

In Chapter 2, I identified gaps in the literature on the lived experiences of veterans after PTSD and the few qualitative studies on the quality of life for veterans with PTSD. None of these studies examined the medication side effects of veterans’ PTSD medications, nor the impact these side effects had on their quality of life.

While studies have been done on the impact that a PTSD diagnosis and treatments have on a veteran and his/her family, the interviews in this study revealed a silent story embedded in the veterans’ accounts – stories of loss of personal identity as a result of PTSD and frustration when this sense of self was not regained through treatments and prescription medications. Who were these veterans as persons, husbands, fathers, and soldiers before their trauma? What roles did those personal and valued
identities play in shaping their reactions to the illness and its medication treatments? What was the quality of life trajectory for each following PTSD? While health care providers are educated to provide holistic care to patients to ensure they are cared for as persons first, and disease and treatment second, this is not always the case. In hospital settings, a patient is often referred to by their illness and room number (“the gallbladder in room 202”), or by their behaviours and diagnosis (“the distressed man with PTSD”). Such approaches happen to veterans with PTSD when diagnosed and treated in military care centres following their return home from combat.

An ominous question arises with veterans living with PTSD and discharged home: do they ever really return “home” – home to themselves, their families, their lives. The health care system may be overlooking one of the most important factors of recovery – finding wholeness within the self and feeling “at home” with oneself with one’s sense of personhood. The veterans in this study returned home with the hope that they would be welcomed, supported and cared for by their country, their regiment, their comrades, and their families. However, their journey with PTSD resulted in a sense of loss, through stigma, and the expression of the medication side-effects on the veteran’s family and career relationships, as well as in all the roles that once brought them joy and comfort. Rediscovering an old self and reconstructing a life story into a new self while healing from trauma is a difficult journey. Some veterans may be fortunate enough to come through this journey, while others may find that no relationship returns to what it was before PTSD. The veterans I spoke with experienced unpredictable reactions and engagements with others due to the side effects of the PTSD medications. As the veterans tried to process what was happening they found themselves facing mental
anguish or difficulties at home for which they have no preparation. They were not aware of the supports they needed or the meaning of their feelings. The pain they experienced as a result of traumatic flashbacks and psychological complications was unknown. In military training, these soldiers practiced the military skills necessary to enable them to enter into a warzone. However well prepared the veterans were for the physical battles, no training could have prepared them for the psychological wounds that war left with them. Moreover, such wounds, perhaps invisible to peers and superiors, left the veterans disconnected from comrades and from themselves. With no words, no language to make sense of their distress and trauma, how could these veterans have reached out for help? Without intending to do so, they brought the war home and their internal hidden battle rages on.

As described by the participants, when soldiers are deployed to a war zone, they may witness unimaginable horrors. For the veterans in this study, such horrors came back in nightmares. Their upbringing and military training had not prepared them for the experience of PTSD. Encountering a lack of compassion and respect for human life in war-torn countries challenged their values of what it means to be “good”, “true” and “just.” and left the veterans trapped in experiences of pain and shock. Returning home to their wives, children, family and friends was not as each veteran had expected or hoped for. The disruption and devastation that PTSD and its medication treatments carries with it brings home a different kind quality of life not only for the veteran, but also for family members.

In a recent CTV coverage of the seventieth anniversary of the Canadian Forces liberation of the Netherlands, veterans from WWII, now in their 90s, were interviewed
and spoke about their war experiences. They described their pain and deep sorrow as a burden they kept hidden and protected for seventy years. It was difficult for them to find the words to describe how they felt, or to name the deep need to protect civilians even in peace-time from the horrors they had witnessed. Al Stapleton, in an interview with the Canadian Press, recalls coming home at the end of WWII:

I didn’t do too bad. On a day-to-day basis, I don't think about (the war) too much.

That's looking back and it doesn't get you too far….A lot of people don't want to remember [the war]…They'd prefer to forget. (np)

The veteran’s memories and pain are locked in the moments that occurred at age twenty, during WWII. In a veterans’ geriatric center at Sunnybrook Centre in Toronto, Sylvia Buchana, a patient care manager, discussed the current situation of a WWII veteran in his nineties. In an interview with the Toronto Star newspaper she said: "We try to convince him the war is over, but it's a hard sell. He's back there!" (2009). After seventy years the memories remain and the unending trauma is witnessed by today’s health professionals caring for these veterans. PTSD continues to affect soldiers currently as evidenced by the rising incidence of PTSD and suicides of Afghanistan veterans. Retired General Rick Hillier (2014) discussed PTSD with CBC radio stating:

I don't think we had any idea of the scale and scope of what the impact would be....This is beyond the medical issue…I think that many of our young men and women have lost confidence in our country to support them.

Steven, one of the veterans interviewed for this study reiterates this statement by saying:
I gave 25 years of my life to that organization and... you know... that’s all I ever wanted to be in my life when I was a kid was to join the military and either be a soldier or a pilot or something, and when I truly needed them to be there for me, they weren’t.

As a nurse, a wife of a Canadian soldier, a mother of three sons who may find themselves in military conflicts someday, and as a person who has personally experienced a form of PTSD through post-partum depression, I feel that I have a degree of legitimacy via an “inside” understanding of military culture and the impact of war, trauma, and depression on an individual with PTSD and their families. As a registered nurse I have witnessed the negative side effects of medications on patients over my 10 years of experience at the bedside in haematology/oncology, surgical and medical nursing units. As a wife of a Canadian Forces soldier, I am frequently a witness to the toll that military life, deployments, and PTSD have on families and friends. I have seen marriages crumble, children act out and veterans self-destruct as a result of PTSD. As a mother of three sons who adore their father and are proud of his work as a soldier, I dread the possibility that one of them may choose a military career path and have their lives shaped by experiences of war or the aftermath of war on peacekeeping missions. As a woman who has experienced post-partum depression and challenges with anxiety, I felt a connection with the veterans who participated in this study and who struggle to stay positive while living with PTSD and journey in their path toward wellness.

When I, with the knowledge of a nurse and a researcher, engaged in interviews with the veterans living with PTSD and the medication side effects, I was humbled by their stories and the ways in which their stories touched my own life experiences. It took
me time and much reflection to grasp the deeper meaning of this trauma to the veterans. There were layers upon layers of meaning, nested one into the other and often protected by professional and personal coping skills – shields, if you will, that myself as a nurse, a mother, a military wife, similarly donned to help me get through painful experiences and move on. My confidence was shaken as I tried to analyze and categorize the veterans’ PTSD and medication experiences into a research chapter. I found it difficult to describe their experiences in a way that would honour the depth and breadth of their traumas. Relationally, as a military wife, I lived amongst military personnel who showed signs of PTSD and I felt helpless in not knowing how to support or care for them. My encounter with the young veteran at the military function that I described at the beginning of this thesis drove this point home for me. PTSD, in that moment, became real to me. Veterans of war are not only the WWII generation, but also the often young, brothers, sisters, sons, daughters, spouses, mothers and fathers from the recent Iraqi and Afghanistan missions as well as the Bosnia and Kosovo peacekeeping missions of the 1990s. As a mother, I wanted to understand in order to protect and care for my sons who will likely follow in their father’s footsteps into the military and who will need the skills to cope with the trauma they may one day encounter. How do I prepare them? What skills do I help them develop? Will they be enough? As a granddaughter of a soldier who spoke very rarely of his WWII experiences with the British army, I wanted to understand what my grandfather endured so that I could guide others living with parents and grandparents suffering from depression, isolation, and haunted memories from PTSD to understand it better.
The military is an unusual career, with intense preparation for combat and civil protection, but one that seems to deny the trauma that a soldier with PTSD faces or the protection and care that such soldiers need. PTSD has been masked throughout history under different names – “a soldier’s heart”, “shell shock”, “combat neurosis”, “weak composition”, to name a few. The journey through PTSD is a tumultuous one, where every step forward toward a hope for wellness can result in two steps backward when a treatment regime masks rather than addresses the problem. Unlike other military operations which may be mapped out in detail or a military tour which has a start and end date, a PTSD journey has no predictable pattern of beginning, expression, action or ending. Medication treatments can be changed or discontinued within a certain time frame, yet the PTSD will remain for a lifetime, as WWII veterans have recently attested.

In this research I have come to understand that with every question answered, two or three more questions seem to arise. This study extended, unexpectedly, beyond an examination of quality of life for veterans living with PTSD into an in-depth analysis of the impact PTSD and PTSD medications have on the veterans and their identity as human beings. In learning from the veterans’ experiences living with PTSD and their quality of life challenges, I reflected on my own journey toward mental health when our first child was born while my husband was deployed overseas in a war zone. I have come to appreciate that there is more to the experience than “depression” and its influence on a person’s quality of life; there is a deeper and more profound human experience of suffering a loss of identity and personhood that medications may mask but not heal. I gained strength in knowing that the veterans who courageously told me their deep and difficult stories had “been there” and persevered to make a new life that did not
reject PTSD but tried to weave it into a new story of wholeness and personhood, a “both-and” rather than an “either-or” story. As I worked through this entire research process of writing, analyzing themes, and understanding each veteran’s meaning of quality of life and self-discovery, I felt alone at times, lost in my questions and in the depth of my findings. There were times when I too found it difficult to describe my frustrations, or to clearly convey to others what I hoped they could hear. My hope for the veterans who, in their desire to help others living with PTSD and the side effects of medications, shared their painful stories, is that they find ways to meet their individual sense of personhood – their I-Thou – once again, and that the military find ways to help their members heal from the traumas of living with PTSD. Perhaps, rather than, or along with, using medications, treatments could include narrative healing processes so that biographical fractures can be healed.

Through the subthemes of family, guilt, discovering meaning, problem solving, and identity that were discussed in this thesis, the themes of family and identity evolved for each veteran in relation to their larger stories of loss of self and grief. The veterans raised fears that the support networks once available seemed to have crumbled when previous strong relational bonds with the military were severed. One key sense of loss that came through was the anticipated loss of the person they might have been as a soldier, a father, a husband, and a man. This deep and profound loss of self was implied metaphorically, rather than stated verbally, which the veterans used to express its meaning. Such a loss of an imagined and hoped for future leaves a person feeling vulnerable in facing the unknown without support or guidance, thereby further complicating healing from PTSD. The dynamic of the relationships with self and others
has been interrupted, following the trauma. Loving gestures are misinterpreted, passion may be lost as a result of altered sexual function and fatigue, familiar noises and sounds are now distracting or threatening. Not only has each veteran shifted his identity as a soldier, his partner and family no longer seem to fit into the traditional military socialized circles. They need to adjust to this displacement and to a new and perhaps unpredictable family dynamic and try to rebuild cherished relationships. Thus, the PTSD side effects may also be lived by the veteran’s family. The implications of these losses on the family unit seem to be perpetuated since there is no definite end point to when PTSD is healed. There may be no return to “normal” as that the old normal no longer exists. As the veteran struggles through treatments, a loss of self may potentially impede progress and perpetuate grief for the person he was and what is happening to his family and the world around them.

As caregivers, professionals tend to want to “fix” the source of illness for clients. Steven stated that, “I was told they were going to essentially rewire my brain” with medications. Medications come with side effects and the veterans in this study experienced intense and unpredictable behavioural and psychological reactions and responses. Rather than seeking a “fix” for PTSD, health care professionals could accompany veterans through their experiences, with an implicit understanding of what they may be seeking. Respecting and appreciating the silence in conversations gives space for a deeper response and for questions to be raised and memories given language and meaning. Accompanying the veterans and their families through the PTSD journey needs to be a priority with every treatment plan and every interdisciplinary team member as they work through the difficult process of understanding their stories. Considering
that these experiences are deep and often unspoken, time needs to be planned in order to support veterans in processing and reflecting on their experiences. Time and care are required in supporting the creation of a new sense of personhood – one that integrates the old with the one formed following PTSD. A holistic team approach is required in enabling veterans with PTSD deal with the potential painful experiences of loneliness, isolation, and loss of the self and in creating an anticipated healthier future for themselves and their families.

This study began with an examination of medication side effects and their impact on the quality of life of two Canadian male veterans living with PTSD. Examining the stories of veterans who participated in this study provides further knowledge about the quality of life of Canadian male veterans living with PTSD and how medication side effects affected their quality of life. However, through the veterans’ stories, the research has revealed complex themes, far beyond the medication side effects of fatigue and sexual dysfunction, which have the potential to provide new insights into the holistic provision of care needed for veterans with PTSD. Evidence from the veterans’ interviews, their analyses and the literature on various topics has revealed the complexities of PTSD and medication side effects. The meanings from these storied experiences may be used to guide care of veterans with PTSD who seem to have been left to their own devices for the most part to understand their illnesses and treatment side effects. The study has provided only a glimpse into the lived experience of veterans diagnosed with PTSD and how PTSD medication side effects impact their quality of life. The sub-themes from this study point to the complexities and intricacies of the PTSD experience and the impact of medication side effects on quality of life. There is much to
learn and many layers to peel away to promote the healing and the rediscovery of self for veterans with PTSD.

At the time that I began this study I had difficulty finding literature sources on Canadian veterans diagnosed with PTSD. Though combat induced PTSD has become more mainstream and publicized over recent years, more research, from a variety of methodologies, on PTSD as a whole, the impact on the self and family, as well as the PTSD recovery process, are needed to provide still more insight into the lives of veterans. Holistic and interdisciplinary team approaches can facilitate the veteran’s journey toward wellness. Understanding who a veteran was before his diagnosis may offer insights into how best to approach comprehensive and holistic treatment. Moreover, more longitudinal studies on veterans living with PTSD and the effects on their families and children could offer a rich area of research and knowledge to inform military practices before deployments to war zones and treatment afterward for emotional trauma and PTSD.

PTSD not only affects military veterans, it affects first responders, firefighters and police officers or anyone who encounters disturbing incidents or has repeated exposure to emergency trauma situations. Workplaces that condone bullying, stigmatization and isolation of certain employees also need to be studied for the short and long-term influences on the employee that may result in PTSD. An example of this would be soldiers who experience violence because they do not conform to the military’s heteronormative, gendered cultural expectations. Sinclair (2009) describes it best as: “Homosexual men and women have been subjected to constant discrimination and stigma while trying to do what most heterosexual individuals take for granted,
serving their country” (p.1, abstract). Sexual assaults are also an ever-present threat in
the military where women endure threats of assault and silencing even at the highest
levels (Castro, Kintzle, Schuyler, Lucas, & Warner, 2015). As with the veterans with
PTSD, the trauma is potentially more destructive and has career implications for those
who speak out.

In reflecting back on the study, although two participants is an acceptable
number of participants for a narrative research project, a research project with a larger
number of participants could be undertaken and shine more light on the significance of
giving veterans with PTSD time, space, respect, and compassion so they can tell their
stories. A study of women veterans with PTSD would also no doubt reveal a deeper
understanding of how gender impacts the experience of PTSD and medication side
effects. Also, military members from a variety of countries could participate in
interviews to see how military culture, approaches to care (e.g., medications), and
overall experiences and viewpoints may differ between countries. The participants in
this study were both from the army branch of the military, so examining veterans from
the Navy and Air Force may bring different perspectives, adding to treatment insights
and the improved quality of life for all veterans.

As I have learned, there is more to narrative research than just a desire to provide
insight into an issue. Engaging in narrative research is not only an examination of lived
experience; it is a lived experience in itself. Every question on the journey through
PTSD can be understood as a piece of a greater learning experience in which answers
may not be known, but in which knowledge and experience gained and shared
throughout the experience is invaluable.
Having been honored by the veterans who told me their PTSD and medication side-effects stories, understanding their challenges, witnessing the empowerment they exhibited to share those stories that have been buried and locked away has revived my desire to continue my studies. The themes of loss of self or personhood were paramount in this study as well as in my own sacred story. Throughout this thesis I was able to reflect deeply on the participants’ stories and draw strength from their courage in sharing to explore my own sense of self and narrative unity.

This thesis journey has been long and filled with challenges. However, as a result, my life has changed forever. I have come face-to-face with an I-Thou relationship, and reclaimed my own life.
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Appendix A

Application For Review of Research Involving Humans
Revised February 2009

University of New Brunswick
Application for Review of Research Involving Humans

Principal Investigator(s): Name(s); Academic Status (Faculty, Undergraduate Student or Graduate Student); Academic Unit, e-mail Address, Office Telephone, Home Telephone:

<table>
<thead>
<tr>
<th>Debra Bastien, Master’s Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Studies, School of Graduate Studies</td>
</tr>
<tr>
<td><a href="mailto:dbastien@unb.ca">dbastien@unb.ca</a>, 447-3109, 455-6959</td>
</tr>
</tbody>
</table>

Title of Proposed Research:

| Battle on the Home Front: Post-Traumatic Stress Disorder (PTSD) Medication Side Effects & the Quality of Life of Canadian Male Veterans |

Commencement Date: March 1, 2011 Completion Date: August 1, 2011

Co-Investigator(s): Academic Unit, e-mail address, Office Telephone:

| N/A |

Supervisor(s) (if Principal Investigator is a student); Academic Unit, e-mail address, Office Telephone:

| Dr. Linda Eyre, Assistant Dean School of Graduate Studies, Professor Faculty of Education, lerye@unb.ca, 453-5161 |

1. **Summary**: Provide here, in approximately 300 words, a summary of the proposed research, indicating clearly the role of the research subjects and any procedures to which they will be subjected.

   The purpose of the study is to contribute to the interdisciplinary knowledge base regarding the PTSD medication side effects for Canadian male veterans. Using a narrative inquiry methodology, I will conduct open-ended interviews with two male veterans diagnosed and medicated for PTSD. I will explore their stories about the impact of medication side effects on their everyday lives.
I will conduct a minimum of two face to face interviews with each veteran; each interview will take place for approximately one hour. Journaling between interviews by both researcher and participants will be encouraged but shared voluntarily. The interviews will be taped and transcribed by a transcriptionist. I will identify themes and potential core stories and share my analysis with each participant.

2. **Risk:** In your opinion, does this research pose more than minimal risk (Tri-Council Policy, Section 1.C1) to participating subjects? 
   - Yes
   - No
   - X

If yes, provide here a statement that describes in detail the aspects of the research procedure that pose a risk to subjects, and provide your assessment of the risk of harm (probability and severity). Note that not only physical injury but also anxiety or embarrassments are included in the concept of harm. Describe means adopted to minimize risk, and means (such as provision of counseling) to deal with harms, which subjects may experience. Describe as well the potential benefit, which will result from this research, which justifies the above risk of harm.

There is a potential for story telling to trigger some emotional responses from the participant. The interview can be interrupted or stopped at any time if the participant feels that emotional responses are creating discomfort. The researcher, a registered nurse, may also interrupt the interview to ensure the participant's wellbeing. If this situation arises, we will proceed together in seeking out support or intervention as needed and as directed by the participant. Each interview will conclude with a period of debriefing to allow for a return to everydayness and step back from the interview experience. The investigator will contact the participant a few days after each interview to follow up with any concerns that may have arisen following the interviews and journaling processes.

3. **Deception:** Does this research involve deception or partial disclosure? 
   - Yes
   - No
   - X

If yes, refer to the Tri-Council Policy, Section 2, specifically Article 2.1(c) and subsequent commentary, and provide here an explanation of how you plan to comply with the requirements of that Section for debriefing. Describe as well the potential benefit, which will result from this research, which justifies waiving the normal requirements for full disclosure.

4. **Funding:** Has funding been received for this research? 
   - Yes
   - No
   - X

If yes, from what agency and for what period?
If yes, from what agency and for what period?

5. Research Subjects:

5.1 Number of Subjects: How many subjects will participate in this research? 2

5.2 Recruitment: How will they be recruited, and from what population?

I will contact local physicians and provide them with an information letter about my study. (see attached). I will seek their cooperation in contacting their patients medicated for PTSD to inform them about my research interests. I will request that interested participants contact me via email or telephone. I will set up an initial meeting at a location of their choice to explain the study and answer any questions they may have. Participants will be male, active members or retired members of the Canadian Forces. Participants must be English or French speaking.

6. Informed Consent:

6.1 Informing Subjects: How will the nature of the research be explained to potential subjects, in compliance with Section 2D of the Tri-Council Policy? Attach a copy of any document(s), such as an explanatory letter, to be used for this purpose.

An explanatory letter outlining the study will be provided to the physicians (Appendix A) and the participants (Appendix B). To ensure informed consent, I will meet face to face with each participant to explain the study in detail and answer any questions pertaining to the study. I will also explain the procedures I will use to maintain confidentiality and anonymity.

6.2 Consent: If written evidence of informed consent will be obtained, attach a copy of the consent form. (See Requirements for Informed Consent Forms.) If written evidence of informed consent will not be used, explain here, in detail, how you intend to comply with the requirements of Section 2A of the Tri-Council Policy: see particularly Article 2.1(b) and subsequent commentary.

Consent form attached as Appendix D.

6.3 Children as Research Subjects: If the proposed research involves children as subjects, provide here a statement indicating how compliance with Section 2E, and specifically with Articles 2.5, 2.6 and 2.7 of the Tri-Council Policy, will be achieved.

N/A

6.4 Incompetent Adults as Research Subjects: If the research involves adults of diminished competence as subjects, provide a statement indicating how compliance
with Section 2E, and specifically with Articles 2.5, 2.6 and 2.7 of the Tri-Council Policy, will be achieved.

| N/A |

7. **Inducements:** Will any inducements (money, grade points, etc.) be offered to encourage participation? **Yes**  **No X**

If yes, indicate here how compliance with Section 2B of the Tri-Council Policy (concerning voluntariness) will be achieved. If academic rewards are to be used, give details of alternative means of achieving equivalent rewards.

8. **Private Information:** Does the proposed research involve accessing identifiable personal information about subjects by means of surveys, questionnaires, etc.? **Yes X** **No**

If yes, indicate here, in detail, how you propose to meet the requirements of the Tri-Council Policy, Section 3, specifically Article 3.2. A copy of any questionnaire, survey document or interview schedule to be used should be attached as well.

| All research data will be kept in a locked cabinet in the researcher's office and remain there for the duration of the research project and destroyed one year after. Qualitative information will only be shared with the committee and thesis supervisor. All identifying factors (rank, trade, postings) will be removed from the text to maintain anonymity. Pseudonyms will be used throughout. |

9. **Feedback:** Describe the measures, which you propose for providing feedback to research subjects concerning the outcome of the research.

| Transcriptions and interpretations will be brought back to the participant for clarification after each interview. I will meet with each participant separately to discuss recurrent themes gleaned from the interviews and the journals. I will provide each participant with a copy of my thesis if desired. Participants will be informed of any subsequent publications. |

10. **Data Security:** Describe the measures, which you propose for ensuring the security of any identifiable personal data, which will be retained after completion of the research.

| All research data will be kept in a locked cabinet in the researcher's office and remain there for the duration of the research project and one year and then destroyed. The information will only be shared with the committee and thesis supervisor. Only the investigator will have a key to the cabinet where data are kept. |
11. **Continuing Review:** All research requires brief annual reports and a brief report upon completion of the research. Suitable report forms are included at the end of this file. **Research involving more than minimal risk may require additional measures for continuing review.** If your research involves more than minimal risk, describe here the measures you propose for facilitating continuing review of this research, in compliance with Article 1.13 of the Tri-Council Policy

| N/A |

12. **Additional Information:** Please feel free to append any additional information, which you feel may be helpful to the REB in evaluating this application.

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Through graduate course work I have gained comprehensive knowledge of narrative inquiry as a methodology as well as critical, feminist, and post-colonial theories. I have completed a graduate political science course on gender and war. Assignments, journals and class presentations were completed to ensure deep reflection and understanding of each topic.

As a registered nurse for over a decade I have been a front-line practitioner and educator in the care of acutely ill, high risk patient populations. I have had extensive experience managing physiological and psychological crises on many levels (e.g. Emergency room, hematological emergencies (mainly bone marrow transplants), cancer and palliative care, rape trauma intervention, and internal medicine with a majority of cardiac care patients). I have an extensive knowledge of therapeutic communication and counseling in a variety of settings. I am confident in my abilities to provide a safe environment and provide holistic care to my patients, and in terms of research, for my study participants. Through my practice I have developed collaborative relationships with local psychologists and family physicians. I have earned their respect as a competent and compassionate professional. My nursing career has also provided me with a knowledge base of medications. I have a literature review on medications used for PTSD published and have presented this and narrative material at local and international conferences.

Finally, I am military wife. I have been immersed in the military culture for over ten years and have gained much insight into the complex nature of the military way of life. I have had the opportunity to witness the nature and manifestations of PTSD on veterans and the impact PTSD has on individuals and their families. I am confident that I am well qualified and prepared to carry out this qualitative research study.
Appendix B

Information Letter for Participants

**Title of the Project:** Battle on the Home Front: Post-Traumatic Stress Disorder (PTSD) Medication Side Effects & the Quality of Life of Canadian Male Veterans

**Investigator:** Debra Bastien RN  BScN, University of New Brunswick, MIDST student

**Introduction:** PTSD is increasingly being recognized as a serious concern among veterans. Retired General Romeo Dallaire estimated as many as 3,000 Canadian soldiers suffer from PTSD, many of them silently. Although a screening process for PTSD is in place, reportedly few veterans actually complete the required questionnaire. Moreover, a questionnaire cannot provide an in-depth depiction of the unique experiences and the emotional responses to veterans’ involvement in wars such as Afghanistan. Through open-ended interviews, I will examine the impact that undesirable medication side effects have on the everyday lives of Canadian male veterans. New understandings can result in an increased awareness of medications and their side effects prescribed for PTSD.

**Invitation to Participate:** I invite you to take part in this study. I am interested in learning about the lived experiences of Canadian male veterans who are currently medicated for PTSD and how the medication side effects have affected your lives. I am inviting you to participate because you are a veteran who has been diagnosed and subsequently received medications for PTSD. Understanding the meaning behind your stories and the impact medication side effects have had on your quality of life will help caregivers better understand the implications of medication side effects and endeavour to improve follow up after a prescription has been filled.

**Purpose:** To establish meaning through the stories of Canadian male veterans' who experience PTSD medication side effects. The information collected will be used in the researcher's Masters Thesis and may appear in future scholarly publications and public reports.

**Study approach & method:** A narrative approach to qualitative research will be used to gather veterans' stories through a series of interviews. Face to face interviews will be conducted and take place over approximately one hour. Following each interview, they will be transcribed, and themes will be identified. Potential sub stories will be created and then brought back to the participant for validation. During the validation process, participants will have the right to withdraw or modify material and information from the transcript of the interview. Any material withdrawn will not be used by the researcher in any way.

**Benefits:** I will endeavour to create an opportunity for you to tell your story. The development of knowledge surrounding the lived experiences of veterans who experience PTSD medication side effects will aim to educate an interdisciplinary team's approach to best support veterans who suffer with side effects of their medication regime.

**Compensation & additional costs:** You will be reimbursed for any long distance phone calls, by the investigator. There will be no financial or other compensation provided to you.
**Risks & discomforts:** There is a potential for story telling to trigger some emotional responses within you. The interview can be interrupted or stopped at any time if you feel that emotional responses are creating discomfort. The researcher, a registered nurse, may also interrupt the interview to ensure your wellbeing. If this situation arises, we will proceed together in seeking out support or intervention as needed and as directed by you. Each interview will conclude with a period of decompression to allow for a return to everydayness and step back from the interview experience. The investigator will contact you a few days after each interview to ensure that no concerns have arisen from the content of the interview process. Journal writing will be encouraged by both researcher and participant to document any emotional responses or insights between interviews. These journals do not have to be submitted as part of the research study, but may be donated voluntarily.

**Confidentiality:** This research information is entirely confidential. Your identity will never be attached to your data during the research process or in the future. In any public presentation or publication you will be identified only by pseudonym, and no facts or personal information that might allow others to deduce your identity will be used. However, you should be aware that anonymity cannot be absolutely guaranteed in research of this nature. There is always the small chance that individuals who are already very familiar with you may recognize you from the narrative provided in public presentations of the data. The Researcher will be happy to discuss this issue with you in detail. My supervisors and transcriptionist will listen to the interviews only after the consent has been signed and undergone an oath of confidentiality. All transcripts, tapes, and research material will be kept in a locked cabinet, in my office at the Faculty of Nursing at UNB. This project is on file with the UNB Research Ethics Board as 2011-023.

The main goal of this research project is to identify and discuss recurrent themes in your experience with your PTSD medication side effects. The chapters of my thesis will examine these themes, rather than narrate your individual stories. If excerpts are taken from the interviews they will be anonymized and details fictionalized as needed to ensure that no identifying factors unique to your story exist. You will have the opportunity to review the excerpts and approve them for use in my thesis and possible future publication.

**Your Rights:** You have the right at any time during the interviews or at any point of the research process to change your mind about answering any questions and/or participating. At no time will your decision not to participate result in any coercion from the investigator. You also have the right to deny the use of certain excerpts in my thesis.

**Additional information:** If you have any questions or concerns about this study, feel free to contact the investigator, Debra Bastien, at any time. I can be reached at dbastien@unb.ca and/or (506)447-3109. You can also contact my supervisor Dr. Linda Eyre at leyre@unb.ca and/or committee member, Dr. Dolores Furlong at dfurlong@unb.ca. You may also contact Dr. Steven Turner, Chair of the UNBF Research Ethics Board at turner@unb.ca.
Curriculum Vitae

Debra Lynn Bastien RN, BScN, MIDST

Education

2016  MIDST   Master in Interdisciplinary Studies
       University of New Brunswick

2009  DUT     Certificate in University Teaching
       University of New Brunswick

1999  BScN (Hon)   Honours, Bachelor of Science in Nursing, Post RN
                   Program, University of Ottawa

1997  RN Diploma  Registered Nurse Diploma Program
          John Abbott College

Refereed Publications

Bastien, D. L. (October 2013). Narrative inquiry as a research methodology:
Discovering meaning from the stories of Canadian veterans diagnosed with
PTSD (Post-traumatic Stress Disorder). Psychology Research 3(10)(Serial
number 28), 547-562.


Publications


Conference Presentations

and assessment for IENs in the Maritimes. Partners in Education &
Integration of IENs - 8th Annual Conference. Toronto, Ontario.

in the nest. XXXIII International Congress on Law and mental Health.
Amsterdam, Netherlands.

Canadian male veterans. Honor Society of Nursing, Sigma Theta Tau 24th
International Nursing Research Congress. Prague, Czech Republic.


