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The human-animal bond and combat-related posttraumatic stress symptoms

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Abstract

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MS, Walden University, 2010

BS, Park University, 2008

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Abstract

Early into the Afghanistan and Iraq wars, reports revealed that less than half of individuals displaying symptoms of posttraumatic stress disorder sought help from the mental health community. As a means to cope with the stresses of war, many soldiers turned to animals for emotional support, and anecdotal reports identified reduction in the severity of distress among soldiers. However, no study was found that investigates this phenomenon. The purpose of this study was to explore the lived experiences of service members with combat-related posttraumatic stress symptoms and the human-animal bond. The study applied a blend of constructivism and phenomenology to address how the construction of knowledge and perception interacts with trauma exposure to develop distress—the diathesis-stress theory of posttraumatic stress disorder. The single research question inquired into the lived experiences of Operational Enduring Freedom and Operation Iraqi Freedom military personnel with posttraumatic stress disorder symptoms who have a companion animal. Data collection consisted of 12 in-depth, participant interviews, which were analyzed using the phenomenological techniques created by Moustakas. The analysis revealed 4 themes: (a) rich descriptions of deployment events, (b) the experiences of returning from a deployment, (c) participants' perceptions on their pets' influence on posttraumatic stress symptoms, and (d) other personal comments and opinions related to participants' experiences. These findings illuminate the experiences of combat-related posttraumatic stress and the importance of animals in the therapeutic process. These detailed descriptions may help develop alternative treatment options and help policy makers assess the current management of posttraumatic stress in the military and Veteran's Administration systems.

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Dedication

To those suffering from combat-related posttraumatic stress and the four million animals euthanized in shelters across the United States each year.

Acknowledgments

Father – Abba, without You this dissertation would not have been possible. Only You truly know the highs and lows of this journey.

To the only people on earth capable of handling *my* leash – Mom, Estelle, and Dr. Crocker – words cannot adequately describe the gratitude I have towards each of you. To all my friends who encouraged me during the past two years, thank you!

Finally, to the volunteers who participated in this study – my co-researchers – thank you for trusting me with your experiences. You are this study.

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Chapter 1: Introduction to the Study

Introduction

History is full of accounts describing the psychological disturbances resulting from the horrors of combat, but until after the Vietnam War, these problems were often misdiagnosed or else dismissed as personal inabilities to cope with stress (Boone & Richardson, 2010; Friedman & Marsella, 1996; Lasiuk & Hegadoren, 2006a). Since the formal recognition of posttraumatic stress disorder (PTSD) over thirty years ago, there are still obstacles to identifying vulnerabilities to the disorder (i.e., risk factors), creating reliable screening tools, and producing effective treatment programs. These obstacles are most evident when addressing mental health issues with the United States Armed Forces.

Military operations in Afghanistan and Iraq exposed American service members to extended periods in combat environments for the first time since the Vietnam War. Going into Operation Enduring Freedon (OEF) and Operation Iraqi Freedom (OIF), the majority of knowledge about combat-related PTSD came from research conducted on Vietnam veterans years after their war had ended. In 2004, military leaders realized that while advancements in medical technology greatly reduced the number of physical casualties in OEF and OIF, mental health policies were failing in the face of (a) the higher operational tempo associated with modern combat environments combined with (b) the increased frequency and duration of deployments (Hoge et al., 2004).

Two primary differences were immediately recognized between service members supporting OEF and OIF and those who served during the Vietnam War: today all

military service members are volunteers and a higher percentage of service members experienced multiple deployments to Afghanistan, Iraq, or both (Erbes, 2007; Hoge et al., 2004).

This study reviewed the policies governing deployment-related, psychological screening and mental health treatment options for military service members and veterans. Research in this area has grown considerably since 2001. Two troubling trends were uncovered in research on OEF and OIF service members: those more at risk of developing PTSD are not being identified and those who identified as experiencing distress after combat exposure often do not follow up with mental health services and treatment. Fewer than 50% of service members scoring above the PTSD cut-off score entered some type of treatment program (Litz, 2007; Tanielian et al., 2008). In the hope of increasing the efficiency of PTSD screening and treatment programs, alternate mental health policies and treatment options that are more compatible with the current military population need to be considered. By examining the lived experiences of participants, this study examined the role of the human-animal bond as a tool that could enhance existing treatment modalities.

The next section of this chapter reviews the background of PTSD and the mental health implications of exposure to combat during OEF and OIF. An overview of the human-animal bond is also presented, with an emphasis on the observations of a major military medical center after canines were introduced into a number of combat recovery and rehabilitative settings. The chapter then describes the problem statement, purpose of

the study, conceptual frameworks, definitions, nature of the study, scope, assumptions and limitations, and finally, the potential significance of the findings.

Background

This section provides a brief review of PTSD and the human-animal bond. A comprehensive review is given in Chapter 2.

Posttraumatic Stress Disorder

PTSD is a collection of psychological responses to trauma exposure, including the reexperiencing of the traumatic event, avoidance and emotional numbing behaviors, and periods of hyperarousal (American Psychiatric Association [APA], 2000). The classification of PTSD in the 1980 edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 1980) came almost five years after the end of the Vietnam War. Initial research on PTSD studied a military population whose psychological disturbances manifested at a minimum of five years after the trauma, yet these findings became the foundation for the psychological screening and treatment practices for more current military generations (Friedman & Marsella, 1996; McKeever & Huff, 2003).

Since October 2001, over 2.4 million service members have served in support of OEF and OIF (Defence Manpower Data Center [DMDC], 2012). Three years into the first combat operations in Afghanistan, the Department of Defense (DoD) realized that the mental health needs of service members in combat were rapidly overtaking established capabilities (Hoge et al., 2004; Litz, 2007; Tanielian et al., 2008). To avoid

the problems of stagnant recovery with psychological disturbances, as experienced during the Vietnam War, policy changes were required. The Department of Veterans Affairs (VA) increased mental health staffs and fiscal programming to meet the growing demand of caring for returning service members (Tanielian et al., 2008; VA, 2012). However, the number of active duty using available services dipped as low as 10% and rates have continue to remain lower among active duty service members than among veterans (Erbes et al., 2007; Hoge, Auchterlonie & Milliken, 2006). Two factors appear to influence this problem. First is the negative attitude about mental health treatment based on cultural and personal stigma (Britt, Wright & Moore, 2012; Erbes et al., 2009; Hoge et al., 2004; Kim et al., 2010, 2011; Langston et al., 2007; Litz, 2007; Lorber & Garcia, 2010; McKeever & Huff, 2003; Sayer et al., 2011; Tanielian et al., 2008; Wright et al., 2009). Second is that less than half of individuals in treatment programs received the minimal care as outlined by the DoD and VA, which may feed into the overall perception that PTSD treatment is ineffective (Chard, Schmumm, Owens & Cttingham, 2010; Erbes, Curry & Leskela, 2009; Jones, 2012; Litz, 2007; Tanielian et al., 2008; Wright et al., 2009).

By 2007, the media networks began reporting on the increased frequencies of suicides, violent acts, and PTSD among service members returning from war, even as combat operations began to decrease (Adfero Group, 2009; Hayes, 2012; Kuhen, 2009; Thompson, 2012). Left untreated, PTSD may become comorbid with depression, alcohol and substance abuse, or other anxiety disorders, increasing the frequency and severity of

behavioral problems, such as those mentioned above (Kessler et al., 1995; Litz, 2007). When secondary and tertiary problems combine with PTSD, therapeutic programs in excess of the standard 6 to 12 months are often required (Adamson et al., 2008; Courtois, 2008; Kessler et al., 1995; VA, 2010). The more common social results of untreated PTSD include higher rates of family conflicts, employment difficulties, and increased rates of homelessness (Adamson et al., 2008; Kessler et al., 1995; Litz, 2007). At the extreme end of untreated PTSD is the story of the the staff sergeant who, in March 2012, killed 16 Afghans during his fourth deployment to the Middle East (Leonning, 2012).

The other side of the treatment issue is the projected cost. Tanielian et al. (2008) estimated the cost of treating PTSD and major depression for 2 years after a deployment to range from $5,900 to $25,760 per case, and costs are explected to rise. However, for individuals leaving active military service the VA extended its cost-free coverage for OEF and OEF-related PTSD treatment from 2 to 5 years (VA, 2010). But the VA is not only conerned about the rising costs of treating OEF and OIF veterans, it also has to consider service-related PTSD from other American conflicts. Time limits for veterans seeking PTSD treatment due to other wars and combat operations were not identified.

Compensation for service-related disabilities are awarded on a percentage scale. For example, an individual receiving 100% service disability may be awarded up to $28,512 per year, not including other entitlements and benefits (Arbisi, Murdoch, Fortier, & McNulty, 2004). According to Arbisi et al. (2004) and Marx and Holowka (2011), PTSD is the most common psychiatric condition for which disability benefits are sought,

creating a backlog in disability claims and forcing the VA to prioritize requests in determing who will be compensated. In 2004, Arbisi et al. (2004) found that the number of veterans receiving PTSD disability between 1999 and 2004 was approximately 200,000; this number increased to almost 400,000 by 2010 (Marx & Holowka, 2011). These numbers do not solely reflect OEF and OIF personnel, but also veterans who delayed entering treatment after other conflicts.

In 2012, President Obama directed a budget cut of $13 trillion to the military's Tricare health provider, signaling future struggles in caring for America's military veterans (Herb, 2012). The proposed cut was backed with a threat by the White House to veto any Congressional budget proposal that did not include the health care cuts (Herb, 2012). More than ever, the financial difficulties facing military and VA budgets place a precedence on developing treatment programs and policies that would result in more service members engaging with mental health services.

Research on OEF and OIF personnel generated the first substantial collection of combat-related PTSD literature that offered a different persepective of the psychological impact of war than that from Vietnam (see Chapter 2). However, as reviewed in Chapter 2, questions remain about the generalizability of findings (Litz, 2007; Litz & Schlenger, 2009). According to Litz and Schlenger (2009) and Ramchand et al. (2011), there is no common definition of, nor a functional boundary across the literature on: PTSD characteristics, differences in combat exposure, and variances in the demographic make-up of convenience samples. These areas also resulted in greater uncertainty about

forecasting trajectories in PTSD, resiliency to stress, and effective options in caring for American military personnel. PTSD prevalence rates and the military services are further discussed in Chapter 2.

Human-Animal Bond

In attempts to relieve the emotional and psychological struggles that surfaced during deployments, many service members turned to the stray animals encountered at forward locations, even against orders prohibiting interaction with local animals (Brody, 2011; Office of Multi-National Corps, 2009; Pannella, 2011; Smith, 2012). Similar stories about returning soldiers turning to companion animals for psychological relief also were common on the news and the Internet (Carollo, 2011; Mohtashemi, 2012). Moreover, recently created animal rescue organizations, such as Pets for Patriots and Pets for Vets, stand ready to pair homeless animals with veterans and the Society for the Prevention of Cruelty to Animals International and Puppy Rescue Mission coordinate efforts to reunite stray animals "adopted" during deployments with their military members back in the United States (Mohtashemi, 2012).

Literature on the human-animal bond reports improved psychological and emotional well-being and reduced levels of anxiety and depression in elderly, child, and prisoner populations where some type of animal-assisted activities was introduced (Britton & Button, 2005; Furst, 2006; Harkrader et al., 2004; Hooker, Freeman, & Stewart, 2002; Sacks, 2008; Turner, 2007; Walsh, 2009; Yorke, 2010). But, the number of empirical studies on the human-animal bond in therapeutic settings remains low

(Walsh, 2009). For example, no data was found on the human-animal bond and combat-related PTSD until Walter Reed National Military Medical Center (hereinafter Walter Reed) released its first-hand observations (April 2012) from a collection of programs in which animals were introduced to rehabilitating Wounded Warriors (see Chapter 2).

Located outside of Washington, D.C., Walter Reed is the largest military medical hospital in the United States, with over 100 clinics and specialties to meet the needs of Armed Forces wounded in combat. The current structure was established on November 10, 2011, following the Base Realignment and Closure Act of 2005, which directed the consolidation of the National Naval Medical Center and Walter Reed Army Medical Center on the grounds of the campus in Bethesda, Maryland (WRNMMC, n.d.). The Departments of the Army and Navy jointly manage Walter Reed; as such, the highest percentage of wounded combat personnel receives care at this location.

Problem Statement

Early into the Afghanistan and Iraq wars, reports revealed that less than half of individuals displaying posttraumatic stress disorder symptoms sought help from the mental health community, which prompted an investigation of DoD and VA mental health policies (Erbes, Curry, & Leskela, 2009; Hoge, 2004; Litz, 2007; Tanielian et al., 2008). The policies governing mental health care for the military community stem from the research conducted after the Vietnam War, providing a single, after-the-fact perspective of the psychological issues resulting from exposure to war (Erbes, 2007). Since PTSD research began many years after the Vietnam War ended, it is impossible to

speculate whether issues about treatment existed (e.g., cultural influences, stigmatization, and availability of treatment options). A discussion on the barriers to mental health care begins below and then follows in the literature review of Chapter 2. However, a larger concern is that using the early research from the 1980s and 1990s in creating mental health policy and treatment for the current military population may not account for the generational gap that exists between the two populations.

First, for many Vietnam veterans, their PTSD symptoms may have manifested for years prior to even the recognition of PTSD (Erbes, 2009). The second issue concerns the fact that samples for the studies were typically obtained through VA medical centers, where participants were likely to be veterans and involved in some part of the PTSD treatment process (Erbes et al. 2009; Hoge, Auchterlonie, & Milliken, 2006; Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2008; Wright, Cabrera, Bliese, Adler, Hoge, & Castro, 2009). As recommended by Erbes et al. (2009), contemporary mental health policies should reflect the characteristics of a military population that is engaged in multiple combat locations, faces frequent deployments, maintains a strenuous training regimen between deployments, and constitutes a demographic that is reluctant about getting treatment.

To begin reversing the low volume of military member who seek treatment, the DoD required the creation of educational programs at the unit level to address areas believed to reduce personal reluctance in seeking mental health help. These areas included: (a) the stigma of mental health treatment, (b) an unaccepting environment about

mental health issues, and (c) too few counselors qualified to treat PTSD (Britt, Wright, & Moore, 2012; Erbes et al., 2009; Hoge et al., 2004; Hoge et al., 2006; Kim, Thomas, Wilk, Castro, & Hoge, 2010, Kim, Britt, Klocko, Riviere, & Adler, 2011; Langston et al., 2007; Lorber & Garcia, 2010; McKeever & Huff, 2003; Sayer, Spoont, Murdock, Parker, Hintz, & Rosenheck, 2011; Seal et al., 2010; Tanielian et al., 2008; Wright et al., 2009). The above literature discussed the *under*utilization of PTSD treatment programs, but did not offer alternate or modified treatment program suggestions.

With regard to concerns about PTSD treatment influencing the service members' military career, there are no hard and fast rules or simple answers. All medical treatment received by military members is recorded in each member's medical folder, which is typically not part of their personnel or career record. The DoD is interested in addressing the psychological problem created from combat exposure prior to the development of emotional or behavioral difficulties that may result in negative consequences for the military member. An example is a member's use of illegal drugs or abuse of prescription medication to counter PTSD symptoms, which could lead to the termination of the individual's military career. The ultimate goal is to keep military members on full active status wherever possible; individual cases, with their associated details, are considered during the decision process. Further discussion of this topic is beyond the scope of this paper.

One lesson from the Vietnam War is that untreated PTSD can become chronic and resistant to treatment once adaptive behaviors (i.e., substance abuse) manifest

(Courtois, 2008; Kessler, 1995). Given the military population's general opinions about mental health services, and their resistance to seek help, treatment options should also address the overall stigma and other barriers that service members might feel. Unless individuals are encouraged to seek help and unless they feel that therapeutic programs are beneficial, low treatment effectiveness and utilization rates will continue to challenge military leadership.

Purpose of Study

The purpose of this study was to describe the experiences of OEF and OIF veterans who developed PTSD symptoms due to their deployments, and had companion animal after their deployment. The trauma experienced in combat is unique for each person, influenced by the personal factors brought to the traumatic event (Hoge et al., 2004; McKeever & Huff, 2003; Vasterling, Daly & Friedman, 2011); understanding the phenomenon through the first-hand perspective from persons living the experiences is often missed with quantitative research. A second intention was to begin a foundation of scholarly research on the phenomenon began by the anecdotal reports provided by Walter Reed and media stories. The reports published by Walter Reed are discussed in Chapter 2.

The literature on the human-animal bond suggests that the presence of an animal can increase physical, biological, and emotional well-being. The literature also shows that the presence of an animal enhances client-clinician rapport and trust-building in a number of populations (Barker, Knisely, McCain, Schubert, & Pandurangi, 2010; Beck et

al., 2012; Furst, 2006; Lefkowitz, Paharia, Prout, Debiak, & Bleiberg, 2005; Ritchie & Amaker, 2012; Sacks 2008; Turner, 2007; Walsh, 2009; Yeager & Irwin, 2012). Outside of the Walter Reed literature released in 2012, empirical data on the human-animal bond using a military sample was not found during the database searches and only two studies were located in which animals were introduced to the treatment plan for trauma victims (Hamama, Hamama-Raz, Dagan, Greenfield, Rubinstein, & Ben-Ezra, 2011; Lefkowitz et al., 2005).

Examining the experiences of military members regarding their OEF and OIF deployments, their combat-related PTSD symptoms, and their companion animals from a phenomenological viewpoint afforded an opportunity to understand the features of the relationship between the human-animal bond and with combat-related PTSD. The study sought to establish a baseline of themes that reflected participants' experiences in order to add to the existing literature. A second area of interest was to analyze participants' shared experiences for common characteristics that could prove beneficial for future therapy. Finally, this inquiry sought to discover whether the presence of an animal actually influences PTSD symptoms, as experienced and reported by the participants. Military members remain a high-risk population for developing PTSD and providing appropriate care will continue to challenge policy makers as long as America exposes its Armed Forces to combat environments.

Research Question

Data collection in phenomenological studies uses interviews, document reviews, observations, and art (Moustakas, 1994). The exploratory nature of this phenomenological study required a guiding question to define the study, followed by interview questions and probes to uncover the individual experiences, as recommended by Creswell (1998). To understand the experiences associated with combat, combat-related PTSD symptoms, and the presence of a companion animal, the following research question guided the study:

> What are the lived experiences of United States military members who served in OEF and OIF, developed combat-related PTSD symptoms, and have a companion animal?

Conceptual Framework

The three theories creating the foundation for this project were (a) a blend of constructivism and phenomenology, (b) the diathesis-stress theory of PTSD, and (c) the concept known as the human-animal bond.

Constructivism "[relies] on the participants' view of the situation . . . to inductively develop a pattern of meaning" (Creswell, 2007, pp. 20-21). This worldview recognizes social and historical interactions operating in a person's life create subjective meaning. The researcher's objective is to understand the processes of these external interactions in order to create a rich, textured description of the lived experience (Creswell, 2007; Moustakas, 1994). To reach the level of understanding required to

produce a descriptive analysis of a phenomenon, the application of phenomenology is recommended. The philosophical lens of phenomenology challenges the researcher to approach an experience free from preconceived beliefs and expectations; according to Moustakas (1994), "the researcher to become a blank slate, returning to the things themselves . . . and be presented with the consciousness of the participant to unveil the unity of the real and the ideal" (p. 27). Using constructivism and phenomenology in this study sought an understanding of the sensations, feelings, and meanings of a specific experience from the participant's point of view, without bias.

The principles behind constructivism and phenomenology help the author to understand and interpret the phenomena in question (Moustakas, 1994). For this study, the focus was to understand the phenomena behind the experiences associated with combat-related PTSD symptoms, perceptions surrounding mental health treatment, and the perspectives on the relationships individuals had with their companion animal.

The second and third theories that helped form a foundation for this study were the diathesis-stress theory of PTSD and the human-animal bond, as described below.

Diathesis-Stress Theory of PTSD

The term *diathesis* has been long associated with a biological or genetic tendency towards a disease, but has recently come to include any characteristic that increases the likelihood of developing a disorder; the *stress* or stressor is the environmental element or event to which an individual is exposed that exceeds his or her natural capacity to cope (Zuckerman, 1999). The diathesis-stress model states that individual factors such as

personality traits, childhood familial environments, biological and genetic factors, social support, and response patterns to psychological stress, combine with the severity of a traumatic event to create vulnerability towards the development of a psychological break, leading to psychosis (Benight, 2012; McKeever; Huff, 2003, Monroe & Simons, 1991; Zuckerman, 1999). In simple terms, as individual risk factors towards PTSD increase (e.g., number of exposures to a combat environment), the severity of a traumatic event required for an individual to "break" decreases.

This model of PTSD etiology in the military is important to understand. In addition to personal factors, every time a service member experiences exposure to a traumatic event – whether multiple exposures within one deployment or over multiple deployments – each occurrence increase PTSD vulnerability (Adler, Huffman, Bliese, & Castro, 2005; Hoge et al., 2004; Duma, Reger, Canning, McNeil, & Gahm, 2010). Vasterling, Daly, and Friedman (2011) claimed that PTSD is a disorder with no single developmental trajectory; the internal and external factors feeding into psychosis are unique to each individual.

Human-Animal Bond

Domestic animals have had various roles and relationships with humans for thousands of years, but it was only after World War II and the work of Dr. Levinson in the 1960s that the possible therapeutic uses of animals with human behavior received attention (Chumley, 2012; Walsh, 2009). The human-animal bond is a dynamic relationship between people and animals that results in positive psychological and

physiological influences observed in a number of environments (Gregg, 2012; Walsh, 2009). The bond is linked to decreased blood pressure, relief from depression, reduced anxiety, and increases in overall feelings of well-being. These findings are especially relevant for socially isolated individuals in facilities such as nursing homes, hospitals, and prisons (Beck & Katcher, 2003; Britton & Button 2005; Chumley, 2012; Coren, 2003; Furst, 2006; Lefkowitz et al., 2005; Sacks, 2008; Turner, 2007; Walsh, 2009; Yorke, 2010).

Some theories about the relationship approach the topic use biological or evolutionary, neurological, and social support explanations; others use cognitive explanations (Beck & Katcher, 2003). Pinpointing the theory that best explains the human-animal bond is beyond the scope of this paper. However, the author recognizes that some individuals experience physical and psychological benefits as the result of a relationship with an animal.

The therapeutic influence of animals has been widely accepted outside of empirical evidence (e.g., Walsh, 2009) but the use of the human-animal bond as a potential tool for combat-related PTSD was only recently acknowledged through the findings of researchers at Walter Reed (Alers & Simpson, 2012; Beck et al., 2012; Gregg, 2012; Shubert, 2012; Yeager & Irwin, 2012; Yount, Olmert, & Lee, 2012). The overwhelming favorable response to the introduction of animal-assisted activities at Walter Reed is promising, but a structured program is required for empirical testing.

Nature of the Study

Moustakas (1994) stated that qualitative research enables people to describe their unique experiences and understanding of the phenomenon being researched. In this study, the subject was the experiences and perceptions of OEF and OIF veterans regarding their PTSD symptoms and their companion animal. The goal was to determine if (a) patterns existed among PTSD symptoms, (b) the participant relationships with their companion animals included therapeutic qualities, and (c) participants had any other common experiences that could have implications for future research.

Posttraumatic stress is recognized by a hypersensitivity to trauma-related stimuli in which observable symptoms manifest differently for each individual (APA, 2013). With this sensitivity in mind, the phenomenological approach considered the personal elements that create the experience in order to understand the relationship between the consciousness developed and the existing objects in the individual's world (Moustakas, 1994). The author wanted to understand the experiences behind the service members' gravitation towards animals, because that understanding could help in the discovery of new treatment tools. To accomplish the above goals and gain a deep understanding of the perceptions behind the phenomena, it was determined that in-depth interviews could best elicit the experiences analysis using the phenomenological methodology suggested by Moustakas (1994). Chapter 3 provides a complete discussion of the methodology used in this study.

Definitions

This paper uses terms that require definition for the reader.

Animal-assisted therapy (AAT). AAT is a goal-directed intervention directed or delivered by a health and human service professionals with specialized expertise and within the scope of practice of their profession. The goal of the AAT design is to promote improvement in the human physical, social, emotional, or cognitive functioning (Delta Society. n.d.).

Animal-assisted activities (AAA). Animal-Assisted Activities are the casual "meet and greet" activities that involve pets visiting people. The same activity may be offered to many people at the same time, unlike a therapy program that is tailored to a particular person or medical condition (Delta Society, n.d.).

Companion animals. A term recognized, but not legally defined. Commonly referred to as a pet (Delta Society, n.d.).

Human-animal bond. Also known as the human-animal interaction, this concept identifies basic developmental and therapeutic dynamic interactions between people and animals and the relationship's impact on the human physical and psychological health and well-being (Griffin, McCune, Maholmes, & Hurley, 2011).

Posttraumatic Stress Disorder (PTSD). An anxiety disorder that occurs following exposure to a traumatic event where the threat of serious injury or death was experienced or witnessed causing feelings of intense fear, helplessness, or horror (APA, 2013). Throughout this paper, PTSD is used interchangeably with posttraumatic stress (PTS) to

reflect the absence of a formal diagnosis of PTSD for individuals who experience the disorder symptoms, but have not followed through with mental health services.

Reserve Component. The entity of the United States Armed Forces consisting of the state controlled Army National Guard and Air National Guard forces, and federally controlled reserve forces from the Army, Navy, Marine Corps, and Air Force. The majority of personnel attached to Reserve Component units maintain a 'part-time' status unless activated (DoD, 2007).

Service animal. A service animal is any dog individually trained to do work or perform tasks for the benefit of an individual with a disability. This can include guide, mobility, sound alert, and medical alert or response work. Their work is *"handler-focused"* specifically trained to the owner's disabilities. Federal law generally permits qualified people who have disabilities to be accompanied by their service animals in all places of public accommodation. Service animals are not considered pets (Delta Society, n.d.).

Service member. Individuals on active status with one of the service departments or attached to the Reserve Component. When addressing OEF and OIF service members, this indicates that the individual was on active status at the time of his or her deployment, but may have retired or separated from military service since (DoD, 2007).

Therapy animals. Therapy animals are trained to provide specific human populations with appropriate contact with animals. They are usually the personal pets of the handlers and accompany their handlers to the sites they visit, but therapy animals may

also reside at a facility. Therapy animals are usually not service animals (Delta Society, n.d.).

Traumatic event. A traumatic event is any event or experience that involves the threat of death, serious injury, or damage to physical integrity, which elicits intense fear, helplessness, or horror. The event may be experienced directly or witnessed (APA, 2013).

*Veteran or veteran status***.** Individuals who have separated from the military through retirement, completion of service commitment, medical review board, etc. This term applies to individuals who served with either active units or Reserve components (DoD, 2007).

Wounded Warrior. Any military service member who incurred service-connected wounds, injuries, or illnesses on or after September 11, 2001. Initially founded by the Army and located in Washington D.C., each military service manages their own Wounded Warrior Program for their specific personnel after initial assessment at Walter Reed (WNMMC, n.d.). For simplicity, this paper refers to Wounded Warriors at the Walter Reed rehabilitative center.

Assumptions

This study was subject to several assumptions. The primary assumption with this study was the severity of PTS symptoms, and their associated issues were severe enough to limit the participant's ability to function at times. A second assumption was that the participants' answers were an honest representation of their experience, so as not to bias

the study results (Creswell, 2007; Moustakas, 1994). Reports of symptoms, experiences associated with OEF and OIF deployments, and the participants' companion animals were assumed to be true. The third assumption was that participants understood the meaning of PTSD and its symptoms, as it relates to psychological distress due to combat exposure. Chapter 2 discusses the initiatives that directed military departments to provide educational training on PTSD and associated symptoms, as well as the required psychological screening at specific time intervals before and after combat deployments. Further discussed in the next chapter is the formal diagnosis of PTSD, which must come from an approved clinician or mental health office, but does not necessarily reflect the existence of PTS in service members.

Limitations

This study was subject to two limitations. First, ownership of an animal is not representative of the military population as a whole. For example, a number of younger active duty military members reside in government dormitories, which prohibit pets. Second, the study sampled military members with combat-related PTSD symptoms resulting from operations supporting OEF or OIF; the results are not representative of PTSD created by other traumatic events (e.g., sexual assault). This project is also not representative of other psychological issues associated with OEF and OIF combat exposure, such as substance abuse and depression not comorbid with PTSD. Despite the study's limitations, the researcher anticipates the findings will provide insight into the

relationship between the human-animal bond and combat-related PTS symptoms, with possible implications toward developing updated treatment options for future research.

Scope and Delimitations

The scope of this study included the individual experiences of 12 service members with combat-related PTSD symptoms as a result of service in OEF and OIF and the have a companion animal. The interview questions functioned as the tool towards understanding the experiences from the participant's perspective. The questions did not specifically request the participants to relive the traumatic event(s), however, information shared about their deployments or the traumatic event was recorded as part of the transcript.

The investigation of a specific population and their experiences may affect the outcome and prospective use of findings (Creswell, 2007). The eligibility criteria did not restrict the type of companion animal; however, the results may not be representative of the relationships with animals not included in the study. The findings do not address psychiatric conditions other than symptoms developed from posttraumatic stress, whether formally diagnosed or not.

The decision to sample the OEF and OIF military population reflects two problems identified with the use of research on a given population of Vietnam veterans in policy-making. First, the selection of OEF and OIF personnel provides the first chance of obtaining a sample of individuals with more recent onset of posttraumatic stress symptoms. Second, the length, frequency, and lethality of OEF and OIF combat

operations are the first of its type since Vietnam, and due to the all-volunteer status of today's Armed Forces, many individuals experience multiple deployments to combat environments. The diathesis model of stress recognizes that individual factors interact with varying severities of environmental exposure – according to this model, the increased frequency and lengths of deployments lower the disorder vulnerability threshold. Kessler et al. (1995) found that the longer treatment was delayed, the greater the risk complication of other issues and of treatment not succeeding. A final boundary of the sample selected was to reduce the chance of comorbidity of other issues complicating PTSD symptoms. This does not mean that participant symptoms were not complicated by comorbidities. Rather, that one aspect of selecting individuals whose combat experiences were more recent may reduce the chance of comorbidity with other problems.

Significance

One major obstacle with combat preparation is the prediction of whether personnel will be exposed to traumatic events and the severity of all possible situations. Lessons learned from previous wars taught leaders and policy makers that immediate intervention and access to treatment is needed to counter the psychological impacts of war (Kessler, 1995). OEF and OIF operations demonstrated the complexities engaged with providing care. When adequate services are not received at the onset of distress, the development of adaptive behaviors exists, often creating complications and resulting in

lengthier and more extensive care (Courtois, 2008; Kessler, 1995; Litz, 2007; Tanielian et al., 2008).

Even as combat operations decrease in Afghanistan and Iraq, the suicide rate of 18.3% (across all military departments) remains above the national average of 11.3% (National Institute of Mental Health, n.d.), and has claimed more lives each year, from 2008 to 2012, than the number of combat related deaths (Armed Forces Medical Examiner, personal communications, January 25, 2013; Kuehn, 2009). Increased reports of violence among OEF and OIF personnel (Adamson et al., 2008; Kessler et al., 1995; Leonning, 2012; Litz 2007) and the number of homeless veterans remains alarmingly high as they make up approximately 14% of the homeless population (Perl, 2012). Lastly, the Congressional Budget Office (CBO, 2011) reported that the VA has spent over $48 billion to treat all the veterans under their care, regardless of conflict. Of this amount, the VA spent an average of $3,800 to $8,300 per year/per individual with PTSD. The per year/per individual cost can increase to $136,000 for personnel with complex or polytrauma, commensurate with the complexity of care required (CBO, 2012). The cuts threatened in the 2012 Presidential Budget (Herb, 2012) and the backlog of PTSD claims introduced by Arbisi et al. (2004) and Marx and Holowka (2011) may mean that some of the America's veterans will go without treatment or instead be approved for a curtailed program. Despite the deployment related-screenings conducted to identify personnel displaying PTSD symptoms, individuals failing to follow through with mental health

services is believed to be the leading factor of increased occurrences of suicide and violence among military members.

The decision to research the human-animal bond and combat-related PTSD was inspired by the stories of deployed service members adopting stray animals for emotional and psychological support during war. The anecdotal reports suggest a therapeutic fulfillment unmet by the traditional treatment modalities, but the literature is scarce. Creating a scholarly foundation regarding the phenomena provides others the groundwork for future research.

An additional area of social significance lies in the concept of Walter Reed's *Dog Tags* program, where wounded warriors assisted in the care and training of shelter animals at the local Humane Society. This program is similar to existing prison pup programs (see Britton & Button, 2005; Furst, 2006; Harkrader et al., 2004; Turner, 2007; Yorke, 2010). The Walter Reed and Washington Humane Society *Dog Tags* program positively influenced the lives of the homeless animals under the shelter's care by creating obedience trained, adoptable pets while providing an alternative therapeutic tool; many participants reported periods of relief from their PTSD-related symptoms while working with the animals (Alers, 2012; Yount et al., 2012). Readdressing the creating of a scholarly work for future research, the concept of helping others (even animals) as part of the therapeutic process, addresses an additional social issue: homeless animals and the overcrowded status of animal control shelters. An estimated 5 to 7 million animals enter

shelters annually; approximately 4 million are euthanized due to a lack of space and limited finances (American Society for the Prevention of Cruelty to Animals, 2010).

To generate an interest to conduct further research, the potential audiences for dissemination of findings include military service members, clinicians dealing with combat related or other trauma responses, and DoD and VA program developers as well as evaluators responsible for the development of standardized programs. Another avenue of dissemination would be the publication of this dissertation in professional journals (e.g., APA journals, Military Medicine, or operational journals) and appropriate for animal-related magazines, humane society and animal rescue newsletters, as well as special interest literature.

Summary

Shortly after the start of OEF and OIF, one concern of senior military leadership was the mental health of individuals returning from combat. The DoD and VA are responsible for establishing policies and funding to meet the needs of those who suffer as a result of trauma exposure. Unfortunately, it is questioned whether the policies, based on research of Vietnam era veterans, meet the needs of the current generation of American military members and multiple combat environments. Stigma and barriers to care continue to challenge policy makers with providing service members and veterans the help they need, especially in an environment filled with threats of continued budget cuts and increased medical costs.

PTSD is a unique disorder with multiple trajectories. Explaining why some people develop PTSD and others do not is as complicated as developing effective treatment options and resilience training. Nevertheless, as the primary provider for the military population, the VA requires treatment modalities to be empirically supported prior to use. This study provides a phenomenological understanding of the human-animal bond and combat-related PTSD. Stories surrounding OEF and OIF service members adopting stray animals for emotional support provided credence to existing literature on the therapeutic benefits of the human-animal bond with other populations. Yet, a study dedicated to understanding the phenomenon with combat-related PTSD was not found and the scarcity of literature on this topic in general justified the exploratory nature of the study. Understanding the perceptions behind the human-animal bond and combat-related PTSD provides insight to an important question, why do people in duress gravitate to animals. The findings of this study are appropriate for potential inclusion towards the development of future treatment options and research.

Chapter 2 reviews the literature on PTSD and the human-animal bond, and includes a section on the therapeutic uses of the human-animal bond in nonmilitary settings. The chapter concludes with a review of Walter Reed's 2012 report on the introduction of canines to relieve stress and improve the therapeutic environments in combat and in military medical facilities.

Chapter 3 discusses the methodology used to investigate the PTSD symptom and human-animal bond phenomenon. The results are presented in Chapter 4. Chapter 5

includes a summary of the findings, the implications for positive social change, the limitations, and the directions for further research.

Chapter 2: Literature Review

Introduction

Over two million United States service members have deployed in support of combat operations in Afghanistan and Iraq since October 2001 (DMDC, 2012). The number of combat-related deaths has remained under 1%, largely due to advancements in medical care and global mobility (DMDC, 2012; Department of Defense [DoD], 2012). However, a combat-related casualty is not always related to physical wounds. They can also be caused by prolonged exposure to combat. But these wounds are invisible.

A 2008 study of mental health issues surrounding Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), reported that the DoD and Veterans' Affairs (VA) recognized the need for policy changes and the reappropriation of funds to support the mental health needs of an increasing number of military members returning with psychological issues (Tanielian et al., 2008). As noted in Chapter 1, problems persist in addressing combat-related mental health issues for both active duty personnel and veterans; the use of military mental health services remains under 50% (Erbes, 2007; Hoge et al., 2004; Tanielian et al., 2008).

The following topics are covered in this literature review: (a) the theoretical and conceptual basis for the study, (b) a historical overview of combat-related trauma and the development of posttraumatic stress disorder (PTSD), (c) the lessons learned after 10 years of war in Afghanistan and Iraq, and (d) the human-animal bond. To identify relevant material, the following databases were used: Academic Search Complete,

Academic Search Premier, ERIC, PsycARTICLES, PsycINFO, Psychology: A SAGE Full-Text Collection, and ProQuest Dissertations and Theses. The following keywords were used: *posttraumatic stress disorder, PTSD, combat-related trauma, risk factors, treatment utilization,* and *barriers towards care*, *pets, human-animal bond, pet therapy, animal-assisted therapy, animal-assisted activities,* and *prison pup programs*. Additional material was found on the RAND Corporation research database, the VA National Center for PTSD website, and the International Society for Traumatic Stress Studies website.

Database searches were conducted from December 2011 to October 2012. Eligible articles were not limited to the past 5 years, but by whether they were original works and relevant to the discussion. For example, literature on the history of PTSD is considerably older than articles focusing on the OEF and OIF population. Table 1 presents the resources used for the literature review and development of the methodology implemented in this study.

Table 1
Summary of Search Results by Topic

Topic	Peer-reviewed articles	Books	Other (i.e., news articles, DoD data sources, etc.,)
PTSD	66	10	7
Human-Animal Bond	22	3	10
Theoretical Foundation/ Conceptual Framework	6	2	0
Methodology	1	4	1
Other [a]	0	0	10
Total	95	19	28

[a] Note: includes suicide rates, deployment rates, information from Walter Reed National Military Medical Center, etc.

Conceptual Frameworks and Theoretical Foundation

This study approached the subject matter through the conceptual frameworks of constructivism and phenomenology. These concepts describe the unique nature of the human experience based on the construction of knowledge and perception. The theoretical framework, the diathesis-stress model of PTSD, describes the development of the disorder through understanding the interaction of life experiences with traumatic events. A brief overview of each framework follows.

Constructivism

Contributions to constructivism come from early philosophers such as Socrates and Immanuel Kant. At its core, constructivism posits that knowledge is individually constructed based on the interpretations of social contexts and world experiences (Mayo, 2010). This view states that knowledge and the individual organization and structure of experiences is unique for each person. Mayo (2010) believed that constructivism embraces the elements of critical thinking commonly associated with Socratic questioning to facilitate self-derived knowledge that is continuously challenged by new experiences and information. Kant wrote, "Human beings construct their own bases of knowledge" (as cited in Mayo, 2010, p. 34), a belief that grew into the modern concepts of *construct* and *schemata* by contemporary constructivists to describe the development of cognitive categorizing and meaning association.

Moving forward to the end of the nineteenth century, William James (1907) asserted, "Human beings are practical creatures who use their cognitive capacities to adapt to their environment" (as cited in Viney, 2001, p.213) through *native reactions*, which drives cognitive processes, and the process of *reaction of ownership* that personalizes the association between ideas (Mayo, 2010; Viney, 2001). These adaptive, internal capacities characterize the unique and subjective nature of knowledge, because previous knowledge and opinions influence the association of new experiences and vice versa. John Dewey, who believed that knowledge is composed of actions, further supported this notion. Dewey held that every act created new meaning, enhanced by the presence of language to share these formulated ideas between people (Kivinen & Ristela, 2003; Mayo, 2010). Today, constructivism commonly aligns with academic and instructional techniques, largely due to the research conducted by Jean Piage and Lev Vygotsky. However, constructivism's well-established roots in epistemology focus on both the historical growth of knowledge and the individual justification of the truth of knowledge (Cobb, 2000).

Phenomenology

Transcendental phenomenology (hereafter phenomenology) originates from Edmund Husserl's love for philosophy and interest in the human experience. Central to his approach is a philosophic system, rooted in a subjective openness to search for meaning in phenomena; Husserl believed "phenomena were the building blocks of human science and the basis of all knowledge" (as cited in Moustakas, 1994, p. 26).

Phenomenology encompasses both a philosophical movement and an approach to research. "The phenomenon is what appears in the consciousness . . . and any phenomenon represents a suitable starting point for an investigation" (Moustakas, 1994, p. 26). Similar to constructivism, phenomenology's philosophical influences seeks to understand the meaning and essence of knowledge that is grounded in physical reality as well as in mental or psychological reality. The shadow of Descartes's objective reality, "I think, therefore I am" is evident (Moustakas, 1994).

Another philosophical influence, Aristotelian philosophy, inspired Husserl's concept of *intentionality*, the consciousness or internal experience of being conscious of something, whether real or non-real (Moustakas, 1994). Husserl labeled the two stages of intentionality as *noema* and *noesis*. Noema refers to the sensory quality, or the perception, of an object and the noesis represents the psychical elements, or the self-evidence, of the experience. Moustakas (1994) described the challenge of understanding human experience:

> [It] is to describe the elements or things of a phenomenon in themselves, to permit what is before one to enter consciousness and be understood in its meanings and essences in the light of intuition and self-reflection. The process involves a blend of what is really present with what is imagined as present from the vantage point of possible meanings; thus a unity of the real and the ideal. (p. 27)

Diathesis – Stress Theory

The diathesis-stress theory of PTSD describes the development of the disorder as an interaction between the individual and their environment. Shortly after the inclusion of PTSD into the APA's *DSM III* in 1980 (APA, 1980), it was quickly discovered that, depending on the population, only a fraction of individuals develop psychopathy after exposure to trauma. The question to answer was *why*. Research discovered etiological factors present in individuals who developed PTSD; the challenge was to understand and predict how personal factors interacted with environmental events.

Historically, the word *diathesis* was associated with medicine to represent a biological or genetic predisposition to a condition or disorder – more commonly referred to as a risk factor. But as research continued to identify personal influences associated with PTSD development, the word diathesis in its definition, also came to include the personal characteristics more susceptible to stress (Monroe & Simons, 1991; Zuckerman, 1999). As it relates to traumatic stress, *diathesis* covers personality traits, childhood familial environments, biological and genetic factors, social support, and former patterns of psychological stress responses (Benight, 2012; McKeever; Huff, 2003, Monroe & Simons, 1991; Zuckerman, 1999). The *stress* or stressor identifies an environmental element or event to which exposure may or may not naturally exceed an individual's capacity to cope (Zuckerman, 1999). As a theory, the diathesis-stress model considers internal and external elements, recognizing that individual risk factors (diathesis) combine with the severity of a traumatic event to create vulnerability toward psychopathy

(Benight, 2012; McKeever & Huff, 2003, Monroe & Simons, 1991; Zuckerman, 1999). McKeever and Huff (2003) further contend that every person maintains a level of predisposing risk factors toward PTSD development.

Applying the theoretical framework, as PTSD risk factors increase (e.g., number of previous combat traumas or other personal stresses), the severity of a traumatic event required for an individual to "break" decreases. Unique to combat deployments, each incident of exposure to a traumatic event – whether multiple exposures within one deployment or over multiple deployments – increases PTSD vulnerability (Adler, Huffman, Bliese, & Castro, 2005; Duma, Reger, Canning, McNeil, & Gahm, 2010; Hoge et al., 2004). The additional stressors that accompany the deployment experience, such as the separation from family and friends and austere living conditions, compound the personal diathesis already present to interact with combat elements.

These conceptual and theoretical influences represent the unique, individually specific nature of trauma-related psychopathology. Constructivism and phenomenology explain the various pathways to building knowledge, which develop individual perceptions and meanings into experiences; given the same event, the interpretation and meaning associated with an experience, may differ between people. Understanding the differences with the cultural and social influences associated in creating knowledge and meaning and how the differences influence an individual's ability to cope and adapt is an important element of the diathesis-stress model. The next section of this chapter focuses

on the lessons learned about PTSD after the wars in Iraq and Afghanistan and the issues challenging military leaders in how to treat the population.

History of a Disorder

Exposure to trauma and extreme stress has confronted humans since the beginning of time, but the concept of PTSD only recently described the individual distress experienced after exposure to traumatic events. Historic figures such as Homer's Ulysses and Henry IV were noted to have responded to war experiences with profound reactions (Friedman & Marsella, 1996), but it was not until the Civil War when the psychological disturbances experienced by soldiers were documented and discussions began regarding the psychological experiences of war. As the Industrial Revolution introduced the innovation of train travel, a high number of civilian complaints and litigations followed the large number of rail crashes that occurred in the early years. Names such as *railway spine* or *post-concussion syndrome* experienced by survivors were used to identify symptoms of sleep disturbances, avoidance of future train travel, irritability, and nightmares of the crash (Lasiuk & Hegadoren, 2006a).

World War I introduced the first attempts to provide psychiatric services close to the front lines for soldiers experiencing *combat neuroses* or *shell shock* resulting from the gruesome nature of trench warfare and the extended combat exposure (Friedman & Marsella, 1996; Jones & Wessely, 2003; Lasiuk & Hegadoren, 2006a; McKeever & Huff, 2003). Despite indications that war affected some soldiers emotionally and psychologically, the common opinion believed that personality problems or character

deficiencies were the catalysts behind distresses experienced, directing research toward creating tests to screen military recruits for service eligibility (Boone & Richardson, 2010; Lasiuk & Hegadoren, 2006a, 2006b). The experiences from the various world wars, coupled with documentation from the Civil War and the railroad incidents, raised the debate of whether the responses to specific events were organic to a disorder. This debate continues today. Due to a lack of empirical research and an unclear connection between psychological trauma and combat, the belief that the human responses to trauma were a result of personal weaknesses and inabilities to cope remained for some time (Boone & Richardson, 2010; Friedman & Marsella, 1996; McKeever & Huff, 2003). This belief was evident in the first two editions of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) through the classifications of *gross stress reaction* and *anxiety neurosis* to address the symptoms experienced following trauma exposure (APA, 1952; APA, 1968).

The Vietnam War was crucial to the understanding of the psychological impacts of war (Boone & Richardson, 2010; Lasiuk & Hegadoren, 2006a, 2006b; Luz et al., 2011; McKeever & Huff, 2003). The introduction of a traumatic event as the catalyst of psychological distress, released in *DSM-III* (APA, 1980), abandoned much of the victim-blaming tendencies with trauma response. The inclusion of PTSD in the diagnostic manual also corrected errors made in diagnosing and treating military members returning from war; returning veterans were commonly hospitalized for schizophrenia or other psychiatric disorders prior to 1980 (Boone & Richardson, 2010; Ozer et al, 2003).

Included in the push toward understanding the psychological impact of war and trauma was data obtained from investigations of cases of civilian rape, domestic violence, and child abuse (Lasiuk & Hegadoren, 2006a; McKeever & Huff, 2003). The *DSM-IV-TR* (APA, 2000) defined PTSD as an onset of symptoms consisting of re-experiencing, avoidance, numbing of responsiveness, and increased arousal following an exposure to a traumatic event.

As recognition of a traumatic event as the primary etiological factor gained support, the focus shifted toward finding characteristics that increased an individual's vulnerability to PSTD and how those factors influenced individual responses. Researchers recognized the simple fact that while many people are exposed to traumatic events, only a small fraction develops PTSD. The question became why.

PTSD Prevalence

In studies using samples from the United States population, the lifetime prevalence of non-combat related PTSD averaged 8 to 15% for women, and 5 to 10% for men. Rates in Vietnam veterans typically ranged between 20 to 30%, but some studies suggested rates as high as 60% (Gates et al., 2012; McKeever & Huff, 2003; Ozer & Weis, 2004; Ozer et al., 2003; Ramchand et al., 2010). Epidemiological studies showed men possess a higher lifetime prevalence of *exposure* to trauma, but as indicated above, rates for the *development* of PTSD is almost twofold for women (Lasiuk & Hegadoren, 2006a; McKeever & Huff, 2003; Ozer & Weiss, 2004; Ozer et al., 2003). A number of factors believed to influence gender differences in response to trauma, including

hormonal influences and women's increased exposure to more assaultive types of trauma (McKeever & Huff, 2003; Yehuda, 1999). Research regarding gender differences in PTSD prevalence of OEF and OIF was not found during the literature research for this project; however, the National Center for PTSD (VA, 2012) has stated that this area needs exploring as female military members are exposed to a higher risk for sexual assault while deployed. Further explanation of the gender differences in PTSD prevalence is beyond the scope of this paper.

Risk Factors

Following the introduction of posttraumatic stress as a diagnosable disorder, research sought to answer the question of who develops PTSD. In two separate meta-analysis studies reviewing research on PTSD risk factors, beyond the severity of the traumatic event, authors identified several risk factors that play a role in determining persons more at risk for developing PTSD. Those risk factors include: (a) gender, (b) level of education, (c) psychiatric history, (d) lack of social support, (e) previous traumatic experiences, and (f) socioeconomic status (Brewin, Andrews, & Valentine, 2000; Ozer et al., 2003).

One final risk factor that received considerable focus is the biological implications associated with PTSD. McKeever and Huff (2003) and Yehuda (2002) suggested that cognitive and behavioral responses can become highly adaptive to stress, but when an individual experiences prolonged exposure or if the stimulus is severe enough, permanent alterations to neural networking and functioning can occur. The

deterioration of physical structures along with the abnormal functioning of the structures responsible for sensory perception and regulation have been found in individuals diagnosed with PTSD (Friedman, 1991; Karl et al., 2006; Klaassens et al., 2010; Weiss, 2007; Yehuda, 2002, 1999). Specific areas of interest include the prefrontal cortex and limbic systems (e.g., decreased hippocampal volume and hyperactivity of the amygdala), the hypothalamic-pituitary-adrenal axis, and the sympathetic nervous system. The full scope of how damage or alterations to these structures influence PTSD development are not reviewed in this study, but the discovery of abnormalities is an important factor with understanding PTSD symptom severity.

Treatment

Three dominant models of PTSD treatment are used in both military and civilian populations: cognitive-behavior therapy (CBT), exposure-based treatments, and pharmacological treatments. The models, reviewed below, are the empirically based models approved for use by the VA for treatment of military personnel (Rothbaum, Gerardi, Bradley, & Friedman, 2011; VA, 2010):

1. CBTs are directive and problem-focused in nature, typically requiring 9–12 sessions at weekly intervals. Techniques include desensitization modalities such as prolonged exposure exercises and *in vivo* to address hypersensitivity to stimuli resembling the event, cognitive processing therapy to help rewire thoughts and perceptions regarding the trauma exposure, and psychological education about PTSD (Hoge, 2011).

2. Exposure-based treatments, or stimuli-desensitizing therapies, include techniques that involve repeatedly exposing patients to re-experience the traumatic event. Exposure-based models typically include various therapies such as prolonged exposure, eye movement desensitization, reprocessing, and stress inoculation training. To varying degrees, each technique facilitates incomplete information processing related to the event through generating more adaptive thoughts or coping skills. This modality should also consist of weekly therapeutic sessions for 12 to 15 weeks (Hoge, 2011; VA, 2010).
3. Pharmacological treatments remain a major portion of treatment, first due to the biological implications of exposure to stress and overall effectiveness, and secondly because of the co-morbidity issues (e.g., sleep issues, depression) often associated with PTSD (Courtois, 2008; Hoge, 2011; Rothbaum et al., 2011; VA, 2010).

Personnel referred for PTSD therapy often receive one of the psychotherapy options, partnered with a pharmacological protocol (Rothbaum et al., 2011; VA, 2010).

A major limitation with the PTSD research conducted during the 1980s and 1990s was that the sample population, Vietnam veterans, had lived with their psychological scars anywhere from 5 to 15 years or longer, prior to participating in the studies. The early research created a foundation of information to build upon, but the knowledge gained only considered PTSD from an "after the fact" point of view and not a process. OEF and OIF provided the opportunity to close this gap in literature; however,

psychological screening tools and treatment options used with PTSD for the more recent wars were created based on studies of Vietnam veterans, not a sample representative of a more current population or combat environment. The next section reviews the lessons learned from military conflicts after.

Lessons since the Vietnam War

The combat environment can create a unique stress brought on by "frequent surprise attacks in settings where it is difficult to distinguish enemies from civilians for extended periods of time, often with legal and political recoil" (Erbes, 2007, p. 359) and there is no question that the military is a high at-risk group for developing PTSD. The accountability associated with combat operations offers little room for error as service members face increasingly complex operations with decreasing number of forces. The situation is now one in which individuals are required to function more efficiently while facing uncertain and unpredictable combat and political environments (Erbes, 2007; Langston, Gould, & Greenberg, 2007).

The acknowledgement of posttraumatic stress as a disorder did not calm the arguments around its causes; debates continue over PTSD's legitimacy as well as its etiology. Defending the diagnosis of PTSD is not the focus of this paper; however, two points are clear, even for skeptics. First, there is something about the exposure to trauma that triggers psychological disturbances for some individuals, and second, "no single trajectory accurately characterizes the development or progression of posttraumatic stress reactions following exposure to extreme stress" (Vasterling, Daly, & Friedman, 2011, p.

36). PTSD is as unique and specific for each individual as the personal risk factors and situations surrounding the traumatic event (McKeever & Huff, 2003).

One goal of research generated from the Vietnam War was to assist with the psychological damages of future wars, but OEF and OIF quickly extended beyond the boundaries established by previous research. The following pages will discuss the main issues related to reported prevalence rates, DoD-mandated psychological screening, PTSD vulnerability factors, treatment quality and implementation, and the relationship between service members seeking treatment and their VA benefits. These issues were selected to identify the number of service members who were affected by combat, the factors leading to the development of PTSD, and the continued battle facing the DoD and VA in terms of caring for the military population.

Prevalence Rates

Reported PTSD prevalence rates vary depending on the sampled population, definition of PTSD criteria (e.g., acute, chronic, or delayed), and the severity of the traumatic event(s). These variables led to controversy over the legitimacy of rates reported (Gates et al., 2012; Langston et al., 2007; Ramchand et al., 2010). For example, Ramchand et al. reviewed PTSD prevalence reported in 62 studies, with rates ranging from 1 to 60%. Ramchand et al. (2010) suggested a lack of uniformity in PTSD definitions, representative samples, and type of assessment (e.g., post-deployment screening versus clinical evaluation) may have influenced the varied rates reported in recent studies.

Lower rates of PTSD exist among service personnel who generally experience less direct combat, such as the Air Force and Naval forces, as compared to the infantry and combat units of the Army and Marines. It has been suggested that the differences among military services averages out the overall PTSD prevalence and may not represent service members whose core mission is direct combat, even under-representing PTSD issues for that specific population (Erbes, 2007; Gates et al., 2012; Hoge, Castro et al., 2004). On the other hand, because assessments also rely on self-reports, differences could also exist when samples are taken from VA or clinical populations; those service members are more likely seeking treatment and less worried about the stigma surrounding seeking assistance (Ramchand et al., 2010, 2011).

PTSD Screening

Psychiatric screening in the military has been practiced since World War II, but outside of identifying mental illnesses and general aptitudes, most selection-based programs have been widely scrutinized and considered invalid (Wright, Hoge, & Bliese, 2011). Yet, beginning in 2003, the DoD decided to screen service members for PTSD, as well as other conditions immediately after a deployment and then again after 3 to 4 months (Bliese et al., 2008; Wright et al., 2011); streamlining coordination efforts to help service members receive help was the intent of the additional screening. In an early study of OEF and OIF personnel by Hoge et al. (2004), 12 to 20% of individuals scored above the cutoff point for PTSD at the 3- and 4-month assessment marks as compared to 5 to 9% immediately after returning from deployment. Thomas et al. (2010) found that a

higher number of individuals scored above the PTSD cutoff score 12 months after deployment than at the initial post-deployment screening. This finding suggests that some combat service personnel may not experience PTSD symptoms immediately after trauma exposure or psychologically recover from their deployment experiences even a year after returning home. Thomas et al.'s findings proposed implications for an immediate review of mental health policy since troop rotation between deployments is typically 12–18 months for many active duty combat units.

Risk Factors

A limitation recognized with previous research on Vietnam veterans was based on the differences that characterize the two generations (see Chapter 1). Erbes, Curry, and Leskela (2009) found that major differences existed in deployment, operations tempo, and the military department status as an "all-volunteer force" since the end of the Vietnam War, in both the active duty and reserve components. These differences are discussed below.

Multiple deployments. Reviewing deployment statistics from February 2012, of the 2.4 million service members deployed for OEF and OIF, approximately 1.2 million experienced more than one deployment (DMDC, 2012). For combat and combat-support forces, deployments typically lasted between 12 - 18 months, not including pre-deployment unit training or post-deployment debriefs (Adler, Huffman, Bliese, & Castro, 2005). Many Army and Marine units are experiencing their fifth or sixth rotation to Afghanistan or Iraq. No research was found on the effects of deployment lengths OEF

and OIF personnel, but in an assessment of Balkan peacekeeping forces, Adler et al. (2005) reported that the length of deployments was directly correlated to increased reports of depression and PTSD.

The number of deployments individuals experience positively correlates with higher reports of psychological disturbances. Examining a sample of National Guard forces, soldiers with multiple OEF and OIF deployments reported more PTSD symptoms and other psychological issues as compared to unit members after their first deployment (Polusny et al., 2009). During pre-deployment screening, service members with previous combat experience scored higher on PTSD assessments and reported experiencing more symptoms than those without deployment experience (Vasterling et al., 2010). Duma, Reger, Canning, McNeil, and Gahm (2010) selected a sample of service members returning from an OEF or OIF tour, with orders to deploy again, and found that while scores surrounding alcohol, depression, and anxiety were lower between the deployment assessments, reported levels of PTSD symptoms were not. The impact of multiple deployments was a focus in the case of Staff Sergeant Robert Bales, the military member accused of killing 16 Afghan civilians in March of 2012. Sergeant Bale's defense representative shared that he reportedly experienced PTSD-like symptoms of replaying the traumatic memories from his three previous tours in Iraq before deploying to Afghanistan in 2012.

Meaning of war, impact of killing, and guilt. The meanings associated with military experiences, notably those attached to traumatic events, are critical to the

psychological adjustments after returning from a combat environment. Research on peacekeeping units showed that psychological distress was higher in members who (a) experienced more traumatic situations during deployment, (b) felt more powerless or threatened, or (c) believed that the mission was meaningless (Currier, Holland, Christy, & Allen, 2011; Dirkzwager, Bramsen, & van der Ploeg, 2005; Hoge et al., 2004; Maguen & Litz, 2006; Orsillo, Roemer, Litz, Ehlich, & Friedman, 1998). In studies of veterans from World War II, the Korean conflict, and the Vietnam War, generalized pride about their military experience was the strongest predictor of successful mental health adjustment after military service (Maguen & Litz, 2006; Orsillo et al., 1998). Other meanings associated with deployment operations included the emotional bearing of killing and the guilt surrounding deployment experiences.

Hoge et al., (2004) conducted one of the first studies including samples of OEF and OIF personnel and reported the following data. They found that 86% of personnel had known someone seriously injured or killed, that 68% saw dead or seriously injured Americans, and that 51% handled human remains. They also uncovered that 77% of participants had fired their weapon at the enemy, 65% were responsible for the death of an enemy combatant, and 28% were accountable for the death of a non-combatant.

Held, Owens, Hansel, Schumm, and Chard (2011) discovered that trauma-related guilt derived from combat experiences resulted in a strong, positive correlation to the use of disengagement behaviors for coping with (e.g., distraction and denial) and in the severity of PTSD symptoms. Service members failing to reconcile positive meanings to

combat-related traumas were also at greater risk of developing PTSD, especially as more time passed since the traumatic event (Currier et al., 2011). Lastly, studying the deployment history of veterans from the Vietnam, Gulf, and OIF wars confirmed that having killed in combat was a significant predictor of developing PTSD (Maguen et al., 2009; Maguen, Lucenko et al.; 2010; Maguen, Vogt et al., 2010; Van Winkle & Safer, 2011). Authors also suggested that service members are typically asked questions about their deployment experiences, creating apprehension in individuals who had killed during their tour. The apprehension intensified for those service members who experienced feelings of guilt, fearing others either would not understand or judge them because of their actions.

Active versus reserve forces. Comparing reserve and active duty forces: 60% of a National Guard sample scored above the PTSD cutoff point during post-deployment assessments, leading to questions about whether part-time military personnel face additional deployment stressors than their active duty counterparts (Ramchand et al., 2011). Guard and Reserve personnel face the additional challenge of integrating back into a civilian life, because they may not be accustomed to the prolonged absences traditionally more common with active duty (Erbes, Kaler, Schult, Polusny, & Arbisi, 2011; Meis, Kehle, Erbes, & Polusny, 2010; Polusny et al., 2009; Riviere, Kendall-Robbins, Mcgurk, Castro, & Hoge, 2011; Vasterling et al., 2010). In a study comparing pre-deployment, deployment, and post-deployment stress, Guard forces scored lower in pre-deployment PTSD assessments, but scores were higher after returning from

deployment than that of active duty personnel (Vasterling et al., 2010). Federal laws protect Reserve personnel from employer reprisal after fulfilling military duties, but this protection may not cover psychological complications that develop (Department of Justice, 2010).

Traumatic brain injury (TBI) and PTSD. An in-depth review of TBI and PTSD is beyond the scope of this paper, however exposure to roadside blasts and other explosives have become an almost signature occurrence for OEF and OIF. Approximately one quarter of deployed service members experienced head and neck injuries (Hoge et al., 2008). While PTSD and TBI have different origins, research indicates that service members with TBI are more prone to PTSD, and many people with PTSD may have co-morbid undiagnosed mild TBI (National Council on Disability, 2009). The Council for Disability (2009) reviewed the symptoms of TBI and PTSD and identified the similarities including delayed surfacing of symptoms, sleep disturbances, irritability, physical restlessness, difficulty concentrating, and some memory disturbances. In a study of approximately 13,000 OEF and OIF veterans screened for TBI, Carlson et al. (2010) identified 86% of participants with a TBI had at least one additional psychiatric diagnosis and 64% having two or more. Continued research is evolving, surrounding links between TBI and PTSD regarding treatment options due to the biological and neurological similarities and issues both have resulting from combat. For more information surrounding the impact of TBI on psychiatric disorders in military veterans and associations between TBI and PTSD, see Golding, Bass, Percy, and

Goldberg (2009), Hoge et al. (2008), Tanielian et al. (2008), and Survak and Barrett (2011).

Utilization of Mental Health Programs

PTSD left untreated increases the risk of substantial personal and social issues developing. Vietnam veterans who did not enter PTSD treatment experienced increased rates of chronic PTSD, drinking and drug use (self-medication), and suicide, depression, and other co-morbid psychological disorders (Possemato, Wade, Andersen, & Oiumette, 2010; Seal et al., 2010). Decreased social functioning was also noted, which was predominantly evident in unemployed and homeless veterans.

Unfortunately, studies on OEF and OIF personnel in PTSD treatment are not promising. Hoge et al. (2004) first showed that fewer than half of the service members scoring above the PTSD assessment cutoff point at post-deployment assessments sought treatment. Hoge, Auchterlonie, and Milliken (2006) further identified this rate dropping as low as 10% in some samples. A number of barriers, discussed below, contributed to the low rates of individuals contacting mental health services.

Culture. Western cultures have become more socially accepting of individuals suffering from mental health problems, especially with military personnel who developed issues because of their military experience (Langston et al., 2007; McKeever & Huff, 2003). However, Lorber, and Garcia (2010) discovered that even with the psycho-educational classes created to further promote an environment of mental health acceptance in the military, many male service members still struggle with traditional

gender role norms, particularly when responding to traumatic events. The influence of traditional masculinity was evident when individuals perceived their ability to lead and accomplish unit missions was questioned (Kim et al., 2010, 2011).

Stigma. Closely associated with cultural concerns is the stigma attached to "mental health" and "therapy." Military personnel who scored above the PTSD cutoff point were twice as likely to report feelings of shame over seeking treatment and feared that unit members and leadership would have less confidence in their abilities and treat them differently (Hoge et al., 2004). Seven years later, Kim et al. (2011) reassessed the influence of stigma after the DoD launched initiatives to bolster leadership support of mental health services and found that a stigma attached to PTSD treatment still existed, especially in environments in which negative attitudes remained among leadership and other unit members. In addition, active duty participants held significantly lower treatment utilization rates and higher endorsements of stigma than those from the National Guard (Kim et al., 2010).

It is unclear why Guard participants reported lower levels of stigma concerning mental health assistance. In a sample of veterans from various wars, substantial stigma-related barriers concerning mental health treatment came from personal feelings of discomfort about seeking help and PTSD severity positively correlated with perceived stigma others had about mental health issues (Ouimette et al., 2011). Conversely, when analyzing the reasons veterans applied for VA mental health treatment or benefits for PTSD, Sayer et al. (2011) found that the need for tangible assistance (e.g., financial

support, access to care, education benefits) were among the most commonly reported reasons for seeking help, but only after experiencing employment difficulties and financial problems. For veterans, an additional stigma attached to PTSD treatment included concerns about being dependent on the government or labeled as "disabled" (Sayer et al., 2011).

Attitudes towards treatment and other barriers. Individual attitudes concerning mental health also affect treatment utilization rates. Querying active duty military personnel, reasons were given for avoiding or dropping out of therapy, including: (a) treatment was not effective, (b) lack of trust in mental health professions, (c) not wanting to talk about experiences, (d) medications had too many side effects, (e) scheduling appointments was difficult, and (f) mission requirements hindered treatment completion (Britt et al., 2012; Erbes et al., 2009; Hoge et al., 2004; Kim et al., 2010, 2011; Tanielian et al., 2008; Wright et al., 2009). Britt et al. (2012) and Wright et al. (2009) stated leadership attitudes towards PTSD treatment and unit cohesion directly influenced service members' attitudes and willingness to use the help available, but a numeric significance was not provided.

The availability of adequate PTSD treatment was also question as a cause for the large number of individuals not using mental health services (Tanielian et al., 2008). Litz (2007) and Tanielian et al. (2008) reported that fewer than half of individuals in treatment received the minimum care as defined by the VA. A CNN news piece (Jones, 2012) uncovered that VA primary care facilitators were not screening for PTSD and almost

one-third of potential new PTSD cases were not seen by mental health specialists within 14 days, as directed by VA policy. Also revealed was that the frequency of therapy appointments averaged once to twice a month, not weekly, also directed by the VA (Hoge, 2011; Jones, 2012).

Finally, as DoD- and VA-approved treatments continue to only include cognitive-behavior and exposure-based therapies, each requiring a minimum of 12–15 weekly sessions, the question turned to the available of care to military and veteran personnel (Chard, Schumm, Owens, & Cottingham, 2010; Hoge, 2011; Ouimette et al., 2011; Rothbaum et al., 2011; Tanielian et al., 2008; Yoder et al., 2012). First, exposure-based therapies are often not available at VA satellite locations, which tend to be the only treatment option for veterans and Reserve component personnel (Rauch et al., 2009). Second, clinician qualifications to provide the specialized techniques used to treat combat-related PTSDs was questioned as personnel were increasingly referred to civilian providers to meet the greater demands created by OEF and OIF (Tanielian et al., 2008). The VA added 1,900 mental health professionals to meet increased mental health treatment demands (VA, 2012); however, the effectiveness of the added staff has yet to be assessed.

Chard et al. (2010) compared treatment responses of veterans from the Afghan, Iraq, and Vietnam wars in a 12-week cognitive-processing program and found that higher rates of OEF and OIF veterans dropped out of treatment, whereas Vietnam veterans were more likely to require 18-32 treatment sessions. Authors suggested the chronic nature of

the Vietnam veterans' PTSD was the contributing factor requiring more treatment sessions. A final finding from Chard et al. was that OEF and OIF veterans who remained in treatment scored lower assessments after treatment as compared to their Vietnam counterparts. In another study analyzing PTSD treatment outcomes for veterans from different wars, found that fewer OEF and OIF veterans completed treatment compared to Gulf War or Vietnam veterans (Yoder et al., 2012). The dropout rates were not provided in this study, however, treatment consisted of 90-minute sessions for 30 weeks. Another point to address with the above two studies is the fact that counselors providing treatment had attended technique-specific training prior to each study.

PTSD and VA Benefits

The VA is obligated to compensate only "service-oriented" disabilities (Arbisi, Murdoch, Fortier, & McNulty, 2004; Young, 1995). The VA's definition of a service-oriented disability is determined by whether the etiological events occurred during the course of the veteran's military duties, because the VA is not in the business of compensating veterans for endogenous depression masquerading as PTSD (Young, 1995). This does not suggest that the DoD is not concerned with updating its PTSD treatment policy (VA, 2012), but rather that the VA is in a position in which it must do more with an increasingly tighter budget. In 2012, President Obama proposed a $13 billion cut to military health care, highlighting future concerns with veterans receiving help after an individual's service commitment is expired (Herb, 2012). As of this writing, no budget has been approved.

Military members in need of PTSD treatment following combat risk negated future veteran benefits and access to therapy when they do not follow through with mental health services while on active status. Pursuing assistance for PTSD-related symptoms ensures that the proper documentation is part of their medical records. The problem may be the type of PTSD treatment offered, reviewed in this chapter. The question now stands: Does the current research on PTSD warrant changing the face of therapeutic modalities to provide military personnel with appropriate treatment options?

The Human-Animal Bond

The human-animal bond has repeatedly shown to improve self-reports of physical and psychological health in a number of civilian groups, but the mental health professionals have been slow to recognize the therapeutic potential that animals may have in counseling settings, as demonstrated by the lack of empirical studies (Hooker et al., 2002; Sacks, 2008; Walsh, 2009). Sigmund Freud wrote about his early reflections of animals' bearing on the human psyche, remarking on the calming effects he experienced with his own personal canines. Carl Jung, in his theory of archetypes, described animals as the unconscious representation of one's self (Coren, 2003).

Boris Levinson first introduced pet therapy in the 1960s after using his own dog to assist in establishing rapport with children in therapeutic settings (Chumley, 2012; Hooker, 2002; Sacks, 2008; Walsh, 2009). In his early work, Levinson found that the dog's presence worked extremely well with children who were nonverbal, inhibited, autistic, schizophrenic, withdrawn, obsessive-compulsive, or culturally disadvantaged

(Hooker, 2002). Research into the use of animals ventured out to recovering cardiac patients, finding that patients with pets were 8.6 times more likely to be alive one year after experiencing a heart attack compared to patients who did not (Friedmann, Katcher, Lynch, & Thomas, 1980; Friedmann & Thomas, 1995).

Further research on the use of animals in therapeutic roles included animal-assisted activities such as interactive visits in nursing homes, in hospice facilities, with Alzheimer patients, and further rehabilitative work with special-needs children. Through observational reports by staff and patients, it was noted that the presence of animals improved psychological and emotional well-being and reduced levels of anxiety and depression in elderly patients (Barker, Knisely, McCain, Schubert, & Pandurangi, 2010; Hooker, 2002; Sacks 2008; Walsh, 2009). The presence of animals had a particularly beneficial role in strengthening autistic children's contact with reality, and activities with animal and therapist increased the social responses of the children involved (Hooker, 2002; Solomon, 2010; Walsh, 209). Of interest to the symptoms experienced by the study's target population, Solomon's (2010) qualitative work with autistic children reported that the presence of an animal increased the children's interaction with the "outside world," through nonlinguistic but highly social actions. Specifically, the dyadic engagement between children and canines featured social interactions containing the following: (a) directed responses by one player to the other, (b) indications of intent, (c) mutual behaviors, and (d) contingent activity.

Prisons Programs

Prison-based programs, albeit having different goals and agendas than a therapeutic format, are increasing in number due to the physiological and psychosocial impacts observed with inmates and the benefits of training shelter animals (Furst, 2006; Turner, 2007). It is important to mention that these programs do not follow a clinical guideline and are not considered animal-assisted therapies, per se. Prison wardens have reported improvements with overall inmate psychological well-being, increased frequency of positive behavioral reports, and reduced levels of inmate anxiety, irritability, and depression (Furst, 2006; Turner, 2007). Additional observations among prison programs were inmate reports of decreased feelings of despair, renewed sense of purpose and direction, and an increased sense of community connectiveness (Britton & Button, 2005; Harkrader et al., 2004; Turner, 2007).

Other Settings

Animal-assisted activities introduced in conjunction with traditional modalities in treating civilian trauma victims found a higher number of sexual assault victims completing treatment for PTSD with the introduction of animals to the therapeutic environment (Lefkowitz et al., 2005). During therapy sessions utilizing desensitization techniques or *in vivo* exposure, clients reported lower levels of anxiety during therapy, leading to higher rates of treatment completion. In another study, Hamama et al. (2011) examined the introduction of animal-assisted therapy in conjunction with prolonged exposure techniques in a sample of physically and sexually abused adolescent girls. The

authors reported decline in PTSD-related symptoms and a reduction of observed risk factors; these results were also found in the control group (Hamama et al., 2011).

The human-animal bond lacks a definitive theoretical framework to describe the rationale behind its therapeutic implications. The most common theory accounting for the phenomenon suggests that the animals function as tools that foster client change (Melson, 2011; Shubert, 2012). This approach suggests a cognitive role, as seen in the therapeutic uses with children (see Solomon, 2010) and a social role for those populations who maintain a solitary status, in explaining the emotional, physical, and psychological influences pets have on the human experience (see Barker et al., 2010; Furst, 2006; Hooker, 2002; Sacks 2008; Turner, 2007; Walsh, 2009). However, a neurobiological explanation has received increased research, as discussed below.

Oxytocin is a peptide produced in the hypothalamus that increases interactive behavior and is believed to be an agent of calm and connection responses (Uvnäs-Moberg, Arn, & Magnusson, 2005; Uvnäs-Moberg et al., 2011), and an area noted for future empirical research of PTSD implications by Walter Reed (Yount et al., 2012). A complete review of oxytocin is beyond the scope of this paper, but Uvnäs-Moberg et al.'s (2005, 2011) analysis of oxytocin noted that female hormones associated with the mother-child bonding during breastfeeding was also found to increase in animal studies with sensations of stroking or petting. Uvnäs-Moberg et al. (2005) identified oxytocin's pivotal role in the decreased release of corticotrophin-releasing factor, which is involved in stress reactions; in studies, rats with extra oxytocin in their system identified lower

HPA axis activity and lower blood pressure—these functions were implicated in the biological explanation of PTSD development. However, the key to this peptide is the subjective interpretation of stimuli, which may explain why individuals with no prior experience with animals or who are afraid of animals may not benefit from animal-assisted activities (Miller et al., 2009).

The Military

In April 2012, the Department of the Army's Medical Command released a special journal dedicated to observations made from a number of settings where OEF and OIF veterans participated in some type of animal-assisted activity since 2007. This section will focus on the military's history of the human-animal bond and the staff reports presented in the Army's newly released journal on animal-assisted activities, and therapies implemented at Walter Reed. The conclusion of this section includes a review of animal-assisted activities and therapies used in non-military settings, as well as their implications and limitations.

Military history with the human-animal bond. Animals have maintained an intricate part in the lives of humans fulfilling roles of substance, protection, labor, companionship, and religious or cultural symbols (Brodie & Biley, 1999; Hooker et al., 2002; Walsh, 2009). Since ancient times, animals were employed as military transportation, cavalry horses, sentry dogs, and carrier pigeons. Lieutenant Colonel George A. Custer had his dogs accompany him during campaigns for companionship, and

during World War II, General Dwight Eisenhower referred to his family terriers as the only "individuals" he could confer with without having to discuss war (Chumley, 2012).

In the years following the two world wars, St. Elizabeth's Hospital in Washington D.C. used dogs with psychiatric patients because their presence had calming effects on the psychological casualties of the trench warfare of World War I. Following World War II, an Army – Air Force convalescent center in New York State had emotionally traumatized patients work with farm animals (Chumley, 2012; Hooker et al., 2002; Ritchie & Amaker, 2012). Similar to the civilian sector, it was known that many individuals suffering from physical or emotional issues could benefit from the presence of animals, but studying the therapeutic effects of animals would go largely ignored (Sacks, 2008; Walsh, 2009; Yeager & Irwin, 2012).

Therapeutic beginnings. By 2007, when the implications of untreated psychological disturbances from military operations in Afghanistan and Iraq garnered large-scale media coverage, America launched a social outcry demanding the care of its Armed Forces. Simply screening for psychological conditions before and after deployment was not enough; help was needed while members were actively deployed to the austere and hostile conditions. However, the traditional models of debriefing and group therapy were quickly criticized by Litz (2007), who suggested that members not only maintained their attitudes about mental health services while deployed, but also that the psychological dynamics of stress response may prohibit members from processing their experiences and sharing this information. A more in-depth understanding was

required in order to help deployed members; recognizing that change was needed, the Army stepped outside of the traditional box to provide other stress relief options.

Deployed canines. One of the first animal-assisted activities introduced by the Army came early in 2007, when the Army Surgeon General sent two therapy dogs to Iraq anticipating that the dogs would provide stress relief that humans could not (Ritchie & Amaker, 2012, p. 5). This action was based on civilian literature recognizing animals' ability to reduce stress and anxiety prompted this action (Krol, 2012; Ritchie & Amaker, 2012). Combat and operational stress control (COSC) teams, responsible for handling mental health programs in combat zones, ultimately deployed eight canines Afghanistan and Iraq. As reported by COSC teams, the presence of the deployed canines reduced the negative attitudes associated with participating in stress-relieving activities and enhanced the facilitation of mental health care services (Gregg, 2012; Krol, 2012). Of special note, COSC teams believed that personnel knowing they could interact with animals during the sponsored activities increased the number of people who participated and enhanced the rapport building phase with COSC teams (Chumley, 2012; Gregg, 2012).

Walter Reed programs. In 2008, Walter Reed introduced a variety of animal-assisted activities to its wounded warrior rehabilitation programs. In an interesting twist to their programs, the Army medical facility also paired with a local animal shelter, expanding the physical settings of available activities (Yeager & Irwin, 2012). To date, Walter Reed appears to be the first military hospital to have investigated the therapeutic use of the human-animal bond in non-traditional therapeutic settings.

Yeager and Irwin (2012) discussed the variety of programs where recovering combat veterans interacted with service dogs, therapy dogs, service-dog training, and animal-assisted therapy. Pairing with a variety of nonprofit organizations who trained service animals, the specifically trained service dogs were trained and then matched to wounded warriors in rehabilitation. In addition to specifically matched service dogs, recovering personnel were also able to use trained therapy dogs in a number of rehabilitative exercises during the recovery process at Walter Reed's Military Advanced Training Center. The Military Advanced Training Center is a multidisciplinary entity providing services from the initial surgery through reintegration in the armed forces or transition to veteran status. It is not clear if the activities using therapy dogs during any of the physical rehabilitation processes followed a set procedure or if the animal was merely present (Yeager & Irwin, 2012).

Wounded warriors also participated in a service-dog-training program, the Warrior Canine Connection, in which patients at Walter Reed trained service dogs for other veterans with combat-related physical disabilities (Yeager & Irwin, 2012). Finally, wounded warriors received animal handling and grooming training with the Washington D.C. Humane Society *Dog Tags* program. This program placed wounded warriors in charge of the care and training of the homeless animals in the shelter. The shelter staff did not provide a statistic on the number of animal adoptions resulting from the program, however, they reported the regular exercise, care, and training that animals received from

the wounded warriors increased the quality of life for the animals and overall placement of animals into permanent homes (Alers & Simpson, 2012; Yeager & Irwin, 2012).

The authors also studied animal-assisted therapy. Clinicians providing PTSD therapies introduced their personal, therapy certified animals as "co-therapists" to enhance rapport building and the therapeutic process. Similar to the deployed canines, the therapy dogs enhanced the patient-counselor rapport building and overall ease of the patient during therapy sessions (Yeager & Irwin, 2012). The discussion on the relationship between service dogs and veterans with PTSD follows.

Service-dog training and PTSD. As mentioned above, the Warrior Canine Connection program was a specialized animal-assisted activity to have Walter Reed patients train service dogs for other combat veterans. Not mentioned earlier was that the program was specifically created for wounded warriors with PTSD. Similar to the *Dog Tags* program with the Washington D.C. Humane Society, the Warrior Canine Connection assists participants with mastering control of their emotions, focus, and social competence, as these skills are required when training a dog (Yount, Olmert, & Lee (2012). Training for both the wounded warrior and the dog begins with simple, basic obedience commands and gradually developed into tasks that were more complex. The concept, mastering of the wounded warrior's emotion and focus, was often correlated with the level of task complexity the dog was capable of accomplishing. This type of activity required the participant to confront social environments, each step creating more

comfort for the individual with PTSD and building on the attention skills of the service dog in training. As of the writing of this paper, the program is still in operation.

Therapeutic Implications

The Walter Reed hospital staff observed a number of behavioral and emotional changes in the wounded warriors participating in animal-assisted activities. Of special interest, patient responses identified an increase in patience, impulse control, sense of belonging, and improved sleep, as well as statements of decreased emotional numbness and complaints over depression and anxiety (Alers & Simpson, 2012; Beck et al., 2012; Yeager & Irwin, 2012; Yount et al., 2012). Additionally, fewer pain and psychiatric medications were observed. Comments made by participants with PTSD and involved with the service-dog training and *Dog Tags* programs included: (a) strong bonds developed with the dogs they trained, (b) less stress and anxiety when working with the dog, and (c) renewed sense of a social connection. Highlighting the social connectedness, participants further shared feelings of increased pride through knowing their work benefitted others and renewed confidence in their ability to lead and train as they once did with their soldiers (Alers & Simpson, 2012; Yount et al., 2012).

Recognizing the importance animals have to some military members the Deputy Assistant Secretary of Defense for the Wounded Warrior Care and Transition Policy held a meeting, in 2011, to discuss policy development for service dogs on DoD installations (Watkins, 2012). One intent of this new policy is to address the establishment of animal-assisted activities and animal-assisted therapy on DoD installations, as well as

categorizing animals used to assist with PTSD cases. Watkins (2012) reported that the policy is still being reviewed and no publication date has been determined.

The mission of the wounded warriors is to heal, followed by a return to active duty or transition to veteran status. The observations by Walter Reed did not include service members outside of the Wounded Warriors program. Considering the successful reports by COSC teams in deployment theater, and the other reports by Walter Reed, introducing animal-assisted activities may be a valid alternative to reverse the underutilization rates among service members, but it lacks empirical support. Additionally, understanding why animals appear to be so successful with PTSD was not addressed. Some of the Walter Reed authors included comments made by participants, yet, no studies dedicated to the experiences of the phenomenon were located during literature searches.

Research Method

The literature reviewed on the human-animal bond was narrowed to specific examples of its application as a therapeutic tool to treat symptoms similar to PTSD and on studies using a military sample. The scholarly literature on the human-animal bond in general is sparse. Johnson (2011) believed this is due to a lack of "a unified, widely accepted, or empirically supported theoretical framework for explaining how and why the relationship between humans and animals are potentially therapeutic." Furthermore, there is a lack of a structured guidance in the application of animal-assisted activities and

therapies, which is discussed at the conclusion of this section. The methodology overview of the literature used for this review is described below.

Quantitative Studies

Barker et al. (2010) conducted an exploratory study on the stress-buffering response patterns in a purposeful sample of 10 non-clinical participants. The variables measured were the bio-behavioral responses of blood pressure, heart rate, salivary production, and self-report after participants were exposed to a stressful task, then engaged in a 30-minute dog interaction followed by 60 minutes of watching a neutral video. Participants interacted with their own pet or an unfamiliar therapy dog. Both groups showed decreases in stress patterns after the intervention of the therapy dog after the stressful task; however, the participants interacting with their own dog reported less stress and anxiety, whereas the group provided with an unfamiliar dog produced greater reductions in physiological measures. The sample in this study held favorable attitudes about animals.

Hamama et al. (2011) introduced animal-assisted activities into the treatment program of physically and sexually abused teenage girls in the investigation of whether presence of animal would reduce their psychological distress. The study included a cross-sectional, longitudinal design to determine if introducing the dog reduced the impact of PTSD symptoms and improved self-confidence as compared to the control group. The findings revealed a rapid decline in PTSD symptoms and a significant reduction in the presence of risk factors as compared to the control group.

In a quasi-experimental design, Beck et al. (2012) studied the impact of the canine-assisted activities used at Walter Reed with the Wounded Warrior program. The measures collected came from standardized assessments addressing mood, stress, resilience, fatigue, and function in a sample of $n = 24$ service members. While the studies did not retrieve significant results between the treatment and control group, this was probably due to the small sample size, participants from the treatment group reported feeling more calm and at ease in the presence of the dogs and improvements on all assessments were observed.

The subjective nature of the production of oxytocin levels led to the investigation of its potential role in reducing stress. Miller et al. (2009) conducted a crossover design to assess oxytocin levels in a sample of $n = 25$ men and women after being separated from a bonded family dog after a day of work. The results were mixed. Men possessed the same levels of oxytocin when reading and interacting with the dog, whereas women produced higher levels of oxytocin when interacting with the dog versus reading. The researchers were unclear on what generated the different responses and to what degree hormones, personality traits, levels of daily stress or activities influenced the response.

In the above review of quantitative research conducted on the human-animal bond, of note is the small sample size used in each study, which is often the case in exploratory and pilot studies. The small number of available research also (1) demonstrates a subject matter largely ignored by empirical research (Walsh, 2008) and (2) a large gap in literature given the amount of anecdotal articles available. The

following section addresses the qualitative studies found on the human-animal bond with samples of trauma survivors, or another population with similar difficulties, and military members with PTSD-related symptoms.

Qualitative Studies

In a pilot study proposing a new treatment model for sexual abuse survivors, Lefkowitz et al. (2005) introduced animal-assisted therapy to PTSD prolonged exposure techniques. The strength of this study was the succinct identification of patient apprehension to engage in a treatment in which they would re-experience traumatic stimuli, but when dogs were brought into therapy a gradual and systematic increase with therapeutic intensity occurred. The presence of a dog during treatment lowered anxieties and psychological arousal during exposure exercises and resulted in an increase in the number of patients who completed the treatment program. Lefkowitz et al. did not report the sample size associated with the study nor if participants required more therapeutic sessions than the prolonged exposure protocol suggested.

Solomon (2010) reviewed five ethnographical case studies in service dogs were introduced to the therapy of autistic children. The intent of the action was to draw the children outside of their autistic world by promoting social engagement through the interactive relationships and activities with the dogs. A symptom of autism is the more elaborated and structured social actions become, the less manageable they are for children affected by the condition. Solomon's observations outlined how the interaction between the children and dogs developed using highly repetitive, local action sequences

that required little or no speech. Solomon's findings were also very similar to those made of wounded warriors who participated in the service-dog training programs that began with minimal difficulty, and grew into highly interactive and repetitive actions, increasing in difficulty as both parties were ready (Yount et al., 2012).

The research conducted by Lefkowitz et al. (2005) and Solomon (2010) focused on specific populations that had stunted social affect yet identified the ability individuals possess to increase the levels of therapeutic complexity when animal-assisted activities were used. Similar in the problem with quantitative research, qualitative studies were also scarce. The studies that have emerged are important in the overall discussion surrounding the use of animals as a therapeutic tool, but too many holes exist for a thorough reflection and synthesis of the topic. Further, a scholarly exploration of the lived experiences of the human-animal bond and psychological disturbances was not found during literature searches, PTSD or otherwise.

Anecdotal Literature

The largest body of information regarding the human-animal bond surrounds observational and reflective commentary. Literature by Britton and Button (2005), Furst (2006), Harkrader et al., (2004), and Turner (2007) are based on observational and self-reports provided by the prison staff or inmates. The most common prison programs consist of inmates either "adopting" a small animal or volunteering to provide basic home and obedience training to shelter animals in preparation for adoption. The more frequent observations among literature cited included a lower number of behavioral problems

among the inmates participating in the animal programs, and prisoners reporting lower levels of depression and anxiety and higher levels of well-being and sense of purpose (Britton and Button, 2005; Furst, 2006; Harkrader et al., 2004; Turner, 2007).

The Walter Reed programs were overwhelmingly successful, observing decreasing stress, anxiety and the severity of PTSD-related symptoms in the wounded warriors participating in the animal-assisted activities. Yet, outside of Beck et al. (2012), the other articles were anecdotal or informative in nature (Alers & Simpson, 2012; Gregg, 2012; Ritchie & Amaker; 2012; Yeager & Irwin, 2012; Yount et al., 2012). Alers and Simpson (2012) approached their review of the Dog Tag's program with a similar, informative nature. Staff observations and self-reports were shared, but the article focused more on the actual canine training program and the number of soldiers and dogs that participated. Gregg (2012), Ritchie and Amaker (2012), and Yeager and Irwin (2012) provided a general overview of the rehabilitative canine interaction activities available at Walter Reed for recovering service members and their beliefs regarding the therapeutic implications animals have on recovery. Finally, Yount et al. (2012) reviewed service-dog-training programs specifically designed for wounded warriors with PTSD and included some comments made by participants; however, the authors noted the anecdotal nature of the study.

The major limitation is the lack of other environments using programs similar to those at Walter Reed to understand how the human-animal bond enhances the therapeutic process (Yeager & Irwin, 2012). The DoD and VA only authorize empirical proven

treatments for military-related psychological issues, requiring more than a handful of observations with added personal input by participants. This is similar to the civilian sector in which Melson (2011) identifies the struggles and challenges of researching the human-animal bond result from an absence a standardized approach to a therapeutic definition and application (see Johnson, 2011; Walsh, 2009). The anecdotal literature reviewed presents an impetus for further investigation into the understanding of the human-animal bond with combat-related PTSD.

The primary use of qualitative research is to explore novel topics about which little is known (Creswell, 2007). Because little systematic research, quantitative or qualitative, exists using the military population, the anecdotal literature provides a means for triangulation in this study. Revealing the individual experiences and perceptions living a phenomenon through a structured study may uncover themes leading a fuller understanding of the elements involved. Even with the smaller samples' sizes used in phenomenological studies, a foundation of literature is created to guide future inquiries on other populations and to provide a basis for future studies.

Summary

Combat operations supporting OEF and OIF were equipped to deal with the possible psychological issues of policies and treatments based on research conducted on a military population whose war ended five years prior to the formal identification of PTSD. The literature review supporting this study presented a historical view of PTSD and the lessons learned since the Vietnam War. The research relating to PTSD upon its

inclusion into APA's *DSM-III* (APA, 1980) provided a look into the disorder from a one-dimensional perspective in which victims had lived with their disturbances for years, possibly decades, increasing the likelihood of behavioral adaptations to develop in attempts to dull the severity of symptoms (Courtois, 2008; Kessler, 1995).

OEF and OIF provided researchers with the first opportunity to research the psychological impact of war as a process. Incorporating research learned from Vietnam veterans quickly proved ineffective for the current military generation. We know the current military generation is an all-volunteer fighting force, of which at least half of its OEF or OIF veterans experiencing more than one deployment and many of the Army and Marine combat units deploying more than four times (DMDC, 2012). Considering the diathesis-stress model of PTSD, each traumatic event, whether during one deployment or over multiple deployments, increases a person's PTSD vulnerability (McKeever & Huff, 2003).

New policies introducing pre- and post-deployment screening for psychological issues do not appear to have provided relief to the problem. The literature review showed discrepancies with PTSD prevalence due to a lack of consistency of definitions and a potential "averaging" that may result in an under representation for combat forces. A second issue was individuals who score above the PTSD cutoff during post-deployment assessments, but do not follow up with mental health services; the number of individuals seeking treatment was reported at approximately 50%, but has been as low as 10%. Investigating the reasons for the *under*utilization of PTSD treatment it was found that

specific barriers to treatment included feelings that treatment was ineffective, lack of trust toward counselors, lack of desire to talk about the traumatic events, existence of too many side effects with prescriptions, and difficulties scheduling and adhering to the treatment protocol. VA-approved treatment modalities often consist of prescribed pharmaceuticals along with therapy for a minimum of 12 to 15 weekly sessions which must be incorporated into the person's daily routine; for those on active duty and attached to a Reserve component, this means incorporating treatment with the unit's mission requirements and training, which may include preparation for a future deployment. In the evaluation of OEF and OIF related studies, not one suggested changes to treatments protocol or the creation of different treatment options.

Service members remain a high at-risk population for combat-related PTSD development as long as the potential for American involvement in war exists. One question arose through the literature review: Can findings from previous research transfer to future wars and populations? Additionally, does the individual uniqueness of risk factors require that PTSD treatments options have some component that meets each person at their level? A final question: When two barriers that keep service members and veterans from seeking treatment include (a) a lack of trust in counselors and (b) an unwillingness to talk about trauma experiences, what are chances that the current, traditional models can help those individuals?

The Department of the Army and Walter Reed embarked on a non-traditional therapeutic journey by introducing animal-assisted activities in the deployment theater

and during the rehabilitative process to ease the emotional and psychological stresses of military members. The Army's actions generated great improvement with trauma-related symptoms, including decreases in the reliance on prescription drugs required by wounded warriors, enhanced rapport establishment during stress-relieving activities, and increased numbers of participants in COSC activities in Iraq. One gap in the literature is the scarce empirical evidence on the effect of the animal-human bond in therapeutic settings, notably with a military combat population. As stated earlier in this study, PTSD-related symptoms are as unique as the individual risk factors; to understand why animals appear to relieve emotional distress a systematic approach to uncovering the lived experiences could best contribute to this body of knowledge. The intent of the proposed study is to understand the phenomenon from the individual's point of view.

In Chapter 3, the research methodology used in this study will be discussed.

Chapter 3: Research Method

Introduction

The purpose the study was to explore the experiences of a sample of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OEF) veterans, with combat-related posttraumatic stress disorder (PTSD) symptoms, and have a companion animal. Reviewing the diathesis-stress model of PTSD introduced in chapter 1, I found that the trauma experience is unique to each individual, given the personal characteristics and risk factors that interact with a traumatic event (Hoge et al., 2004; McKeever & Huff, 2003; Vasterling, Daly, & Friedman, 2011). The model also suggests that every individual is vulnerable to developing PTSD (McKeever & Huff, 2003). Applying this theory to military personnel, each experienced exposure to a traumatic event increases the risk of developing PTSD. However, providing mental health care to America's armed forces and veterans continues to challenge policy makers and military leaders. Since 2004, studies show that less than half of the number of returning OEF and OIF members scoring above the cutoff score for PTSD after deployment actually enrolled in treatment (Britt et al., 2012; Erbes, 2007; Erbes et al., 2009; Gates et al., 2012; Hoge et al., 2004; Hoge et al., 2006; Hoge, 2011; Jones, 2012; Kim et al., 2010, 2011; Lorber & Garcia, 2010; Ouimette et al., 2011; Possemato et al., 2010; Sayer et al., 2011; Tanielian et al., 2008; Wright et al., 2009).

Animals have provided relief to the psychological causalities of war. In combat environments, deployed OEF and OIF service members reported gravitating to stray

animals to ease their distress, even despite Department of Defense (DoD) guidance to avoid stray animals (Office of Multi-National Corps, 2009; Pannella, 2011; Smith, 2012). In response, the Army began introducing animal-assisted activities in various military and rehabilitative environments in 2007. In 2012, Walter Reed released a collection of observations that included increased numbers of service members participating in mental health and medical service programs. The literature also included reports of decreased psychological stress and need for prescription medication among participants (Alers & Simpson, 2012; Beck et al., 2012; Brody, 2011; Chumley, 2012; Gregg, 2012; Krol, 2012; Pannella, 2012; Ritchie and Amaker; 2012; Smith, 2012; Yeager and Irwin, 2012; Yount et al., 2012). Even as indicators pointed to the importance of animals as a potential therapeutic tool, literature on the human-animal bond among military personnel is limited to the observations published by Walter Reed. A gap in literature existed in the form of a scholarly investigation into the lived experience of combat-related PTSD symptoms and of the human-animal bond.

This chapter describes the research design and justification, my role as the researcher, the methodology, and the issues of trustworthiness.

Research Design and Rationale

Anecdotal reports from Chapter 2 introduced the phenomenon of OEF and OIF personnel finding comfort in the presence of animals, yet scholarly literature regarding the human-animal bond is scarce, and a gap in information exists regarding the lived experiences of a military sample experiencing combat-related PTSD symptoms. To

address the gap, I decided to investigate the phenomenon from the individual perspective by using a qualitative design. Creswell (2007) stated that in order to understand complex issues where no research defines why a phenomenon occur, it is beneficial to encourage individuals to share their stories in order to provide this insight. In Chapter 2, I described the uniqueness of posttraumatic stress, including the risk factors involved and the struggles symptoms create for those who have developed the disorder. Uncovering these experiences is best achieved through talking directly to people, ensuring their experiences are told, free from expectations and judgment (Creswell, 2007; Moustakas, 1994).

Accepted PTSD research traditionally revolves around quantitative methods, providing decision makers with the statistical significance to support policy decisions. However, the phenomenon existing between combat-related PTSD symptoms and the human-animal bond is a dynamic experience requiring a complex and detailed understanding. To meet this objective, it was immediately determined that the data collection methods of close-ended questions, questionnaires, and controlled tests traditionally associated with a quantitative approach were not appropriate (Creswell, 2007).

Qualitative analysis includes various research designs within the tradition. Five of the more common approaches used to investigate human and social topics include (a) narrative research, (b) phenomenology, (c) grounded theory, (d) ethnography, and (c) case studies (Creswell, 2007). All of these traditions focus on gaining knowledge about

the human experience. There are, however, important differences among them, which assisted in the determination of a phenomenological tradition for this study.

Narratives provide an in-depth view of the human experience using interviews, life histories, personal journals, and other documents of a small number of individuals. Narratives apply a technique called *restorying,* which is the process of reorganizing personal stories into a general framework, from a chronological view (Creswell, 2007). Due to the small number of planned interviews and the chronological view of life experiences involved with narrative studies, it was determined the approach was not appropriate. My goal was to understand the elements relating to the experiences after an OEF or OIF deployment and the inclusion of a pet into the participants' lives, not a reorganization of life histories of the selected population.

Grounded theories move beyond assigning meaning to an experience to create a theory through exploring the views of a large number of participants (Creswell, 2007; Moustakas, 1994). Grounded theory research analyzes the interviews of 20-60 participants, along with personal observations, documents, and other sources of data to explain a situation. The option of developing a theory through this tradition is a possibility for future research in the investigation of the human-animal bond with combat-related PTSD symptoms, but the broader boundaries associated with grounded theory research was beyond the scope of this study.

The tradition of ethnography involves extensive fieldwork, immersing researchers into the daily lives of their subjects to observe the group (Creswell, 2007; Moustakas,

1994). Ethnographic studies focus on the meaning of behaviors, languages, and interactions among a culture-sharing group (Creswell, 2007). The intention of this study was to understand the lived experiences associated with combat-related PTSD symptoms and the inclusion of a companion animal, as a phenomenon, not a culture. This difference determined that ethnography was not the appropriate tradition to explore the experiences.

Finally, case study research explores an issue through the analysis of a single or a few cases over time using several data sources. Data collection is traditionally extensive, typically requiring that six different sources of information be used during the analysis portion of research (Creswell, 2007). Two factors identified that approaching the subject matter through this tradition was not appropriate. First, due to the number of data sources required, a case study was not feasible. Second, the participants were likely to have served in the military at different times and acquired their companion animals in different ways and for different reasons; I did not anticipate finding the criteria to constitute a bounded system. On a final note, I found that the use of in-depth interviews was the best method to elicit participants to share their experiences, in an unencumbered nature (Creswell, 2007).

Phenomenology

Moustakas (1994) stated that the goal of phenomenology is to "determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description" (p. 13). Phenomenology is reflective, descriptive, and

subjective, often used to provide detailed accounts that assist in the development of policy and practices for the sampled group (Creswell, 2007). Understanding the perceptions and meanings associated with post-deployment experiences and the human-animal bond, from persons with PTSD symptoms resulting from their OEF and OIF deployments, may assist the enhancement of PTSD treatment options and provide a foundation for future quantitative studies and other inquiries.

Phenomenological studies analyze data through inductive reasoning to establish core themes and categories (Creswell, 2007). The exploratory nature of this inquiry supported the use of phenomenology to engage the stories behind the experiences of combat-related PTSD symptoms and the human-animal bond. Perception is an undoubted source of knowledge in phenomenological research; it creates a reality of the world through the subjectively colored lenses of personal experiences (Moustakas, 1994). Moustakas (1994) explained that the primary challenge to researchers is to refrain from the suppositions and judgments of the everyday or ordinary way of perceiving things.

Reducing the individual experience to its basic essence requires that the researcher become the key instrument of data collection and analysis (Creswell; 2007). The human-science researcher Moustakas (1994) embraced a focus on the entirety of an experience and a search for the essence from first-person reports on their life. This requires a researcher to abandon all personal prejudices and expectations, to approach the participants' perceptions from their point of view. To accomplish this, Moustakas (1994) used techniques of epoche, phenomenological reduction, and imaginative variation.

Epoche is a state of mind that refrains from judgment. The mental transparency does not "eliminate everything . . . only the natural attitudes, the biases of everyday knowledge, as a basis for truth as reality" (Moustakas, 1994, p. 85). Chapters 1 and 2 introduced PTSD as a unique, individual experience, dependent on the different, personal characteristics that interact with the traumatic event or multiple events. The experience of PTSD and the triggers that initiate a symptom attack are as different as the individuals who develop the disorder. The process of epoche creates a focus, clarity of thought, and a new perspective for researchers to approach the phenomenon as a blank slate, free from preconceptions of ought to be. In practicing epoche, no position is taken. The researcher is in a position to see what is before them and attain the truths of the experiences shared through reflection and meditation (Moustakas, 1994).

Creating a textural description of a phenomenal essence, through epoche, is the product of phenomenological reduction. The researcher describes what is seen in terms of both the external object and the internal act of consciousness (Moustakas, 1994). Sometimes referred to as "pure consciousness" or "transcendental ego," phenomenological reduction challenges the researcher to return to the story several times, with each visit reaching deeper into the layers of the nature and meaning of the experiencing person's inward reflection. The researcher mediates and reflects on each experience – first considering its singularity, then in its totality – to create brackets that focus on the topic and research question. According to Moustakas (1994), reduction is a

long, detailed process, further examining established brackets by constructing textural meanings and invariant constituents, then establishing and organizing horizons.

Imaginative variation arrives at a structural description of an experience through identifying the "how" of the condition, which highlights the "what" of the experience by approaching it from various angles and functions (Moustakas, 1994). In this step, the textural-structural themes are synthesized into a representative essence of the phenomenon inclusive of the study sample. Moustakas (1994) stated that the essence of any experience is never exhausted; its reflection is only specific to a particular time and place.

Research Question

The following question guided the process of understanding the experiences associated with combat-related PTSD symptoms and the presence of a companion animal:

> What are the lived experiences of United States military members who served in OEF and OIF, developed combat-related PTSD symptoms, and have a companion animal?

Role of the Researcher

Contrary to the standard procedures used with quantitative studies, researchers conducting qualitative inquiries often engage their participants in the fulfillment of their roles during data collection and analysis (Creswell, 2007, 2009; Moustakas, 1994). In this study, I filled the following roles: participant recruiter, interviewer, data collector,

interview transcriber, data analyst, and interpreter of findings. Quantitative studies rely on questionnaires or instruments to collect data; in contrast, qualitative researchers engage with participants during the data collection process (Creswell, 2007). A detailed outline of the methodology used in this study follows later in the chapter.

The number of roles a researcher may fill during qualitative research creates an environment where an individual bias may exist. This project incorporated steps to counter the potential of bias in order to safeguard the project's credibility. A participant debriefing process-required study volunteers to review a textural-structural description of their story, generated by my analysis of their in-depth interview. This review ensured that I accurately captured their story. I discuss the trustworthiness associated with the study later in this chapter.

Next, I considered the possible influences of my personal and professional affiliations on the study. To ensure that none of my associations influenced interview responses, no prior relationship existed between any of the participants and myself. Next, I reflected on my 22+ years of active duty military service. This project was not associated with a DoD agency or part of a career-enhancing program; outside organizational influence was not a factor. My familiarity with the overall military lifestyle and unique obstacles with the combat environment helped with understanding the phenomenon of PTSD, but did not create a preconceived opinion regarding the subject matter. The same critical reflection was applied to my ownership of two companion animals and volunteer experience with animal-assisted activities. Again, the

familiarity assisted with understanding the broad concept of the human-animal bond phenomenon and identifying the gaps in the literature, but did not create a bias or prejudice entering the interviews.

Lastly, regarding the nonprofit organizations contacted to assist with advertising the study, I was familiar with the operation and objectives of both organizations but I am not an active member or participant in said organizations. Despite a thorough examination of my roles as the researcher for this project, the practice of epoche, as directed by Moustakas (1994), required a great deal of reflection. The inclusion of triangulation and member checking lend further credibility to the study.

Methodology

Participant Selection

Creswell (2007) stated that the use of purposeful sampling in qualitative research assists in recruiting participants possessing knowledge of the phenomenon being studied. Moustakas (1994) further instructed that study participants must share a predetermined set of characteristics (e.g., OEF or OIF deployment) and have experienced the phenomenon to qualify for inclusion in phenomenological studies. Adhering to the guidance provided by Creswell and Moustakas, I coordinated and advertised the study, on behalf of two nonprofit organizations, to obtain a convenience sample for the study. Selecting participants through purposeful sampling adds credibility to the sample, but may not be representative of the population, limiting the generalizability of findings (Creswell, 2007). The organizations that disseminated the study flyer (Appendix A) were

Pets for Vets (www.pets-for-vets.com) and Pets for Patriots (www. petsforpatriots.org). The mission of Pets for Vets and Pets for Patriots is to match active-duty and veteran military members with companion animals. Both organizations used their social media channels (e.g., organization website, newsletter, and Facebook pages) to publicize the study. Due to the extensive networking both organizations possess across the United States and the way the study was advertised, I was unable to anticipate the geographical location or other demographics of study volunteers.

Study participation was not only restricted by the presence of PTSD symptoms due to military service supporting OEF and OIF. Additional participation criteria included (a) the ownership of a companion animal *after* experiencing PTSD symptoms, and (b) that participants were not on an in-patient status for psychological treatment; participants engaged in an outpatient treatment or therapy program were permitted. No other characteristics were identified for participant inclusion.

In the study, I interviewed 12 participants, which was sufficient to provide a variety of experiences and establish data saturation (Creswell, 2007; Moustakas, 1994). The participant recruitment flyer (Appendix A) directed interested individuals to contact my Walden University email address. I coordinated a convenient time with individuals to confirm the study (Appendix B). For approved individuals, the discussion addressed the study design, their rights as a participant, issues of mandatory reporting, and answered any questions about providing consent (Appendix C). To obtain informed consent, each participant had the option of providing consent by email or postal mail; all selected to

provide consent via email. Each participant received an electronic version of the Walden Institutional Review Board (IRB) approved consent form (04-05-13-0085310; Appendix C) and documented that they agreed to the study as described by responding to the email stating, "I consent." Participants received their pseudonyms and the interview appointment was scheduled. When individuals did not meet the study criteria requirements or did not consent to participate in the study, their personal information, including emails, were deleted.

Data Collection

The data collection process consisted of semi-structured, digitally recorded telephone interviews. Two questions (Appendix B), reflecting the study research question, were designed to navigate the interview process; participants were provided the opportunity to express comments as part of their story. The use of open-ended questions allowed the discussions to have a natural, interactive flow, and the use of prompts assisted with maintaining consistency across the individual interviews (Moustakas, 1994; Sayer et al., 2009). Related to the research question, one interview question inquired specifically about participant experiences after deployment, while the other asked about experiences after adopting their companion animal. The use of pseudonyms protected participants' identities.

The interview questions were designed to allow the participants to share their stories naturally. Questions were not intended to elicit details about traumatic events or specific PTSD symptoms; however, I recommended that participants schedule a

counseling session or another form of support with their provider on the day of the interview, if the participant was engaged in outpatient therapy. The toll-free 1-800 number for the Veteran Crisis Hotline was provided on the consent form and readily available during the study process. Literature by Ritchie and Amaker (2012) and Yeager and Irwin (2012; see Chapter 2), and others, shared accounts where the presence of an animal enhanced the patient-counselor rapport building and overall participation by individuals in various types of therapy programs. In the hope of finding a similarly enhanced rapport, participants were encouraged to have their companion animal during the interview.

The decision to conduct all interviews via telephone was made in order to maintain consistency in the data collection process with each interview; because of the far-reaching networks of Pets for Vets and Pets for Patriots and the social dissemination of the study flyer, participants lived all over the United States. Prior to beginning the digitally recorded portion of the discussion, I reviewed the mandatory reporting requirements, as outlined in the informed consent, and provided participants the chance to ask any questions. The recorded telephone interviews varied in length, but averaged between 30 and 90 minutes. The disparities in interview lengths reflected the amount of information each participant was comfortable sharing or wanted to share.

Electronic versions of the interview, transcripts, and other study documents are maintained under a password-protected folder on my personal computer. A locked, fireproof security box contains the CD copies of the recorded interviews, paper

documents pertaining to the study, and external hard-drive containing back-up copies of electronic files. Data relating to the study will be stored for 5 years after the completion of the study. All data will be destroyed after that period.

Data Analysis

Phenomenological data coding and analysis uncover the significant statements from the participant interviews and create themes from the clusters that are discovered (Creswell, 2007; Moustakas, 1994). Moustakas (1994) stated, "The organization of data begins when the researcher places the transcribed interviews before him or her and studies the material through the methods and procedures of phenomenal analysis" (p.118). Phenomenal analysis consists of identifying expressions relevant to the experience, and then builds meaning or units of meaning to develop textural descriptions of the experiences (Moustakas, 1994).

The data analysis technique used for this study was the modified van Kaam methodology developed by Moustakas (1994). Following the completion of the semi-structured interviews and transcription process, the transcribed interviews were uploaded into the NVivo© qualitative data analysis software. The use of NVivo© assisted with identifying the thematic categories and invariant constituents of the phenomenon of combat-related PTSD symptoms and the human-animal bond.

In order to generate the requisite themes to answer the research question, and in order to uncover the lived experiences of the participants, the following steps were taken, as prescribed by Moustakas (Moustakas, 1994, p. 120-122):

1. Listing and preliminary grouping of relevant experiences;
2. Reduction and elimination of extraneous data to capture essential constituents of the phenomenon;
3. Cluster and thematize the invariant constituents to identify core themes of experiences;
4. Final identification and verification against the complete record of the research participants to ensure explicit relevancy and compatibility;
5. Construction of individualized textural descriptions based upon the verbatim transcripts using relevant and valid invariant constituents and themes, for each participant;
6. Construction of individual structural descriptions based upon individual textural description and imaginative variation, for each participant;
7. Construction of a textural-structural description of the meaning and essence of the experiences for each participant; a complete textural-structural description was developed representing a composite description of meaning and essence of the experience for the whole group (Moustakas, 1994).

The data analysis was conducted as presented and the results provided answers to the research question based on the lived experiences of the participants. The results of the data analysis are presented in Chapter 4.

Issues of Trustworthiness

In qualitative research, validity refers to the accuracy in the findings, as well as credibility, dependability, reliability, and authenticity of the study (Creswell, 2007). Polkinghorne (1989) stated that the quality of phenomenological studies is judged by how deep readers are drawn into the researcher's discoveries (Creswell, 2007). Four qualities that help evaluate the power and trustworthiness of a phenomenological study include vividness, accuracy, richness, and elegance. Polkinghorne suggested the researcher should first consider the following questions (Creswell, 2007):

1. Does the interviewer or researcher influence the contents of the participants' responses?
2. Are the transcripts an accurate reflection of the interview?
3. Upon completion of the transcripts, was there more than one conclusion that could be reached?
4. Is it possible to account for the content and connection of the experiences through the general description and the transcript?
5. Is the structural description situation specific or does it hold true in general for the experience in other situations?

Because the study was qualitative, the data collected required validation with the consistency of the patterns of themes and accuracy (Creswell, 2007). Creswell (2007) and Moustakas (1994) recommended a number of techniques to verify the validity of qualitative inquiry; the applications incorporated in this study are described below.

The first method was member checking, which is considered the "most critical technique for establishing credibility in data" (Creswell, 2007, p. 208). Included as part of the informed consent, participants agreed to review an analyzed narration of their individual textural-structural description, to ensure that I truthfully and accurately captured a rich, thick description of their experience. The rich, thick description used to define the themes from the collected data allows readers to make decisions regarding the transferability of results (Ponterotto, 2006). Participants received a summary of study results upon university approval.

Additionally, triangulation corroborated the results with other sources. Since little empirical research was available on the topic, I compared the results from the analysis against other first-person human-animal bond accounts to assess generalized findings (Creswell, 2007; Moustakas, 1994; Pets for Patriots, n.d.; Pets for Vets, n.d.). Finally, Creswell and Miller (2000) suggested a peer review or debriefing of the research process by an individual external to the study. The thorough, critical review, addressing the comments and questions presented by the Walden University dissertation panel, enhanced the trustworthiness of this project prior to approval and publication.

Ethical Considerations

Several measures ensured the ethical treatment of participants. First, Walden University IRB approval was required prior to the execution of data collection procedures. In the process of obtaining consent, a thorough discussion engaged participants regarding the study's structure and the rights afforded to them as participants,

including mandatory reporting issues and confidentiality (Appendix C). The assignment of pseudonyms (Participant 1 [P1], P2, P3, etc.) to approved individuals protected their identities throughout the study process as access to personal data was restricted to the University-approved chair and myself. Pseudonyms were also used for pet names. All study materials maintained on the researcher's computer are password protected. No one else has access to this computer. Back-up copies of materials (e.g., copies of interviews and external hard-drive) will remain stored in a locked, fireproof box for the required 5 years.

The general questions asked during the interviews were designed to elicit participants' experiences from their perspective, not inquire about specific traumatic events or detailed symptom descriptions. However, some participants shared experiences regarding their deployment(s) and symptomatology. Participants were permitted to request a change in the direction of the interview discussion or to terminate the interview and remove themselves from the study at any time. I encouraged the participants to have a trusted friend or counselor available if they encountered any difficulty during the interview phase. Volunteers were also encouraged to have their companion animal with them during the interview. The National Veteran's Crisis Hotline toll-free number was provided on the consent form and available at the participant's request.

Summary

This chapter provided a concise blueprint of the exploratory study of combat-related PTSD and the human-animal bond in a sample of individuals who have deployed

in support of OEF and OIF in a military role. I discussed the justification behind the selection of a phenomenological design, reviewed the steps taken with recruiting volunteers, and provided the specific criteria required for study participation. I also covered the data collection process, the in-depth recorded telephone interviews, the handling of all study-related documents, and outlined the phases followed during data analysis. Further attention focused on the ethical measures built into the study to ensure the protection of participating volunteers and levels of trustworthiness applied.

Chapter 4 presents the results.

Chapter 4: Results

The purpose the study was to explore the experiences of a sample of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OEF) veterans, with combat-related posttraumatic stress disorder (PTSD) symptoms, and have a companion animal. A phenomenological approach was used in order to hear the experiences from the individuals who lived the events. This chapter presents the results. I discuss the data collection process, participant demographics, data analysis and management, evidence of quality, and the major themes and subthemes uncovered.

Demographics

To participate in the study, all volunteers must have been deployed during OEF or OIF and must have a companion animal. Additional participant information was limited to the characteristics needed to create a full understanding of their experiences (see Table 2). The participant profiles (Table 2) help to understand the individual textural-structural narratives (see Chapter 3 and Appendix F), provide a full context for the experience, and capture the diversity of their experiences.

Table 2
Participant Demographics

Participant	Gender	Type of Pet	Military Service	Deployment	Year	Number of TDYs
1	Male	Dogs	Air Force	OEF/OIF (2)[a] Pre-9/11 (2)[b]	2005, 2008	4
2	Male	Dog	Army	OIF	2009	1
3	Male	Cat	Army	OIF	2004	1
4	Female	Dog	Army	OEF	2010	1
5	Male	Dog	Navy	OEF (1) OIF (1)	2001 2003	2
6	Male	Dog	Army	OIF	2004	1
7	Male	Dog	Army	OIF	2004	1
8	Female	Dog	Army	OIF	2006	1
9	Male	Dogs Cats	Marines	OIF (2)	2003 2004	2
10	Male	Dog	Air National Guard	OEF (2) OIF (1) Pre-9/11 (3) [b]	2002, 2009 2003	6
11	Male	Hedgehog & Cats	Army	OEF	2003	1
12	Male	Dog	Army	OIF	2004-2009	5

Note. [a] denotes military role supported both campaign operations. [b] Dates provided represent Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) deployments. TDY = Temporary Duty or Deployment.

Participant Profiles

The construction of the textural-structural narratives (Appendix F) detoured from the recommendation of Moustakas (1994) and read more like a profile and summary of experiences than a conceptual narrative. This change addressed two concerns that came to mind as I progressed through the participant interviews. First, most of the interviews did not follow a strict chronological or topical flow. One benefit of open-ended questions is the freedom to follow a natural dialogue, a personal interaction, which at times varied

in direction. I attributed this to the intimate nature of experiences surrounding combat experiences and the development of PTSD symptoms. To ensure that I captured a thorough picture of the participants and their experiences, I felt it necessary to provide a summary-style narrative, opening an opportunity for readers to engage with each individual. A second concern was that many of the participants expressed feelings such as "People don't know …," "People don't understand …," and "We don't have a voice." To address these feelings, it was important to me that I extend the extra effort to provide the essence of each participant's full story, including their own words when possible, for the reader to approach their experiences with the rich sense of the participants' points of view.

Data Collection

For this study, I conducted twelve in-depth, semi-structured telephone interviews (Appendix B) over a period of two months. The interviews lasted between 30 minutes and 90 minutes depending on the experiences participants felt comfortable sharing and the level of detail involved. For example, some of the interviews included descriptions of their deployment experiences to enrich the understanding of their PTSD development and others did not. Also, the question, "Is PTSD curable?" was added after a commentary by one of the participants and its relevance to the subject. This change is discussed fully in Chapters 5. Using a Philips© Voice Tracker to record each interview, I saved copies on my personal computer and an external hard-drive, and then burned a final back up version onto a CD. My computer is password protected and the external hard-drive and

CD copies are stored in a locked, fireproof security box. There were no additional changes to the security measures introduced in Chapter 3.

Data Analysis

The data analysis technique used for this study followed the modified van Kaam methodology developed by Moustakas (1994). After each interview, I used the NVivo© qualitative data analysis software to assist with the development of the verbatim transcript and to identify the thematic categories and invariant constituents of the phenomenon of combat-related PTSD symptoms and the human-animal bond (Appendix D). Invariant constituents fell into one of three themes based off the interview questions during the first analysis: (a) experiences after deployment; (b) experiences with the human-animal bond; and (c) additional findings. Based on the thematically categories identified, I constructed the textural-structural narratives for each interview (Appendices D, E, and F). Appendix E presents the full list of themes and subthemes created from the horizons generated from the interview transcripts. Not applicable to all interviews, a fourth theme, deployment experiences, served to capture those experiences shared by participants comfortable enough to share them. A member check validated the contents of the narratives. Each participant reviewed their narrative to verifying the accuracy of the narrative's representation of their story and to identify areas that required correction or clarification. A sample interview transcript is located at Appendix G.

Moustakas (1994) instructed that phenomenological reduction is a long, detailed process, where the researcher should repeatedly review the data to gain a thorough

understanding of each participant's story. A second review of the interviews, along with the narratives and transcripts, served to reengage with the participants' stories. After loading the reviewed narratives into the NVivo©, horizons were identified for each participant using the software coding option. Similar ideas were grouped by the conceptual theme. For example, statements surrounding treatment, groups, prescription medication, and general Veteran Affairs (VA) experiences became subthemes under the theme Treatment. Establishing the "additional findings" category captured those statements, which did not necessarily represent experiences during deployment, following deployment, or the human-animal bond but were important comments, opinions, or other events giving depth to the participants' perceptions. Statements not representing the participant's experiences or able to be coded were excluded from analysis.

As I progressed through the data analysis, I found it difficult to identify discrepant data within the various themes and subthemes. Drawn from the experiences were comments such as "cookie cutter approach to PTSD"; reflecting on comments as such, I shifted my approach during the analysis process to be consistent with the openness participants wished society held. When discussing an intimately unique event such as individual experiences after trauma exposure, and understanding the varying characteristics associated with each story, I made the decision not to label any response as "discrepant."

Evidence of Trustworthiness

Reaching back to the issues of trustworthiness introduced in Chapter 3, I adhered to the approved study protocol during the data collection and analysis processes. Polkinghorne (1989) stated four qualities help evaluate the power and trustworthiness of a phenomenological study: vividness, accuracy, richness, and elegance. To validate the data and narrative accuracy, the participants reviewed the analyzed narration of their individual description. Already addressed, presenting the textural-structural narratives in more of a story versus a conceptual review strives to bring the non-military reader into the participants' experiences; creating the story around the experiences, placing the reader in the center through the four qualities of which Polkinghorne spoke. The thoroughness of this individual composite also allows readers to assess the transferability of results.

During data collection and analysis, when personal thoughts or reflections surfaced, I made note of the idea, then set it aside to return to the story in front of me. I address these thoughts in the discussion of the results in Chapter 5. I also corroborated the experiences with anecdotal information from Walter Reed, Pets for Vets and Pets for Patriots websites, and other personal accounts to generalize findings. Finally, a thorough peer review, by individuals external to the study, fielded questions and comments by the Walden University dissertation panel, further enhancing the trustworthiness of this project.

Results

In this study, I intended to uncover the experiences following a deployment and the human-animal bond in a sample of OEF and OIF veterans with combat-related PTSD symptoms. The interview questions generated for the data collection reflected on the research question: what are the lived experiences of United States military members who served in OEF and OIF, developed combat-related PTSD symptoms, and have a companion animal? Besides opening the interview allowing participants to share other information they wanted attached to their story, a third question, "Is PTSD curable?" was added after a participant made the analogy of PTSD resembling diabetes. The follow-up questions presented during the interviews pertained to the direct experiences of the individual interviewed, in keeping with a natural conversation.

Each experience was unique; some participants endured direct combat, others encountered repeated gruesome scenes as part of their daily tasks. Some participants faced multiple deployments and others had compounding, personal factors affecting their situation. As a result, all participants provided a thorough assessment of experiences surrounding combat-related PTSD symptoms, life after deployment, and the role(s) their companion animals filled. My analysis consisted of main themes identified across all the interviews; Appendix F presents the rich, thick descriptions of each story. All participant quotes correspond to the study interviews conducted in 2013. In order to provide a thorough understanding of the varied experiences shared during the interviews, the review of themes include comments from each participant, as applicable (Appendix E).

Theme 1: Deployment Experiences

All of the participants interviewed in this study served in the U. S. military and experienced at least one deployment to OEF or OIF during their active duty commitment. The sample captures deployment experiences from 2001 to 2011. Due to the sensitivity of recalling specific traumatic events, the first interview question focused on experiences after deployment. Still, some participants chose to share stories from their OEF or OIF experience, providing the context behind the development of PTSD.

> I was still supporting my mortuary duties stateside which also, in 2006, we did more mortuary cases than any other bases, non-combatant deaths. So, I am coming back from a deployment, where I did, in my experience, minimal casualties in Kuwait, but what I saw were … some of the things I saw was really grievous. Total body burns, guys with no eyelids. (P1)

> I would say the combat operations were at its highest. We were getting things calmed down by the time we left. It got pretty wild there for a while … we wound up going all over Iraq … Every time we moved … you would have a totally new scenario. Different types of attacks, it was more than just a change of scenery, it was a change of people and so their styles were different. That would cause, well it did cause me, to have different types of panic attacks when I came back. I had more things that would trigger unwanted memories and trigger me back into survival mode. (P3)

> And you watch the tapes and you don't see Taliban, you don't see terrorists … you see little kids, women, and goats and these homes that just happened to live next to some site that they probably didn't even know was a missile to begin with and they would just happened to get obliterated. (P5)

> I was no stranger to trauma and death … but *nothing* prepared me for this. I had seen plenty of kids over there, 22, 23, 18 years old … we did 357 MedEvacs in 4 months and I carried almost every one of them on a litter up [to] that airplane … I would see their first sergeant or sergeant major sometimes a week or two later asking "how's so-n-so", "he died". I don't forget the local kids we tried to help, one was burned so bad, black like an inner tube … this kid had his eyes open and this oral pharyngeal in his mouth … I'm carrying this kid in my arms to the doc, what the *f...uck* am I supposed to do with this kid? The doc said, "Just give him some medication, make him comfortable, that's all we can do." (P10)

> If I fell back to help somebody out, someone else steps up into my position and took over that role. Every time that happened, one of them died. So now I think about, "well you know what, if I would have just picked somebody else to go help the person I was helping, that would have been me [who died]." (P12)

Theme 2: After Deployment

Each interview began with asking participants to share their experiences after coming home from their deployment. The main subthemes created include experiences

surrounding participants' coming home, separating from the military, PTSD, and treatment. The responses were mixed, but most participants started the interview with sharing how they felt coming home.

Subtheme 1: Coming home. The following excerpts focus on the horizons emerging from the descriptions after returning from a deployment. The first set of statements present the participants who immediately felt different, regardless if they recognized it as PTSD symptoms at that time. The second set to statements shares the perceptions of the two individuals reporting not feeling PTSD symptoms immediately after their deployment.

> Fortunately I did not suffer from the anger, violent outbursts that a lot of the guys do. I went into more of a deep depressive state. Nightmares … night terrors … a lot of screaming in my sleep to the point where I was losing my voice. I didn't know what it was. (P1)
>
> Yep, I found it was very hard to adjust after I got out. … People expect you to be the same person that you were when you left to join the military versus come back from deployment. Trying to adjust to that life yet. (P2)
>
> When I came home I was in pretty rough shape. I was suicidal. I was depressed. I had sort of anger, a lot of anger, towards what happened during my deployment and then what was going on with my unit and the chain of command. (P4)
>
> When I came back, I didn't do a whole lot with anybody. I shut myself off

from people and drank a lot more. Quite a bit more. (P6)

Shying away from being around people, it caused a lot of anxiety. Going to places. Kind of a fear but you didn't know why. Kind of, a little bit of depression because you're isolating yourself. You don't really know why you're doing it. You are kind of like on auto. (P7)

It was a little different than before. Well, it was a lot different from before … I didn't want to be around anybody, could care less if I saw, heard or talked to anybody. Didn't want to go out to eat with anybody, didn't want to go to public places … Emotions ran high, a lot of times I didn't know where to turn to or who to talk to or anything else. It was tough. (P8)

After my first deployment, when I came home, I had hypervigilance, the kind of jumpiness. I couldn't really turn those off, the life saving habits of combat. By the time I came back from my second deployment, it had gotten to the point where I didn't like being anywhere that had lots of people or I didn't have the control … there was anger, anger was the response whenever something, to uncomfortable feelings. (P9)

My wife told me, said that she started noticing a bigger change in my personality and my demeanor and so forth, after my tour in Iraq … (P10)

I went back home to that and it was all different … I came back really angry. I still, still deal with that. Not being, feeling like I can't relate to others, really, with experiences and stuff. (P11)

> I was really overprotective, overbearing. Protective issues over my kid … It took me awhile to even drive with her in the car. I never couldn't get it out of my mind that "pot holes in the road were just pot holes in the road and not IEDs and things that could hurt me."… Flashbacks, even after I left the Army and came back it felt like it was getting worse and worse and worse. (P12)

Two veterans did not report experiencing problems immediately after coming home:

> The more you can calm down and be in a safe environment, the more your brain … You have a card sitting in the middle of your brain going, "not relevant, no, no, no, OK this has to got to go forward right now," and the rest of it is just shoved into a file cabinet and when things start calming down that card goes, "we have to go through the filing cabinet and get all this stuff cleaned out." And that's when we started exhibiting or experiencing the problems. The card says it's time to clean out the closet. (P3)

> The experiences were weird. I don't know how else to put it, but [I] felt very cocksure and confident I guess … very gung ho, very immoral feeling and just kind of lived, on reflection, like a terrible frat boy, really. But that was just the reaction to what I saw, I don't know, it's weird to think about it. (P5)

Subtheme 2: PTSD.

PTSD screening. Due to the varying dates when participants deployed and the DoD's increasing the frequency with post-deployment mental health screening, my analysis focused on statements applicable to current procedures. One aspect of PTSD

that emerged from the interviews is that the stigma surrounding admitting problems continues. Participants also suggest inconsistencies with the screening process:

> It's that bravado, chest out, "*ahh-haaa* – I can't be affected by this" … once you become a broken egg, the guy with PTSD, the guy with a medical profile … we shun them as a community. I never had a profile until I was diagnosed with PTSD, then I became a dirt bag, especially among my peers. (P1)

> [I] pretty much checked the blocks and because it was so fresh, I didn't have any time to unwind and get the stuff to actually start popping up. … She said, "Well, yes, I definitely think you have PTSD but I don't think it is that bad so I'm just going to diagnose you with adjustment disorder." (P3)

> When you get back they screen you, I think it was 30 days [approximately June 2011], and they kind of, sort of tried to help, they recognized that I needed help. They sent me to an off-post counselor who was horrible, and, it wasn't helping. I mean it was to the point where my chain of command from my unit was having somebody call me on a daily basis to make sure I wasn't like going to kill myself, but that was as far as it went with helping me. It was probably wasn't until September or October when I went back to be screened, and then they called me as I was leaving the building and said to come back in, "we have to help you." (P4)

> It was a very simple debriefing. He came in, I did the post-deployment paperwork, they sat me down with a doctor and "anything going on." I told them

> I just lost my brother, "oh normal things, go on back to work." … Like with a lot of other soldiers, I didn't, admitting I needed help was admitted a weakness, and that's not something you do. I fought that for a long time. (P8)
>
> Quite honestly, it was a joke. We were involve in some pretty hefty stuff … it was like "do you see, hear, or smell anything you found disturbing," [sarcastically] "*Ahh, no"*… we were afraid if we said we were having problems with nightmares, problems sleeps, or having problems with self-medication of over drinking, we all just lied about it. If we don't admit it, it's not there. "We're Marines, we'll just push through it." (P9)
>
> I went and they gave me an evaluation on paper, I sat in a room, how long after, two or three weeks before I actually got in before they gave me the psyche eval. It really wasn't an psyche eval, they gave me a test, put me in a room, I filled in the blanks and she came back, took it away and said, "I'll get back to you." It was a long period of time and they called us back in for a consultation and told me my signs and symptoms weren't severe enough to get help, I'd have to get my own help. (P10)

The discussion surrounding the stigma associated with PTSD continues later in this chapter, but under a separate concept dealing with society's approach to the topic.

PTSD symptoms. The impact of PTSD symptoms and veterans' ability to function greatly differed across individuals. All of the veterans shared the limitations their PTSD symptoms created – the "different" person who emerged after combat

deployments supporting OEF and OIF. A number of symptomatology descriptions surfaced during the interviews. Due to the diverse nature of experiences, statements about PTSD symptoms are presented in numerical order of the participants' pseudonym:

> I had a super hypervigilance. I would drive 20 miles per hour down the highway. A 30-minute drive was taking me an hour to get home. … I started having symptomatology, in me was an olfactory hallucination, when I put my uniform on, I would start smelling decomposing bodies. This is very troubling for me because I knew there was no decomposing bodies. … I would get sick at work and have to leave really early. I would go in at 0730 and be gone by 0800 or 0900. I was running away from having the uniform on; that was becoming a problem. (P1)
>
> Relating to people was the main stressful thing. People expect you to be the same person you were when you left to join the military versus coming back from deployment. … I am very easily startled. (P2)
>
> A festival opened across the street from our housing development. It opened with fireworks. I was wide-awake when the first one went off and was out of the bed when the second one went off. It was at least three hours before I could go back to bed; I sat in the living room absolutely frozen. … When they fired the tanks, I would literally want to crawl under my desk, "where's my gear," and just really have a panic attack. (P3)

I felt I was truly emotionally out of control and I definitely was having a lot of anxiety, nightmares, and flashbacks. Hypervigilance, that kind of stuff. (P4)

I was waking up every other night with cold sweats, I'm freaking out, I don't know where I am, I'm clenching jaw, feeling very hypervigilance and always on edge … people will come up behind me and tap me on the back and I swing at them and I don't know what is going on. (P5)

I have issues with driving. I was a combat driver and I don't care for driving at all. I drive fast, I get aggravated. (P6)

Kind of shying away from being around people, it caused a lot of anxiety. Going to places. Kind of a fear but you didn't know why. Kind of, a little bit of depression because you're isolating yourself. You don't really know why you're doing it. You are kind of like on auto. (P7)

Depression, the anxiety, the not sleeping, and the not eating, and everything else. By that point, I was barely sleeping, couldn't go anywhere in public by myself, all that good stuff. (P8)

I had hypervigilance, the kind of jumpiness. I couldn't really turn those off, the life saving habits of combat … there was anger, anger was the response whenever something, to uncomfortable feelings. (P9)

I still have bad flashbacks, and the one thing I really hate is when I dream, I dream in color, so it's like it's happening all over again. I don't, like now,

people … I used to be able to deal with things, like one thing, people who were missing legs and stuff, it didn't bother me, [but] I can't do it any more, it just freaks me out. It totally freaks me out. … I have hypervigilance and hyper focus. … For a while, there was a whole year that my wife and I didn't sleep together because I was so rammy in bed, I hit, her in my sleep. One time she came to go to bed, she said I hit her so hard, she thought I broke her jaw … we weren't fighting; I would never hit a woman. It's not right … one time I was laying on the couch. She bent over to try to kiss me, I came across and hit her right in the head. I knocked her down to the ground. She was crying. I felt like shit because I hurt my wife. (P10)

In traffic, I stop a good car length behind the person in front of me, just like we were trained to do in convoys. It's a constant alertness. … I just stay awake for some times days, just being awake, not being able to go to sleep because of it. … I fight every day not to get into a rage about something. If I hear someone complaining about their day, I want to explode, "what do you know about bad days?" … I can feel my body, my blood pressure, my breathing gets heavier, faster, it's almost like a panic attack. (P11)

I am living with it day by day, minute by minute, second by second, and nobody is picking up on it. … There's points in time that I just want to, I just want to explode. I want to scream. I want to punch things. I want to do whatever I want to do. I want to get on my Harley and I want to go. I want to just leave

> everything behind. I'm angry … and then there are times I don't want to get out of bed, I'm sorry, I'd rather lay in the darkness and put on some boring TV shows and just lay there, play a game on my phone. Then there are times I'm just overly happy. In a good mood. Then there are some days I get up and realize the water line just broke and go oh well, it happens. (P12)

Another feeling addressed by some participants was guilt. This feeling surfaced for different reasons; for some, it was survivor's guilt, for others it was guilt over what they events during their deployment experience.

> With your children, you're fearful to share your experiences with your children … my kids lived it every day. … You try to shield them and shield the ones you love from that … It's not dad, it's not husband anymore...it's "I don't know who you are anymore." I would say a good percentage of these guys get divorced and are left truly alone, which makes the nightmare real. (P1)

> Yeah, guilt over the fact that my men were going into combat and that I wasn't going to be able to go and share the risk and share the danger with them. So, that added into it and PTSD can be a multiplier of things. If you have one problem … you talk to some of these vets, my experiences in Iraq were actually very mild for the Army. But then, to come back and not be able to continue, I think that played a multiplier role. (P3)

> There's survivors guilt, there's guilt about killing women and kids and innocent people … there's all this guilt you feel about different things and there's

nothing you can really do besides … if you have to really talk about it, talk about it. (P5)

I have survivor guilt. You know, I know I'm not God, and I know that I can only do so much. I know that I can only do so much in the scope of what I did as a tech and I know there are times you can have the best people in the world around you, to help the person who is injured, and it's not going to make a difference, the person ends up dying. The truth is, your heart tells you something different. I wish I could have done so much more to help these guys. I wish I could have done so much. There were so many of them. Too many of them, "don't stop, keep pushing, we're almost there," and sometimes they just wouldn't listen. (P10)

The civilian counselors they call it survivor's guilt. … Which yes, I do agree with that, I do agree that people on my team, people in my unit that died instead of me, it should have been me. *It should have*, because me being protective, kind of always being the helper, me always trying to help someone in a jam. My team follows through with, if I fell back to help somebody out, someone else steps up into my position and took over that role. Every time that happened, one of them died. So now I think about, well you know what, if I would have just picked somebody else to go help the person I was helping, that would have been me [who died]. (P12)

Subtheme 3: Separating from the military. All of the participants departed active duty service prior to participating in this study. For some veterans, leaving active duty was their choice; for others, sustained injuries required their retirement. However, comments made about separating from the military came from participants who had a negative experience form the events.

> Once I went to inpatient treatment, that was the marked point to the end of my career … they started the MEB process and as I was retired in February in 2013. … It's ridiculous, it's bullying. (P1)

> I came back in February and my ETS was June. … I went from something I knew every day to "I don't know what I am going to do for work, I don't know what I am going to do, I don't know where my skill sets fall, kind of had *no clue* of what to do with the civilian world anymore." (P8)

> The fact they tell you when you claim PTSD it is not a career stopper, that is a bold face lie. … The only relief I got after being discharged, the only relief I got was not being screwed with anymore. You're drugged through a system that is so over-inundated with stuff that you have to fight for everything you get … That makes me mad. Especially after I start talking to somebody and they said "you need help," OK I'll try to get help and I'll try to get squared away. And then when I told them, that's when they said there's a possibility you could get discharged. (P10)

> I came out of combat theater May 27th and I was out of the Army June 19th and I kept pushing my command, "hey, this is going a little fast" … I never had time to go to the doctor and get medically treated, I never had time to go to my combat advocate to release the thoughts that were in my head, get that reassurance that everything was OK. (P12)

Subtheme 4: Treatment. Discussing PTSD treatment revealed a variety of experiences, some good, some not so good. Three subthemes surfaced; prescription medications, the use of groups in treatment, and experiences with the VA. This is another topic where policy changes have occurred in the past 10 years. The availability of services to combat veterans has increased, however, it appears the consistency of treatment modalities offered throughout the VA locations and the qualification of staff members influenced each participant's experience.

Prescriptions. One prominent theme from the interviews was the use of prescription medications in treating PTSD. Setting aside the physical injuries requiring pain management, most of the veterans held negative views over the heavy emphasis of using psychotropics to treat PTSD, but two have managed to establish some sense of functional balance.

> I met a captain who was really supportive of alternative therapy. They really respected my wishes, never really pushed any medications on me. … [While in the hospital] I tried some antidepressants for a while and it really didn't help and had side effects. … I'm not talking about withdrawals; I mean I heard my

eyeballs moving. I mention this to my doctor and he said, "Yeah, I've heard that before." That will drive you insane. I mean every time you move your eyes you can hear them moving and I mean loud. It's really unnerving. (P1)

When he bumped me up to 150 [mg], I started having freaky dreams … they were *freaky*. They weren't combat, they weren't … you could tell … they weren't real. It was almost like being in the Twilight Zone. … I'm able to maintain at 100 mg. (P3)

One of the Army's solutions to all of my issues, which they do to everyone, they had me on so many medications I was afraid to drive my own car. I would drive to work, give my friends the keys, and they would drive me around. A psychiatrist put me on an excessive amount of anti-depressants and of course Klonopin for anxiety. There was stuff for sleeping and after that; I was in a lot of physical pain, so narcotics. (P4)

She turned to me and said, "OK we're going to prescribe you something, something, something," I don't even know the names. I took them for like four or five days and what would happen is that … it was about a mile walk to school every day and the second day I took them, I was walking, it literally felt like … the best way I can describe it … like a first person camera, then it felt like a third person perspective. The camera was like slightly above me and I was watching my self … I was cold and numb … it just didn't feel right. (P5)

They were using some anti-psychotic for pain management … They use it

for both … mood enhancer, whatever. But I hate stuff like that. I really didn't want them. … The only thing I've ever told them is occasionally when I get aggravated I would like to have valium. And they've offered Xanax and Ativan and I know how I get, if I take Xanax I get mean. They've offered and I'm like "*nooooo*." (P6)

It took awhile to finally get the medications right. Some you'd get from primary care and then some your neurologist would prescribe, sometimes they would interact with others. It was a couple years for everything to smooth out. (P7)

They went through four or five different anti-depressants in the beginning. Some of them made me eat constantly, some of them stay away for 72 hours … She's added another one to help me sleep, which I only take it if I need it, if I'm going through a spurt where I'm not sleeping or when the nightmares get that bad. The anxiety medicine is newer, I've been on it probably about two or three weeks now and I can already tell a difference. My nerves stay calmer, I still hate going to public places, but that's a given. … It maintains somewhat of a normal life, not 100% but I've tried it, I've tried to come off the medicine and it's not pretty. (P8)

I went to the Navy Corpsman, the doctors, they prescribed Zoloft to me, and go to go talk to a counselor once every other week. Ummm, it was helpful. It kept me going. It helped with that will to fight, but I don't think it was, it really

> wasn't … it kept me grounded, to the point I'm at now, but it wasn't as helpful as it could have been. This was 2005, there wasn't a lot of discussion about PTSD. (P9)
>
> The neurologist gave me this med … the side effect was it made me angry. Yeah, PTSD and a drug that makes you angry. … I would get unconscionable … The first time I went for CBT [cognitive behavior therapy] … she said to me, "are you willing to learn" and I said, "are you willing to teach"… my wife said, "welcome to medicine head." (P10)
>
> I've spoken a couple times, trying to get sleep medication, depression meds, anxiety. It's really hard because, I don't have a vehicle … so I've been really kind of dealing with it on my own. (P11)
>
> I stayed away from the pills; I stayed away from the medication the VA wanted to give me. (P12)

Groups in treatment. Many veterans were exposed to some type of group therapy. Polarized responses generally existed when the theme emerged. First, the respondents feeling the use of group settings were beneficial to their treatment:

> That's what I find when these groups of veterans get together, on these Odyssey, Wounded Warrior Projects, the trips they put together for us … we *really talk* and we don't fear that reprisal anymore and we really share what we've been through. (P1)
>
> As long as I go to the group counseling session and talk with the guys …

sometimes we talk about PTSD and sometimes we talk about everything else but. (P3)

They have groups you kind of attend, talk and figure out how to solve your problems. Some of them are OK, some kind of seem, redundant, you don't really get anything out of them. (P7)

The Vet Center, I went through some groups, some counseling, relaxation classes there, I found was that more helpful. …I am having a reaction and have a positive way to calm myself down or collect myself. … It is very helpful to me, to talk to the older veterans that say, "Hey, good job for addressing it and getting started now. I waited 30 years and I have been miserable for the last 30 years. I've had X-number of marriages. Congratulations to you for at least starting this journey now." (P9)

Others found the experience less effective, whether through their own experience or by watching others encounter the group-styled therapy.

It's like, I had a really hard time coping with that. Not everyone had the same experiences. Combat MOSs [Military Occupational Specialties] and you're sitting them with different combat MOSs or just different MOSs, and it's hard to relate to some of the same experiences they went through. (P2)

One counselor offered to put me into a group, but a buddy who did it, when he was in the group it triggered more of his PTSD because of listening to everyone else describe their problems and what happened to them. He said it

trigger it so bad that he said “screw it” and never talked to the VA again. (P5)

They tried pushing me into a group. I think it would have been OK if we were actually out doing something and not just sitting around talking. I am not going to go sit in a room where a bunch of people talk about issues. I mean we were all there, I don’t need to hear that. I mean, if they got a group of guys together to go out, where the focus isn’t the whole “what happened … what were the experiences …” yeah, I never really dealt with those groups. (P6)

I had considered group therapy, before the anxiety got as bad as it is now, but the more I thought about it and they don’t really offer the groups as much here in Louisiana. It’s difficult to get into one of the groups. I thought about it, and the more I thought about it, I know I wouldn’t want to go in and talk right away. I would need to get a feel for the people before I would tell them my story. (P8)

I know that my situation is different from everybody else’s, and even though we share some similar, but it’s like the VA sees every PTSD case as the same. They give you the same treatment whether you’ve been injured and suffer from PTSD or if you just witnessed something and you have PTSD. They treat you the same. That doesn’t work for a lot of us. Me and my brothers that hit IEDs and were blown up, we have that compounding factor. That, you know, “oh wait a minute, you have no physical injuries from your combat experience, then what are you doing here? Why am I here? Why am I sharing my experiences with someone who doesn’t share my experiences?” (P12)

Other treatment experiences and the VA. Addressing experiences outside of group-styled therapies, four veterans attempted to seek treatment while still on active duty. As an active duty member, the mental health care provider is other than the VA.

> [Entering an inpatient program] I found that so far, the best therapy for me was CPT [cognitive processing therapy] and it forced me to write, in the hospital it forced me to write down my stories and it had such a cathartic effect on me. Now it's on that page and not in my head and I can reference it when I want to. (P1)

> They sent me to an off-post counselor who was horrible, and, it wasn't helping. … [After the second post-deployment screening] what they did, the social worker I met with, she asked me if she could work with me. She started doing my counseling and I stopped going to the off post guy. … She was amazing. I kind of always said she saved my life. She was perfect, she matched what I needed. She was very caring, very understanding. She was amazing in her field. (P4)

> It kept me going. It helped with that will to fight … it kept me grounded, to the point I'm at now … but it wasn't as helpful as it could have been. This was 2005, there wasn't a lot of discussion about PTSD. (P9)

> I never had time to go to the doctor and get medically treated, I never had time to go to my combat advocate to release the thoughts that were in my head, get that reassurance that everything was OK. I never had the chance to get the help I needed while I was in. I got back from combat theater and I was out the

door. (P12)

After separating from active duty, or if the member is Guard or Reserve, the VA is the focal point to receiving mental health care. The counselors tend to be civilian, especially after the addition of more clinicians to help with the demand for PTSD treatment. However, the VA experience regarding PTSD issues held much to be desired for most of the veterans interviewed for this study.

> It took me several months to get in. I started as soon as I got home, I went to the VA the next day, I got home on a Thursday and went in on a Friday, and they scheduled me for an appointment a few months later. I went to psychiatry right away, and they got me in the next month. … But my prescription was going to expire right before I got out, so the medical center called over to the VA to fast-track my referral program so I could get a refill. (P2)

> It took my wife two years to convince me, to admit that there *miiight* be a problem. … We went in there and we talked to her and at the end of it is she said, "Well, yes, I definitely think you have PTSD but I don't think it is that bad so I'm just going to diagnose you with adjustment disorder." My wife was with me so … I didn't go to old school Army and go to "wall to wall counseling" with this woman, but she ticked me off so bad and wound me up so tight when she did that, I didn't think to go to the patient advocate and file a complaint against her. … It was a little over a year before my wife got me, "OK, let's go back and try this again." That time around I got a very professional doctor that said I do have a

problem … as I said, it was incrementally getting worse. … The VA is a very interesting experience. Some sections of the VA are very high quality, some sections of the VA will drive you absolutely nuts. … The real frustration comes when you go in for disability evaluation. (P3)

When I med board, they gave me a rating, meaning they pay me for PTSD. So every year for five years, they have to evaluate me and the purpose of that is to see if I'm better to see if they can lower my rating. Which is honestly pretty infuriating. (P4)

[After his bad experience with the VA prescribing PTSD medication] I called the VA and they said, "Well take *this* pill," I told them "I didn't want to take the pills and guess you guys don't want to talk," I don't know what is going on. (P5)

I had a really good social worker with the VA. She would help me, we wouldn't talk a whole lot about treatment stuff, but she would help me come up with things that I would want to do. … She just gave me ideas of things get out and do. … Every time I tried to talk to someone about that stuff, it just aggravates me … I've tried stuff like that. I tried talking to this one lady, to discuss my driving issues. She started comparing them with her husband, who has never been in the military. (P6)

I would have to make an appointment with primary, that would take a month. Then they would refer you to see someone, that would take a month.

Then it was probably another month to two months out before the appointment. … When I moved, it seems to be a better streamline. I can call and get an appointment with my primary, generally within a week. I can speak to her, if I need something and I'll get directly an appointment within a week or two. Also, they have another lady that is a polytrauma coordinator for veterans with multiple injuries. This lady, that's all she does, helps that you're getting everything done. There's always room for improvements, but I think they try. (P7)

The VA is awesome! I have seen the same PA since day one. … We found that me just going to my appointments is a trigger to my anxiety. They know that and they try to combat it as much as possible … the Vet Center, they were always nice, always professional. I just didn't quite hit it off with that group. (P8)

[Counseling with the VA] It got the discussion started, to the point where I can address the issue, I can discuss the traumatic moments. The Vet Center, I went through some groups, some counseling, relaxation classes there, I found was that more helpful. (P9)

[While on active Guard status] I didn't want to talk about, I just wanted to leave it alone. You know. So I went and I talked to this lady and she kept pushing me and I got mad, I got really mad at her. I told her, "what fucking part don't you understand I don't want to talk about it." … The VA can't even get it together whether I have a TBI or not, even with several professional people telling

me I have a TBI. … The OEF-OIF coordinator, "tell them the truth, that something's bothering you, something is going on told me. You have done your time, you've served your country. Tell them so you get the benefits and the help you need." I've had road rage, [but] I never have gotten into a physical altercation with anybody, but I have had verbal arguments, not a lot. I tell them the truth, I tell them these things, they mark my paperwork that I am a threat to myself and others. Then they turn around and put me on the Brady Bill. (P10)

I do not have a vehicle, to get transportation over there and make appointments, is really a pain. So I've been really kind of dealing with it on my own. If it's anything really important … I could make a call. I just recently, there's a VA rep that comes and visits me every so often, checks up on me, just to see how I'm doing and stuff like that. That's kind of cool. The experience itself was good. They do what they can. … All of them, more or less, are willing to help out and do what they need to. (P11)

They tried to offer help to me, but my gawd, it's been almost three years now. … Anytime I get a call from a therapist, the first thing I hear is "I'm a civilian contractor" and I pretty much shut them down, for me it's a waste of time. What I would need personally is someone I know was in a combat zone, who has dealt with this kind of stuff, who has found ways successive and proficient ways to deal with it. I don't need that 25-year-old girl that just graduated college to tell me "I'm sorry for your loss." (P12)

Theme 3: The Human-Animal Bond

The potential therapeutic use of animals for combat-related PTSD began receiving attention around 2007. Even with individuals having experience with animals prior to developing PTSD, the realization of animals' sensitivity to symptoms did not exist for participants.

Subtheme 1: Acquiring a companion animal. For the 12 veterans, diverse events lead to introduction of their animal into their lives.

> [Getting involved with PTSD service-dog training] I had three dogs and didn't want to add to my pack. … She graduated ahead of her class … the way they work, they train the veteran to train the dog. They never hold the leash, so to speak. (P1)
>
> I see this guy, this little asshole, who had all these puppies in a chicken-wired fence and they were all bloated and had worms and ticks all over them and everything else like that. … They called the SPCA and then they confiscated the puppies … said I would really appreciate having one of the puppies … I said, "I want this one, right here." (P2)
>
> She just showed up at the house. For whatever cat reason, she would just crawl up on my lap and keep butting my hands with her head until I would start petting her and she would start purring and I would be able to calm down and mellow out. She mellowed me out. (P3)
>
> I was having a really hard time dealing with the deployment and all of the

emotional stuff that went along with it. … [My social worker] wrote a letter for me, recommending the [dog training] program … I visited the shelter and I saw Dixie. This program allows you to have your own dog. … There was something about her; I couldn't leave her in the kennel. (P4)

A friend of my in Texas … he was very aggressive. … I saw this guy with the puppy and he was a *changed man*. It was amazing! … I went to the shelter … Runner, my dog now, he smelled me for a couple of minutes, and let me pet him. Then he kind of wandered around the fence area and smelled everything. I said, "I like you dog, I like your style. Kind of like come over, hang out and see what's going on, then you go smell around, do your own thing, then come back." We kind of connected and I adopted him. (P5)

My buddy has a dog … I like animals anyway. I am big in plants and stuff, gardening and growing, making things grow … just seeing the puppies, I just had to have one. (P6)

She was supposed to be my fiancés dog. We had gotten Stella as a puppy and on the way home, I held her, and I guess from that point on, she chose me. (P7)

The entire time I was there [the shelter], there was this little four month … probably, 4-6 week old puppy following me around. … So, I pick up this little puppy, who wrapped her arms around my neck, in a hug, and started snuggling her head underneath my chin, like a little angel …She named herself and came

home with me, and has been by my side ever since and I wouldn't trade her for the world. (P8)

I was traveling and I saw a girl flying with a Dalmatian. … I was having a lot of anxiety about flying and watching that dog just curled up at her feet kind of put me at ease. … There were some days were I could barely take care of myself and fears of being in a serious relationship. Having the responsibility, it was so overwhelming. … As soon as I met Cairo, he absolutely dispelled any anxiety I had about having a dog. I said, "Load up," he smiled and jumped right into the truck. … It was really neat, it was, "you keep talking about it, you obviously want to do it, man up. Step up Marine." … I have seven [cats]. I have four and my girlfriend has one, then there are the kittens. (P9)

My wife wanted to get involved in training service dogs … we went and picked up J in Maryland and I was going to train him for somebody who needed him. I was glad for that…. [Playing with Dane] She said to me, "don't you get it," I said, "Get what." "This is the first time in two years that you've smiled and laughed." I said, "He brings me peace." (P10)

When I got out of active duty, I was living in an apartment by myself; I couldn't have an animal at the time. … Up until about six years ago when I got my hedgehog. I only got him was because the pet store I was in, the tank next to him had a dead hamster, and so I kind of saved him, I always wanted one and he was half off. He can't stay here, so I took him, yeah, he was really cool. … I got

> Rock about, I'm guessing she's about a year. She was just a couple months when I found her, so I am guessing about that. About a year ago for her and I picked Roll up about three months ago. (P11)

> One day, my wife and me decided we were going to go look at dogs and we were walking through and none of them really "spoke" to us and we didn't see anything we really liked. Then we came across Harley. She looks more like a scrub brush. She was jumping and wanting to lick us and play with us. So got them to bring her out, she laid in my lap, licking my face, she did the same thing with my wife, it was just like we knew she'd be a fantastic dog. (P12)

Subtheme 2: Pet responses to PTSD symptoms. Animals respond to participants' PTSD symptoms differently. Presented first are the canine experiences, followed by other the companion animals.

> When the individual has an [PTSD] attack, the dog is placed next to them … initially the dog gets scared and runs away, because this is happening and they can sense the different cortisol or whatever levels in the brain, whatever receptors, they almost immediately become keen to what is going on. … About two minutes prior, I didn't know it was coming because they come out of the blue … I don't really have a definite trigger...she started climbing up into my lap, I was sitting down and she jumps into my lap and started licking my ear to the point where I went "stop, stop, enough of that" where I had to calm her down and pet

her. … Sometimes I avoid the attack altogether. If I'm in the car and she starts licking on my ear … I know I need to pull over and address it. (P1)

He picks up on my symptoms automatically. He'll start nudging me or hopping on me to get me into a petting session or he'll grab my pants leg and start pulling on me or like my shirt or my arm and start pulling on me to kind of like bring me out of a flashback or anything else like that. (P2)

If she senses that I feel anything other than calm, she comes up "what's going on." … My husband suffered a TBI [traumatic brain injury] when he was deployed to Iraq and he sleeps with a CPAP [continuous positive airway pressure]. When we sleep, she lays in a spot where she can see both of us. If I have a nightmare, she checks on me, if he stops breathing, she checks on him. I also think it makes him feel comfortable that she goes everywhere with me. (P4)

I think when he feels that I'm stressed out … he'll come over and sit next to me, put his head in my lap, and want to hang out … he definitely knows, I think, that I need a distraction and I'll turn my attention to him and pet him and stuff. (P5)

He might be a little more playful or what to play, try to get up close to you. Especially at first, I go "go away, I don't feel like dealing with you," then I think about it and it's like "oh, come here, I know." (P6)

She also seems to know when I was having a bad day, she'll come over and lay her head on my lap. I have nightmares and she'll go and alert my fiancé

that something's wrong. She's looks after me more, I guess, than I look out after her. (P7)

She always, and even now, she always knows when my mood takes a turn to the south. She always knows when the depression is worse than it's supposed to be. … She knows when that depression hits, she'll come and lay as close to me as possible. She's trying to show me "hey mom, I'm here." With nightmares … she just snuggles closer, [and] she'll put her paw over me, it kind of wakes me up and I realize, "hey, somebody's here and it's her, and she's trying her little heart to comfort me." If I could take her everywhere with me legally, she'd never leave my side." (P8)

He'll come over and give me a nose bump. He looks like, from the Never Ending Story, Falcor, when he's getting his ears scratched … very relaxing face, he'll come to me and head bump me, "hey dude, just another day in paradise." He's very calming in that aspect. (P9)

He's been trained to help me to take my medicine, because I have short-term memory. He's been trained to help me with mobile issues when my legs don't want to work right and he's been trained to lick me in the face when I have flashbacks so they don't become full blown. He [also] patrols the house and he comes back and lays by my side at night. (P10)

She knows when the different moods are around. She knows when I'm angry, she knows when I'm sad, she knows when I'm happy. The different things

she does. It's great because whenever I'm sad, she'll kinda look up at me or just lay in my lap or lay her head on my shoulder like, "hey, I'm here." (P12)

Dogs were not the only companion animals represented in this study. The following responses reference the cat companion animals, and a hedgehog.

It's really uncanny. You hear about people training dogs to sense these different emotions and different circumstances with people. It's really uncanny how she senses this, she'll just be in my lap "scratch my ears and I'll start purring," it's really magical…here's this cat, who has just latched onto me. (P3)

I've woken up from bad dreams, nightmares; you wake up and you're at 100% and ready to go. And I feel the fuzziness of the cat next to me, it's my grounding agent. It reminds me "you wouldn't have your cat in combat, you're home, you're safe." … I'll get annoyed, obnoxious, and angry at the cat because it's loving me," quickly turns into a "you dummy, the cat's trying to tell you to quit being grumpy. … Their undying devotion and love, it's true friendship. (P9)

She comes to me... yeah, actually. When I'm feeling down, I don't know if she notices or not, but she tends to spend more time with me than normal. … I guess, like if I have a bad day at work, I'll come home and they'll jump on my lap. I have to calm down as I'm petting the cats, it draws my attention on them, I know they help that way. (P11)

> They aren't the most cuddly animals, but I got him when he was small enough where I could handle him and he actually helped me with my depression, a lot … just having something to take care of, I guess, and looking forward to coming home to him after school, coming home and taking him out of his cage and playing with him. It would get my mind off a lot of things. (P11).

Subtheme 3: Other pet benefits. Participants felt that the benefits of having a companion animal did not stop at their PTSD symptoms. Some of the individuals reported taking lower levels of medicine, others mentioned the development of a bond that went unfulfilled elsewhere in their lives. Even getting out of the house was a benefit of having their companion animal.

> It helped me out tremendously and I didn't have to take pills … my leadership was really encouraged in the way that I responded to this treatment. Having her at work … they liked that too. (P1)

> He helped me a lot, especially since I was in a wheelchair when I first got out and couldn't do too much. … I just feel that having an animal, a companion animal or service dog for PTSD it definitely a big factor that can help you recuperate from a lot, a lot sooner and adjust. … Black's my buddy. He is my baby. I've had a couple of girlfriends get pissed because I show him more affection than I did them. (P2)

> She'd start purring and I would be able to calm down and mellow out. She mellowed me out. How it works, I don't have clue because I'm really a dog

person. … I believe [she] has allowed me to stay on a milder medication, at a lower dosage. (P3)

When I got Dixie … there's something having a dog like her that will, it gives you a sense that everything's going to be OK, everything's safe. … I was taking it [Klonopin] quite a bit because I was so stressed out about being in the Army and going to work … I had enough. She's so soothing and so calming, that [Klonopin] was the first medicine I stopped taking. … We have to go outside and walk every day, and play … it got me out of the house. I was sleeping a lot and just laying around in the house … then just having her with me, like going to the store and things like that, I don't focus as much on things going what's on around me, I'm more focused on what she's doing. (P4)

He's very "pet me know at all the right moments." … I walk Runner every day. I try to take him to the campus lake and do a two mile walk with him every day. So it gets me out of the house because I have to take care of his health as well as mine. … he's really helped reestablish my patience and tolerance for certain things like that. He's one hell of a great dog and great presence in my life. (P5)

I think things, especially with my animals, they give me something to focus on and turn my attention. … We started going to the park and started running. It gave us something to do and get out and both of us could get some

exercise. I'm a firm believer exercise keeps you calm, keeps your depression down, keeps you where you don't get as aggravated. (P6)

She's very protective … sometimes with other people, she doesn't want them getting close to me. She kind of provides that buffer zone without my having to back away. … the dog ain't going to judge you about anything, they interact with you without any judgment, you know, that unconditional love. (P7)

I really wouldn't have the sense of normalcy that I have … (pause) …it's a skewed normalcy but a normalcy, in my world, that I have with Heaven and now with Princess … Just at night when I wake up from a bad dream, and I have Heaven curled all the way as close to me as possible on one side and Princess cuddled on the other side, with her head thrown across me, just a comfort comes over me and I know that something at least is right in the world and I my girls are here. (P8)

I'll be grumpy and the cat will be at my feet, just loving me, and I'll get annoyed, obnoxious, and get angry at the cat because it's loving me, then I'll catch myself saying, "you dummy, the cat's trying to tell you to quit being grumpy." 100% better, but when it gets difficult, they don't judge me. They don't have input, "this is what you should do, or maybe you should try this" or all the other commentary I get from people, who are trying to be helpful in their own right … their dying devotion and love, it's true friendship. (P9)

I love Dane with my heart. I love him with my heart. I can be having I was having a really bad day … like he helps me with the road rage, he gets in the truck and he lays his head on my lap, and I'm petting him, and he just goes to sleep, then we get to where we're going, I go "wakey-wakey" and he wakes up and we go and do what we have to do. … He is just like, he means so much to me. I would give my life for him. I would give my life for him. (P10)

When I would go to pet him [hedgehog], or go to mess with him, he would come out. He knew when I was going to take him out and let him run around and stuff like that. He liked it. He seemed aware of it. He would come and sit with me on his own. That was cool. (P11)

I get that sense of unconditional love. Not hope, it's that my dog, I get mad, she does something bad and I get onto her and I scold her, then 5 or 10 minutes passed she's coming right back to love on me, like "hey, I forgot already about it already, let me love on you, let me be a part of you." That unconditional, regardless of what I do, that my dog is always going to be there, she's always in my life, regardless. … Whenever … I feel like I can say what I want to say, whatever is going through my head, that I want to get it out, my dog will come up to me and just "do whatever you need to do, say whatever you got to say," that's where dogs are great. (P12)

Subtheme 4: Dog training programs.

> Paws and Stripes trains rescue dogs to be service animals for PTSD and TBI. … They train the veteran to train their dog; they never "hold the leash." … The good thing, once you're done … you have the ability to train your next service dog …this was helpful to me when Houston got hurt … I was able to train Tech. (P1)
>
> [With] PAWS for Veterans you take your dog, with the help of the psychiatrist, to train your dog so that it becomes your companion animal. Your dog goes through the program. … He was a companion animal at first, later you can have them certified as a service dog for PTSD. (P2)
>
> We had women, guys, we help them train their dogs. … We help them get the dogs and help them train the dogs for free. … We just want to help these people find some normalcy in life again. … If you go to a rescue or a shelter, it's not against them, there's nothing against those dogs, but you don't know the background of the dog, the health of the dog. That's the only thing we ask, get a good dog, from someone that is reputable, but after that, no money exchanges hands in any way. I am glad to be able to do that. Since I can't deploy anymore, this is my way of still trying to help them. Those are the heroes. Those are the real heroes. (P10)

Similar to other programs, Train a Dog Save a Warrior, assists veterans with PTSD in training their dogs. This is the program P4's social worker connected her with. "I didn't meet up with a trainer until August. … They mean well. I don't know if they don't have the resources or what the deal is, they don't train as much as you anticipate"

(P4). Further opinions expressed regarding PTSD service-dog training programs and animal-assisted activities are discussed under Subtheme 3.

Theme 4: Additional Findings

A benefit of open-ended questions is the freedom for participants to share whatever they feel is important. A number of statements addressed topics, not directly related to the participants' PTSD symptoms or companion animal experiences, but still enriched the understanding of the phenomenon as seen from their point of view. The subthemes that emerged were: (a) Is PTSD curable, (b) animal-assisted activities in PTSD treatment, (c) restrictions of PTSD service animals, (e) what needs to change, and (e) comments and opinions on the way ahead.

Subtheme 1: Is PTSD curable? A unique characteristic of the sample with this study was the wide range of deployment dates among the participants (2001-2011). During the screening interview with P3, he shared his opinion and the compared PTSD to diabetes, "you are never 'cured', but you learn how to cope and adapt" (P3). Based on that analogy, others were asked if they felt PTSD was curable.

> Once your brain is rewired and the chemicals in your brain, as I understand it, are changed, they are changed forever. PTSD super-charges the connection between the fight or flight response; it's like a raw nerve, you go to that response instead of a logical response." P1's opinion is PTSD is not curable, "but you learn to live with it, you learn to self-talk, self-sooth, or write it down. (P1)

We talk about this in our group quite often, especially when we get new guys into the group. They want to know if this is something that they will be dealing with the rest of their life, can we cure this. They hear about all these different supposed magic cures, the deep immersion type treatments and all this. We're like "no" we can control it. We can get down to the point "that's a trigger, it's not really happening, I'm safe, I do not need to react in a combat manner." (P3)

No. There can't be. … You can't unsee what you've seen, you can't undo what you've done. (P5)

I'm not trying to cure it, I'm just trying to keep it in check. If I feel myself acting a way I shouldn't be acting, I know I have to change that. If I focus too much on the wrong thing, or I get too aggravated … I try to do something to avoid feeling those feelings and reactions. (P6)

I don't know if it is curable. We still have Vietnam vets who struggle with it, some for over 40 years. I think that have more treatment centers than they did. So veterans coming back from Iraq and Afghanistan may not have as many problems as they did. (P7)

I have gotten worse and it is because I am locked up in my own head 24/7. And that's the only place I can be. The memories are still there, day or night. The triggers are still there and they catch me unaware. Seeing my doctor every couple of months to get my medication, it maintains somewhat of a normal life,

not 100% but I've tried it, I've tried to come off the medicine and it's not pretty. … We are constantly living that moment, the stressors that cause the traumatic stress, it's a constant thing, it's not something we easily forget unless we get amnesia or something. (P8)

I'm not entirely sure, to be truthful with you, that PTSD is something that should be cured. I think it's something that exists in everybody that ever lived, to some greater or lesser degree, I say that the war didn't...make me a man, but it helped define the character of the man I am. It's … not like a broken bone, if you set it just right and work really hard with rehabilitation, a lot of the bones will heal and you can be as good as you once were. It's something … it's entirely different. As individuals, we have to look at who we are, what we have, and what it is, and redefine ourselves … with these little quirks we have now. … They're suffering misinformation. It's scary to redefine who we are. We have a strong mental picture of who we are. The posttraumatic stress changes things. (P9)

I don't think it ... it can be coped with, for sure, it's always going to be there. The few experiences I had were enough, there is no amount of therapy, I don't think I could talk about it or recount the events enough to wash those memories away or how I feel about it. It's just … literally every day is coping with it. (P11)

Each individual war has had something happen to us service members to where we can no longer functionally live with ourselves. … We know the end

> result of us losing this battle with PTSD is death. Whether it is because we had an accident or because we took our own lives, I've lost five in the last year to suicide. Because they just give up. They do not see a light at the end of the tunnel. Neither do I, I don't see a light. I don't see me coming on top of this. And I, pretty much all my brothers that went through combat with me feel the same exact way, we don't see that light at the end of the tunnel. We see that, yes have a family now, yes we have things that we never had before, but we're always waiting for that end. We're waiting for us to explode that one last time, that our spouses are going to leave us. And we're going to lose everything we worked so hard for." (P12)

Subtheme 2: Animal-assisted activities in PTSD treatment. Based on their experiences with the military, PTSD, and the human-animal bond, the participants are in a unique position to reflect on the subject. To begin, presented below are the general opinions veterans had on including animal-assisted activities into PTSD treatment.

> They [Paws and Stripes] tell you when you graduate, you have a new mission. That mission is to get better … I still have my days; there are some situation where I may never walk without the leash, but that advocacy, helping the next guy, that kinship, all of that is the biggest healing product I have found. … It's like going into a restaurant and tasting something that you're like "oh, this is the best thing I've ever tasted," you want everybody to know about it, you're like,

"here, try this, try this"… that's the affect these dogs have. That's why I am into training and into help others. (P1)

That seems, from my understanding, now you have something, like your soldier, that is relying on what you do and bring back that love and affection and caring in return. … You have something saying I don't care, I love you anyway. (P3)

I 100% support it, in fact, if there was a way to federally sponsor a program that would be great. … I think society, people are always trying alternative ways to help deal with these types of things. An animal isn't a person you speak to … it's a responsibility, something you take care of and gives you something back in return. … If there's any way to convince the VA or Congress to allocate money to do research on this, I think it will be a wealth of goodness. (P5)

I think things, especially with my animals, they give me something to focus on and turn my attention. Still, even with them, my desire to talk with people or hang out with people, I just don't do it. (P6)

I think, a lot of people have done it, which shows that it really works. The dog ain't going to judge you about anything, they interact with you without any judgment, you know, that unconditional love. It kind of, you kind of feel safer. (P7)

> I know the VA says it doesn't have funding for this, that, and the other, but they need to put more research into the dogs, in a way the soldiers can relate to the dogs, and it will provide another level of healing to the soldiers. It doesn't have to be a dog, it can be a cat, a horse, a pig. (P8)

> [It] can be an amazing therapy for the individuals that's doing it. It's good for the people there volunteering … but doing something like training service animals, if you don't keep the animal and you hand it off to another veteran, you are bringing that other veteran into the program as well. Now you're helping two or three people along the way. (P9)

> Look at how many times they take therapy dogs and allow them to go to hospitals, convalescence homes, children hospitals, and those folks are being able to put their hands on those puppies and pet them, what happiness it brings them. (P10)

A difference in opinions existed regarding the appropriateness of this type of therapy or pet ownership for individuals with violent tendencies and severe anger and aggression issues related to their PTSD attacks.

> Guys that suffer from violent tendencies, they are extremely helpful because now you have this dog that you care about more than life itself … this dog is your new battle buddy … this dog has your six, you would lay down and die for this dog … when you get to that angry point, the dog will pull away. You can't fight with

> one arm, and you're so hyper-in tuned to the dog's well-being that you would never do anything to put it in danger, so you walk away. (P1)
>
> Grant it, not all veterans should have pets. I have friends who have incredible anger issues and I would not want them to have a small animal, as it would be a detriment to both of them. (P5)

Subtheme 3: Restriction on PTSD service animals. In 2012 and 2013, news agencies reported on DoD installations and VA facilities denying PTSD service animals on their properties. The Army issued Directive 2013-01 (2013) restricting the many service-dog training programs on Army posts and the VA changed its policy, discontinuing benefits for veterans to obtain a service animal due to their PTSD disability (Federal Register, 2012; Spotswood, 2012). In light of these events, participants responded.

> I mean the ADA [Americans with Disabilities Act] had legislature on this since the '90s, March in 2011, they passed that PTSD dogs are viable service animals. They felt the need to put that into the ADA statute. … No one, not Air Force, not military, including the VA, has the legal right to supersede federal law; it takes congress to do that. So when I hear stories of people getting kicked out of facilities, the VA, that stares in the face of the ADA and documented laws on the books. As long as you are well versed … boom! (P1)
>
> How is the DoD measuring what works for a veteran with a service dog? Like what kind of scale do they use, what methods are they using to determine

that it doesn't help? From what I understand, from what I've read, the DoD doesn't seem to think that PTSD service dogs help at all. I can't see how. (P2)

It's kind of crap that since the VA is hard-balling us. So many foundations are losing or lost their funding from the DoD … The Battle Buddy Foundation is another losing their funding … they specialize with animals for PTSD and TBI. With both programs, that all the do, service vets and PTSD dogs. … There's a couple different programs like the American Legion and the VFW and others that do have grants for service animals. (P2)

When I got her … I would see people with the service animals all the time. Shortly after, my brigade commander would not allow anyone to bring their service dogs to work with them … shortly after that I stopped seeing service dogs at the Reset and biofeedback programs, like they kind of banned that on Ft. Hood. … It wasn't fair to her and it wasn't fair to me, because I had been lower my meds so I could function a little better, but the reason why I could function better wasn't allowed. But they don't agree with it. (P4)

Subtheme 4: What needs to change. Considering their journey and their trials, many participants provided input on issues they believe need to change.

We have to stop treating PTSD is something to be ashamed of and to get the help. It has to come from the top down. It's not cookie cutter, you can't treat me like you treat the next guy. That is taxing on the system. I understand the need for budgetary concerns and cutbacks, but if we are going to stop this suicide epidemic

> we have to really ensure these people that are coming back, there will be no reprisal [and] they can speak freely and then follow up. (P1)

After P10 sought help for his PTSD, his career pulled from under him. The Air National Guard began processing his medical discharge paperwork without his knowledge; this happened to P10 and four others:

> You're fighting for what they say are your benefits. And they aren't going to give them to you and you have to know the right questions to ask. That ticks me off. … They get in the pissing contests back and forth. Start taking care of these guys. You promised us, if we got hurt, you'd take care of us, not jerk us around. And that pisses me off. (P10)

Three participants specifically commented on their beliefs that society's view of PTSD has to change with moving forward.

> I think my big thing too … sometimes you feel like you're arguing with talking points and not with real people. … They don't care and so apathetic towards it, and they don't want to hear, because when they hear about it they get upset and they want to do something [and] it adds more shit to their very full plate. (P5)

> We like to stigmatize the words PTSD and all the psychological terms we have to put people into these categories. They are just categorizing and having these negatively stigmatizations and connotations towards people who display these symptoms. They need to understand, "look, it's not like PTSD is something I asked for," it was something I developed from the experiences of something

everyone says, “hey, thank you” for going to do. So you can’t say “thank you for your service” then be afraid of what that service entails or the consequences of that service. I think that is what has to change, more than anything else, the human perception of what it is. I teach and instruct ROTC students. I am often asked about my experiences by these students and afraid to tell them the truth. My fear, if I tell them the truth, maybe they won’t go in. And then, there are media personalities like John Stewart, who don’t always put the military in the best of light. How can I promote sacrificing for an ungrateful nation? (P5)

It goes back to the stigma of the Vietnam veterans, with the postal workers; they’re “going postal” … they were reaching their breaking point. Even then, it was easier to make jokes about it and laugh about it that than was to address that there were some people really hurting inside. … I’ve discovered our nation and our society in general, there’s a reason the war is not covered, the way it is, because they do not honestly what to know what’s going on over there. Ignorance is bliss and there’s a reason it’s easier to have a paid military, that’s got people willing to do it, so, their hands are clean. I had social media with Facebook, I was doing some posts and some writings, I had people say, “Why do I care about Iraq, they aren’t bombing, they’re no threat to my children and all we’re doing is blowing schools up and killing children.” It really made me angry, to the point that, “Hey, are we blowing up schools, yes, but we’re rebuilding them. Because those schools were not schools, they were bomb storage buildings

> and you know what, fuck that kid's father who that put that kid in a car and put him in the middle of a combat zone." (P9)
>
> That's the main problem with our PTSD … we were in the military together. We were always, every day, almost every day we breathed, we were together. … We don't have that cohesion any more. Once we get out we look for that cohesion that we once had. … That's one of my biggest problems. I'll tell you now, I don't think … I have an awesome wife, I have an awesome family, and 99% of the time I don't think that anyone cares. I don't think anyone really gives a crap about what happened. A lot of my brothers feel the same way, it's like everybody around me don't really care, so what that I was in combat and I'm having these thoughts, nobody really cares. (P12)

Subtheme 5: Comments and opinions for the way ahead. Many participants found a connection with veterans from other wars; those who have share similar experiences. Considering the issues facing all former military members, many participants believe veterans helping veterans may be the key to the future of dealing with PTSD.

> I think, if we reached out to the veteran community, something like Veterans to Work … they are already doing peer mentor … it's helpful in both was with advocacy for the veterans, but then these guys can see someone that they know has been through it and not afraid to talk to them. … You are not going to find that peer mentorship because they are still too scared to talk about it. And

because there is a stigma that is still attached to it, I lived it since 2010. (P1)

I knew there were American Legions and VFWs there everywhere [and] speaking to people who had gone through the same experiences as you was really helpful. I found it paramount in the reintegration into garrison life. (P2)

One of the groups I was in Vietnam veterans, we had three Vietnam veterans, and myself, and one other Iraq veteran. The relaxation group was really neat, we actually had a WWII survivor. Seventeen years old on Guadalcanal, kind of a deal is like, "I lied to enlist so I could go fight in the war." … When you listen to that man, you can see what happened 60 years ago hasn't … it defined his character but it didn't define his life. (P9)

I know what they've been through. That's where the connect is, if they feel like they want to talk about it, they can talk, if they don't want to talk about it, I don't care, I don't push. Some people have said, are we going to have to talk about it, I tell them "no, if you don't want to we don't have to. That's not what this is about. … I tell them you will never hear me tell you "I know how you feel, because I don't." I tell them, "I get, I understand where you're coming from. But I don't know how you feel because I wasn't there at the exact moment, at the exact second it happened, but I understand where you're coming from." (P10)

Parting Thoughts

Participants had the opportunity to voice other personal opinions as part of their story. Concerns raised after opening the interview typically did not fit into an established

theme and the topics greatly varied. The following statements were some of the subjects shared by participants, expressed with passion, but not captured elsewhere in the results.

> [I] would send my guys, services troops … onto provisional re-constitutional teams in Iraq and Afghanistan. These guys living outside of the wire for 189 or 365 plus days … putting themselves in danger every day. … That's what we have to stop cookie cuttering ... any person in a support function is going out doing convoys every day because they run the motor pool but yet, they are getting flak from leadership and everybody when they come back because they didn't serve in the traditional combatant role? (P1)

> I think that we really have to focus on … PTSD and the suicide epidemic from a totally different direction. … If the DoD takes the stand, we're not paying death benefits on suicides … it's not the family's fault, we shouldn't hurt the family and I agree with that, but how do we strike a balance between an act and jut giving them the money. … I think we could change the face of suicide, if we took a stronger – it's not going to be a popular one – stance on how we post-handle suicides. (P1)

> Drugs isn't the answer. I know that medications have a purpose, they really do. Just doping people up to deal with different emotions, it's not good. You're not helping the problem. Medications are a band-aid, you are not fixing the problem, it's just a quick fix. So, a lot of time we question the fact, what are they doing just doping these people up so they don't have to deal with them? Is

that what is going on? (P10)

The Brady Bill means that I can't own firearms, ammunition, or any of that stuff. 53 years old, I have never been arrested for domestic abuse, I have never been arrested for fighting … but now I am fighting to clear my name so I can continue to hunt. … I can't do finances, that's why my wife is my fiduciary. But once you have a fiduciary on your paperwork you name automatically puts on the Brady Bill. How in the hell is that fair? I was trying to save lives, I wasn't taking lives. But yet, I was OK to send overseas, I was OK to fight for my country, I come back and I have to fight for the stuff I need. (P10)

A big thing with veterans, we feel like we don't have a voice. You go through, we go through our military career being able to stand up for ourselves and say, "Hey, wait a minute, this isn't right. This is completely morally and ethically wrong." Then we get out and that's taken away from us. If we had someone, or a group, not just a single person of course, but a group that would look at our needs and our opinions and experiences and actually put them into a voice to where the VA, the Senate, the Congress, even the President, would see how, forces upon them to see, "Hey look, we have people that make up about 10% of the population, that they need help from what we defended." We need that help. (P12)

Finally, P1 and P10 both voiced concerns regarding policies surrounding the combat ribbon and the classification of "combat action" as it pertains to benefits.

> This guy went on a convoy to move some stuff from the provisional reconstitution team and they had a car come up and try to hit the convoy … he was the gunner, he put rounds in the car and disabled the car. He didn't kill anybody, but he took enemy aggression and squelched it and he couldn't get a combat action medal because of his career field, because of a number. This has to stop. (P1)

> I was … one of the guys, one of the five that were discharged. He got a combat ribbon. OK. And he was a flight medic and he was fine. I spent my time on the ground, I never left the ground, I didn't get a combat ribbon and because I didn't get a combat ribbon, I don't get special compensation. You get both, VA and military. And because I didn't get a combat ribbon, I don't get that. All because of a stupid medal. … Then on top of it, you get this rating, were your injuries a result of combat. They will mark it "no" but did you serve in a combat zone, "yes." It's a technicality on words because in order to get injured in a combat zone, you have to be in direct contact or an instrument of war, you're either shot at, involved in an explosion, physically involved or something like that. (P10)

Composite Description

Moustakas (1994) recommended that a researcher develop a composite description of the themes identified from the individual participant analyses, constructing a universal narrative, representing the group as a whole. This composition is a way to understand how the participants as a group experience the phenomenon being studied.

The following integration of textural and structural descriptions represents the experiences of this study associated with combat-related PTSD and the presence of a companion animal.

Uncertainty fills combat deployments. After arriving at the deployment location, what combat elements will the military member encounter? How many times has each individual deployed? Are those deploying for the first time prepared for whatever they may encounter? Are the seasoned combat-veterans rested and healthy from their last deployment? The dynamics of war are not the same as those of 60 years ago: distinguishable uniforms do not always exist, the "other guys" do not always play "fair" with their guerilla warfare tactics, and dependent on the circumstances, the non-traditional combat personnel may be required to operate "outside the fence."

The pressure builds. The events encountered may be specific, non-threatening instances on their own, but collected, may chip away at the military member's levels of mental resistance. The events may also be destructive and life threatening, leaving survivors injured and losing members of their unit. The stress builds. The military member typically feels something inside them has changed. They sense they are not the same person they were before the deployment.

Mixed feelings surround coming home. There are happy feelings over leaving the austere conditions of deployment and the reunion with family and friends, but there is also an inability to "turn off" the constant vigilance and other life-saving techniques required from the previous months. Relating to others is difficult, relaxing seems

impossible, and the anxiety is overbearing. Sometimes there is anger; sometimes there is isolation – it is often better to avoid people and crowds than confront the irritation of "dealing with" people who do not understand or constantly scan for "an out" at each location, just in case. Intrusive thoughts dominate daytime existence and nightmares invade their sleep. When driving, every pothole, pile of trash, or other obstacle is an improvised explosive device requiring aggressive maneuvers to avoid. Then there is another feeling – guilt. Guilt because they survived; guilt because of what the military called them to do. Sometimes the military member does not know how to feel, where to turn, or who to trust; they know they might need help, but that is "admitting a weakness."

Seeking help for their PTSD often has the same uncertainty associated with deployment. Will admitting the weakness change how others treat them? Will their military career end? Will they get the help they need? The unfortunate reality is that PTSD treatment often consists of misdiagnoses, potential impacts to military careers, side effects from prescription drugs, struggles in finding a rapport with a group or individual counselor, or even getting help at all. If available, the military member often feels like there is a "one-size-fits-all" approach to PTSD treatment; everyone is treated the same regardless of the experiences and injuries sustained. The availability of new counselors by the military and VA locations offer mainly unqualified persons to address the experiences of war; the alternate of group-styled therapies is often a turn off for the military member. Yet, if the member is lucky, after a few attempts, they find a counselor, group, or other arrangement that assists with developing some sense of relief.

At some point after deployment, the military member acquires a companion animal and finds a connection that has gone unfulfilled with other relationships in their lives. The type of animal is greatly dependent on the individual's life circumstances; however, regardless of the type of pet, the individual has a new focus, a "grounding agent," and "something to look forward to." If the companion animal is a dog, the member may seek a service dog-training program or just have a loyal "battle buddy" there to listen, cuddle, protect, and play. The feline pet lies on the member's lap and purrs their "troubles away" or playfully gazes up to their owner with "undying devotion." Even a hedgehog provides the military member with a sense of companionship, looking forward to time out of the cage, and sitting next to the individual on the floor.

There is a love for the companion animal, a distinct tenderness or playfulness in the tone in the veteran's voice discussing the companion animal. It seems the undying devotion is a two-way street. The animal's presence provides a sense of security, that "at least something is right in the world." Sometimes the companion animal senses oncoming PTSD attacks and helps the individual minimize the severity or even prevent an attack from occurring. For the individual with combat-related PTSD, the animal does not judge or criticize; the member is simply "good enough." The companion animal is a "grounding agent," an unwavering presence in the veteran's life.

The individual has strong opinions and comments about the events in their lives and the injustices they experienced. First, they feel PTSD is not curable, "you cannot unsee what you have seen, you cannot undo what you have done." There is anger at the

politics played with PTSD and the social stigma advocated by many ungrateful media commentators. Also present are feelings that the military did not uphold their promise to take care of the needs of service members and that a voice advocating veterans' issues is absent. Lastly, there is a sense that until society is willing to have an honest conversation about PTSD, the discussion will continue to surround talking points and satire jabs over "what went wrong."

Summary

In Chapter 4, I described the findings from a phenomenological study in which 12 veterans with PTSD symptoms and a companion animal shared their experiences during an in-depth interview. After analyzing the transcribed interviews, four themes emerged; deployment experiences, experiences after deployment, experiences with the human-animal bond, and other. Within the main themes, 12 subthemes emerged; a full presentation of themes and subthemes are located at Appendix E. All themes and subthemes presented the textural examples to capture each participant's experiences.

An interpretation of findings follows in Chapter 5.

Chapter 5: Summary and Recommendations

Introduction

The purpose of this chapter is to summarize and discuss the findings from Chapter 4, which explored the experiences of a sample of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OEF) veterans, with combat-related posttraumatic stress disorder (PTSD), and have a companion animal. The research literature presented in Chapter 2 identified a significant gap in understanding the experiences of combat-related PTSD symptoms and the human-animal bond—from the individual's point of view. To provide a first-hand perspective on such experiences, semi-structured, in-depth interviews were used. The result of this phenomenological design was a rich description of the participants' experiences after deployment and of the perceptions of the human-animal bond in 12 participants lives.

In addition to the two main interview questions that extended from the research question, a third query explored participants' opinions to whether or not PTSD is curable. The interviews also allowed veterans to express comments or concerns for inclusion as part of their story.

Purposeful sampling identified 12 OEF or OIF veterans with PTSD and currently had a companion animal. Although the study was open to veterans or those on active duty, all participants included in this project had separated from the military. The data analysis revealed four themes and thirteen subthemes. The four themes consisted of experiences surrounding (1) deployment, (2) after deployment, (3) the human-animal

bond, and (4) additional findings. Appendix E presents the themes and subthemes that emerged from my analysis.

Through the creation of textural-structural narratives (Appendix F), the experiences disclosed by participants evolved through the conceptual frameworks and theoretical foundation introduced Chapters 1 and 2, constructivism, phenomenology, and the diathesis-stress model of PTSD. A personal interpretation of social contexts and world experiences constructs the individual basis of knowledge (Mayo, 2010); the incorporation of this knowledge consists of sensory and physical elements and creates unique realities consistent with the specific components. The diathesis-stress model of PTSD posits that every individual is vulnerable to the development of PTSD, based on the personal elements that interact with the environment (McKeever & Huff, 2003). In the sample interviewed, participants' shared some of the experiences they believe increased their PTSD vulnerability, such as multiple deployments, direct combat exposure, and other non-military factors.

The remainder of the chapter discusses the interpretation of findings by major themes and subthemes, the limitations of the study, recommendations for future actions, implications for social change, and conclusions.

Interpretation of Findings

The experiences of 12 OEF and OIF veterans provided a glimpse into the world of combat-related PTSD and the human-animal bond. Beginning the study, I anticipated the experiences associated with the human-animal bond to dominate the interviews; in most

cases, almost the opposite occurred. Many of the participants focused more on their military and PTSD experiences than on the bond and interaction with their pets. My feeling is that this may be the first time participants were asked their opinion about their experiences. The following interpretation of findings presents the themes that emerged under the theoretical foundation introduced in Chapter 2, the diathesis-stress model of PTSD, which in itself encompasses the conceptual frameworks of constructivism and phenomenology.

Theme 1: Deployment

McKeever and Huff (2003) and others presented the development of PTSD as the result of personal internal and external elements combining with exposure to one or more traumatic events. These elements consist of factors such as personality, previous traumatic exposures, coping skills, and other characteristics unique to the individual. This theory also suggests everyone is vulnerable towards developing PTSD based on the personal and environmental variables in the equation, squelching the misconception that posttraumatic stress is limited to direct combatant forces.

Five participants spoke directly about their deployment experiences; one veteran's military duties placed him in direct combat, while the other four were combat support roles. A misconception about PTSD is that personnel who do not experience direct combat are not at risk for developing the disorder. Individuals are exposed to different types of traumatic experiences, some of which may not entail life-threatening events (i.e., being shot at). But if details of the events are particularly gruesome or horrific, the

repeated, nonlife-threatening incidents tend to accumulate in the development of PTSD. For example, two participants repeatedly faced the horrendous results of combat, the mortuary non-commissioned officer and the medical radio operator who assisted with patient triage.

The elements involved with the different types of combat exposures appeared to affect the development of PTSD as well as the metamorphosis of symptoms and triggers after returning home.

> Different types of attacks, it was more than just a change of scenery, it was a change of people and so their styles were different … That would cause, well it did cause me, to have different types of panic attacks when I came back. I had more things that would trigger unwanted memories and trigger me back into survival mode. (P3)

The types of exposure may also shape how and when symptoms surface, such as in the case of the Navy electronic warfare technician. His story exemplifies the concept of "delayed onset PTSD," where symptoms do not surface until years after the traumatic exposure (APA, 2013a). These different aspects of the combat deployment also emphasize the APA's changes to the PTSD diagnosis criteria in *DSM-V* (APA, 2013a, 2013b), including "experiences first-hand repeated or extreme exposure to aversive details of the traumatic event, not through media, pictures, television or movies unless work-related" (APA, 2013b).

Understanding the development of PTSD from a variety of experiences provided a more detailed picture of the issues military members face. Naturally, one concern continues to focus on the ground combat forces generally attached with the Army and Marines; however, as budget cuts continue to decrease the number of military personnel, strategic planners rely more on pulling individuals outside of their traditional support functions to fulfill occupational needs "outside the wire." Another concern is the understanding how the repeated exposure to otherwise less severe events when combined with the elements of combat (i.e., medical attention to combat injuries), appears to incrementally deplete an individual's emotional and mental resistance. Repeating a general theme referenced by many of the participants, people returning from war are not the same as when they left.

Theme 2: After Deployment

Subtheme 1: Coming home. Most of the participants returned home carrying residual effects from their deployment experiences, attempting to reunite with a life that continued unscathed by the horrors of war. Previous research described PTSD symptoms in terms of diagnosable criterion and onset, but lacked a detailed description of the experience. Participants described an isolation and depression resembling feelings of being trapped in an invisible prison; difficulties relating to people, privately sorting through what happened, fearing public places and crowds, the inability to "turn off the life-saving habits" (P9), and the rising anger that divides the veterans from the life they once knew. P1 commented on a fear behind protecting loved ones from his experiences,

P7 described it as being "on auto" – the shying away from others, but not really understanding why. The perceptions hint at a sense of confusion towards the newly transformed person that emerged from an OEF or OIF deployment, leading to a growing anger over the uncontrollable nature of PTSD and its contributing events.

Subtheme 2: PTSD.

Post-deployment screening. Coming home included some level of post-deployment screening for PTSD. Screening policies have evolved since 2001 and recently include up to four assessments over a two-year period (DoD, 2013b). But, does increasing the number of assessments increase the number of people who will receive treatment? The responses from the participants in this study suggest not. Noted were two trends with participants' responses on post-deployment assessments: their attitudes towards the assessments and inconsistencies with testing and follow-up actions. Mittal et al., (2013) and others reported that the stigma associated with PTSD negatively correlates with military members admitting help was needed or in seeking treatment, "admitting a weakness is something we don't do" (P8), "we were afraid if we said something" (P9). Comments such as these propose that although policies regarding post-deployment assessments have changed, the attitudes towards it may not have.

The reliability of PTSD prevalence rates reported in literature (i.e., Ramchand et al., 2010) reflect a lack of a common definition, a constant reportable source (post-deployment screening versus confirmed diagnosis), and the sample studied (combat versus non-combat units). However, experiences shared by participants may infer that

inconsistencies exist with assessment practices may be another factor with the percentages published. "She said, 'Well, yes, I definitely think you have PTSD, but I don't think it's that bad so I'm just going to diagnose you with adjustment disorder'" (P3), "[They] told me my signs and symptoms weren't severe enough to get help" (P10). The discussion on experiences behind the development of PTSD are presented under *Group Therapy*. However, sentiments among some of the individuals interviewed on the mixing of combat and non-combat specialties in group therapies might also allude to potential differences in PTSD prevalence rates among occupational units and "averaging" the rate across military functions may be misleading (see Gates et al., 2012; Langston et al., 2007; Ramchand et al., 2010).

PTSD symptoms. PTSD manifested in different ways and times for each participant, but everyone reported some combination of the following symptoms: hypervigilance, flashbacks or olfactory hallucinations, anxiety and panic attacks, uncontrollable emotions, issues with driving, isolation and avoidance of public places, nightmares, increased excitability, and guilt. Reported symptoms were consistent with standing symptoms included in the recently updated *DSM-V* (APA, 2013a). A noteworthy observation is the level of detail many of the veterans used in sharing their experiences to enrich the understanding of the phenomenon. "I felt I was truly emotionally out of control" (P4), "There's all this guilt you feel about different things" (P5), "I can feel my body, my blood pressure, my breathing gets heavier, faster, it's

almost like a panic attack" (P11), "I want to just leave everything behind. I'm angry … and then there are times I don't want to get out of bed" (P12).

The guilt associated with PTSD was a focus for five participants. For some participants it was surviving while teammates died; for other participants it was guilt over the number of lives lost as a result of their combat missions. Then, there was guilt over failing to protect family members from the negative effects of PTSD. Earlier research identified higher PTSD vulnerabilities in persons experiencing guilt resulting from combat experiences (see Held et al., 2011; Hoge et al., 2004; Maguen et al., 2009; Maguen, Lucenko et al.; 2010; Maguen, Vogt et al., 2010; Van Winkle & Safer, 2011).

Subtheme 3: Separating from the military. For a handful of participants, their involvement in OEF and OIF resulted in an unplanned separation from the military. Even after the DoD and military leadership began speaking about the importance of seeking mental health assistance, some participants felt resentment over the perceived fairness of their separation from the military. Also mentioned by veterans was how little prepared they felt with transitioning to civilian life. Physical injuries may have played a primary role with separating from the military for most participants; however, P1 and P10 believed their PTSD directly resulted in their involuntary separation. Experiences such as these only strengthen the fears military members have in admitting problems with PTSD. Britt et al. (2012) and Wright et al. (2009) reported that leadership attitudes towards treatment influenced the overall openness towards seeking treatment. If military members perceive that their leadership either is involved with or supports medical

discharges for individuals with PTSD, it is plausible that the rates of people who voluntarily seek treatment will remain low.

In 2012, the DoD launched a new program to replace the optional Transition Assistance Program, a seminar aimed at assisting military members departing active duty military for civilian life. The new program "changes the current program from a discontinuous set of activities into a cohesive, modular, outcome based program that provides opportunities and aids in successful transition into a career ready civilian" (DoD, 2013a). This is a positive change for current and future military members; however, the DoD website did not mention if access was available for individuals already on veteran status.

Subtheme 4: Treatment. All of the study participants tried getting help for their PTSD; only two individuals reported continuing with some type of therapeutic program other than medication. One possibility for the low number of participants in a maintenance treatment program could be availability of programs across different VA centers; a concern addressed in earlier literature (see Hoge, 2011; Jones, 2012; Litz, 2007; Tanielian et al., 2008). Reported experiences about trauma-focused psychoanalysis and group therapies used in PTSD treatment varied across interviews, partly due to the personal dynamics attached to the program or the availability of qualified providers. Many of the responses indicated an initial struggle with admitting they needed help, and then a struggle to get the help. Dissatisfaction was expressed over the availability and accessibility of treatment programs and the ability of civilian providers to deal with

combat trauma. Earlier research revealed beliefs that PTSD treatment was ineffective and a lack of trust in mental health professions (not wanting to talk about their PTSD) were two of the most commonly reported reasons for not seeking PTSD treatment by military personnel (Britt et al., 2012; Erbes et al., 2009; Hoge et al., 2004; Kim et al., 2010, 2011; Tanielian et al., 2008; Wright et al., 2009).

Prescriptions. One constant among interviews was the prominent role prescription medications play in PTSD treatment with military and Veteran Administration (VA) providers. P4 commented, "they had me on so many medications I was afraid to drive my own car." P10 asked if providers relied too much on medication as opposed to addressing the root issues of PTSD. The side effects associated with most PTSD medications was another common reason why military members refused to seek help (Britt et al., 2012; Erbes et al., 2009; Hoge et al., 2004; Kim et al., 2010, 2011; Tanielian et al., 2008; Wright et al., 2009). Most participants in this study described experiencing undesirable side effects from prescriptions and all participants except one reported actively reducing their need for medications or discontinuing use of pharmaceuticals entirely.

Group-styled treatment. Frustrations exist over a perceived "one-size-fits-all" approach to PTSD treatment, leading some of the participants to give up entirely on therapeutic assistance. For example, P6 admits he is more of an introvert, who still does not want to talk about his experiences, even after almost 10 years since his deployment

and P8's crippling anxiety over public places rule out group-styled therapy. P5 watched his friend's symptoms become worse through attending group-styled therapies.

Pervious literature reported multiple deployments, killing (enemy combatants or friendly fire), and sustained injuries were significant predictors of developing PTSD (Adler et al., 2005; Maguen et al., 2009; Maguen, Lucenko et al.; 2010; Maguen, Vogt et al., 2010; Van winkle & Safer, 2011). These finding were supported first by P8's belief that there are "levels of PTSD" and possibly affect the therapeutic potential of general group-styled therapies. For instance, P2 and P12 feel they cannot relate to veterans whose PTSD developed after witnessing "something happen" as opposed to experiencing life-threatening events such as surviving an ambush. Prior research concentrated on PTSD risk factors and predictors of disorder development, it did not attempt to determine if different types of events resulted in varying levels of symptomatology.

Yet, three of the participants had positive experiences with traditional group settings and offered encouraging ideas about alternative approaches to groups. One idea offered recommended removing the expectation of talking directly about PTSD or deployment events by creating more activity-based programs. This type of approach may create an environment where spontaneous, natural dialogues could occur. Another suggestion generated by the interviews was to look towards others with combat experience in a "veterans helping veterans" approach in dealing with PTSD (Mittal et al., 2013).

Other treatment experiences and the VA. The main impression on the topic of treatment emerging from the analysis of treatment experiences and the VA was "hit or miss"; some participants were lucky and found a program that worked for them (hit), and other participants felt the system completely failed them (miss). Even with the successes, interviewees shared at least one or two failed attempts prior finding a treatment program that worked. The inclusion of civilian providers to meet the growing demand for PTSD treatment (Tanielian et al., 2008; VA, 2012) was not a successful change, based on the experiences shared; "I don't need that 25-year-old girl that just graduated college to tell me 'I'm sorry for your loss'" (P12). However, the social workers paired with participants seemed to have worked rather well, whether matched through the military or VA. Other comments targeted the VA's PTSD disability recertification, "The real frustration comes when you go in for disability evaluation" (P3). Additional literature assessing the effectiveness of the added psychological staff has not been identified.

Consistent with previous literature (Chard et al. 2010; Litz, 2007; Rauch et al., 2009; Tanielian et al., 2008) most participants suggested a number of inconsistencies with the level of services provided at different VA facilities. For P7, there was huge difference in the timeliness of scheduling appointments between two VA centers where he received medical attention, "I would have to make an appointment with primary, that would take a month. Then they would refer you to see someone that would take a month. Then it was probably another month to two months out before the appointment. … I can

call [now] and get an appointment with my primary, generally within a week." With P8, if she wanted to try grouped-style counseling, few options exist at the VA in her location.

Theme 3: The Human-Animal Bond

When interviews transitioned to their companion animals, the change in the participants' tones was immediate. Some voices became playful; others flowed with adoration and affection. The bond between participants and their pets were unique, but collectively, the stress and agitation that encased the deployment and PTSD experiences melted at the mention of their pets' names. Even when the veterans could not accurately capture the sentiments they felt towards their pets, the emotions filled with each sentence conveyed how the human-animal bond met individual needs unfulfilled by other relationships in their lives.

The circumstances surrounding how each animal came into the veterans' lives varied and most participants owned a dog or cats. However, P11 had a hedgehog as a companion, which fulfilled many of the same "needs" mentioned by other participants, just in a different manner. The experiences shared in this study support and amplify the existing literature on the human-animal bond that suggest the presence of an animal can increase physical, biological, and emotional well-being (see Hooker, 2002; Solomon, 2010; Walsh, 2009). P11's experience also opens the discussion to other animals that have interaction styles different from dogs and cats (i.e., birds, hamsters, reptiles, etc.). However, as already identified as a gap in literature, an investigation into the experiences of the human-animal bond in general is scarce and no other works was found where a

military population was sampled. Many of the subthemes that emerged could not be tied to other research or anecdotal literature.

Subtheme 1: Acquiring a companion animal. The first observation was how many participants felt like they "saved" their pet, the former military member exercising that protective nature. "All these puppies in a chicken-wired fence … bloated and had worms and ticks" (P2), "I couldn't leave her in the kennel" (P4), "The tank next to him had a dead hamster, so I kind of saved him" (P11). Another commonality across participant responses was the immediate bond that developed to their animal. ""I held her and I guess from that point on, she chose me" (P7). Whether the animal's presence provided a welcomed distraction, a nonjudgmental companion, or simply a reason to smile, it was an opportunity for the individual to get outside of him or herself and his or her PTSD.

Subtheme 2: Pet response to PTSD symptoms. A growing, informal type of therapy is the use of trained service dogs for PTSD symptoms. P1 and P12 specifically trained their dogs to the service-level certification, but other responses talked about their canine's inherent ability to sense on-coming PTSD attacks. This tendency follows the canine's natural pack orientation and subsequent need to placate their owners. "She started climbing up into my lap … started licking my ear" (P1), "He picks up on my symptoms automatically" (P2), "If she senses" (P4), "She seems to know" (P7). Some techniques participants used to counter PTSD symptoms include refocusing or playing with the dog and self-talk through the symptoms.

It appears that dogs are not the only animal capable of calming their distressed owner. Speaking of the stray cat that walked into his life and her ability to sense his surfacing symptoms, one participant stated, "It's really uncanny. You hear about people training dogs to sense these different emotions and different circumstances with people" (P3). P9 and P11 also remarked their cats tend to be more attentive just prior to the participants' experiencing PTSD symptoms. With P11's hedgehog, it was not apparent that the animal knew or sensed on-coming symptoms, but it recognized and welcomed the human interaction, which meant the world to P11. Some participants commented the presence of their pet also served as "grounding mechanism" when waking from a nightmare or flashback, "You wouldn't have your cat in combat, you're home, you're safe" (P9).

Subtheme 3: Other benefits. The benefits of having a companion animal went beyond alerting the owner of on-coming PTSD symptoms; consistent with human-animal bond literature, the presence of a pet improves overall quality of life (Barker, Knisely, McCain, Schubert, & Pandurangi, 2010; Hooker, 2002; Sacks 2008; Solomon, 2010; Walsh, 2009). Similar to comments made by patients recovering at Walter Reed, veterans in this study disclosed that additional benefits included adjusting faster to civilian life, increased feelings of security and protection (i.e., easing their constant hypervigilance), companionship, a nonjudgmental presence and unconditional love, and a reason to get out of the house and exercise (Alers & Simpson, 2012; Beck et al., 2012; Yeager & Irwin, 2012; Yount et al., 2012). An interesting comment was P3's admittance

that he is really a "dog person" although a little stray cat completely "mellows me out" (P3). Between P3's statement and the hedgehog experience, further investigation on the influence of lower maintenance animals like birds, reptiles, and other small animals is worth considering.

Another benefit discussed by participants was the presence of their pet reducing their need for prescribed medications. Four participants specifically shared that they believed the presence of their pet is helped either reduce their need for prescriptions or is the reason for a lower dosage level, "she's so soothing and so calming, that [Klonopin] was the first medication I stopped taking" (P4). Three other participants shared experiences that their pets assisted in reducing PTSD symptoms in which medications are typically prescribed, "We started going to the park and started running. … I'm a firm believer exercise keeps you calm, keeps your depression down, keeps you where you don't get as aggravated" (P6). These experiences support other observations shared by Walter Reed (Alers & Simpson, 2012; Beck et al., 2012; Yeager & Irwin, 2012; Yount et al., 2012).

Subtheme 4: Dog training programs. The comments and experiences shared by participants with regard to service-dog training programs gave insight on factors to consider if there is a widespread interest in developing such programs in the future. The nonprofit organizations referenced in the participant interviews predominantly rely on volunteers to provide the dog training and each program operated independently. A standard training curriculum does not appear to exist. Because the interview comments

fell more under "items to consider" with creating future service-dog training programs or for the individual interested in training their dog, this subtheme is further discussed under *Implications*.

Theme 4: Additional Findings

The natural flow of the semi-structured interviews allowed participants to comment on topics they felt were important. In one comment during a screening interview, P3 shared his opinion that PTSD is like diabetes. He used the analogy that PTSD "is not curable, but you can learn how to adjust and cope," suggesting there is no cure to the disorder. I was curious how other participants felt about this analogy and posed the question during the remaining interviews. Similar to the participants' statements about the human-animal bond, the range and nature of topics falling under this theme did not have existing literature for comparison.

Subtheme 1: Is PTSD curable? Similar to the "across the board" change in tone when interviews moved to discussing their companion animals, this question elicited a uniform response: PTSD cannot be cured. P1 approached his explanation with a biological approach, "once your brain is rewired … they are changed forever." Participants with deployments over 10 years ago address the amount of time that has passed since their combat experience, "The few experiences I had were enough, there is no amount of therapy, I don't think I could talk about it or recount the events enough to wash those memories away or how I feel about it" (P11). P8 has gotten worse since 2008, "I have gotten worse and it is because I am locked up in my own head 24/7."

Others do not see a "happy ending" to PTSD, "We're waiting for us to explode that one last time that our spouses are going to leave us. And we're going to lose everything we worked so hard for" (P12).

However, in an interesting twist to the question, P9 does not believe PTSD should be cured and recommends approaching the topic from a different angle. He agrees, it is difficult, often scary, to redefine our characters, but a definition exists that includes "these little quirks we have now." Considering that veterans from WWII, Korean, Vietnam, and other conflicts continue to struggle with PTSD, maybe P9's suggestion of approaching the discussion from another angle is the next step.

Subtheme 2: Animal-assisted activities in PTSD treatment. Participants also agreed that introducing animals into PTSD treatment could provide a therapeutic path unfulfilled by the approved, traditional methodologies currently in use. Reflecting on the Army's observations of increased participation in treatment activities in theater (Chumley, 2012; Gregg, 2012; Krol, 2012) and the responses from this study's participants, even with the most introverted personality an animal provides a nonjudgmental ear. P9 and P12 commented directly on the ability to talk to their animals: "They don't have input, 'this is what you should do, or maybe you should try this' or all the other commentary I get from people" (P9), "My dog will come up to me and just 'do whatever you need to do, say whatever you got to say,' that's where dogs are great" (P12). Similar to participants feelings as if they had "saved" their animals and consistent with findings from Walter Reed (Alers & Simpson, 2012; Beck et al., 2012;

Yeager & Irwin, 2012; Yount et al., 2012), the presence of an animal, especially with the pack-orientation of dogs, presents the soldier with the opportunity to lead again, "Now you have something, like your soldier, that is relying on what you do" (P3).

There is also a sort of domino effect that exists with the idea of using veteran volunteers to train other dogs: "That advocacy, helping the next guy, that kinship, all of that is the biggest healing product I have found … the next thing they want to do is go help the next guy and help the next guy and show them how awesome it is and how it's helped them" (P1). P9 similarly believes service-dog training programs, where veterans train dogs for other veterans, may be a better medicine for PTSD, "It's good for the people there volunteering … if you don't keep the animal and you hand it off to another veteran, you are bringing that other veteran into the program as well. Now you're helping two or three people along the way." P10 and his personal involvement with service-dog training, "Since I can't deploy anymore, this is my way of still trying to help them. Those are the heroes. Those are the real heroes."

Subtheme 3: Restrictions on PTSD service animals. The American Disabilities Act (ADA) included PTSD service dogs in its legislation in March 2011 (Department of Justice, 2011b); however, in 2013, many federal agencies were denying veterans to allow their service dogs to accompany them on DoD and VA facilities. The Army issued a directive restricting service-dog training on post and the VA discontinued benefits for veterans to obtain PTSD service dogs and cut funding to nonprofit organizations. Anger does not adequately describe the feeling participants disclosed

regarding these events. However, there is hope; in July 2013, the House Appropriations Committee passed a FY14 budget approving $4.5M towards studies on therapeutic service-dog training programs (GOP, 2013).

Subtheme 4: What needs to change. In society, the stigmatization of PTSD continues (Mittal et al., 2013). Whether from fear and ignorance, the ill intentions of slapstick commentaries, or political 15-second sound bites for constituents, many participants believe the first element that needs to change is the continued vilification of PTSD. Remarked by P5, "You're arguing with talking points and not real people." Society is appalled by the number of Afghanistan and Iraq casualties, but the conversation seems to stop once they come home, "They need to understand, 'look, it's not like PTSD is something I asked for,' … So you can't say 'thank you for your service' then be afraid of what that service entails or the consequences of that service" (P5).

Shortly after this study's proposal was approved, the VA released its 2012 suicide report; 22 veterans commit suicide a day (Kemp & Bossarte, 2012). Identified in Chapter 1, failing to receive effective treatment for PTSD is believed to be the leading factor with the increase of suicides among military members and veterans (Armed Forces Medical Examiner, personal communications, January 25, 2013; Kuehn, 2009; NIH, n.d.). P12's comments reflect such concerns, "We don't see a happy ending to this." Describing the feelings accompanied with coming home and separating from the only people who know and understand, a mental image came to mind of a person standing in the middle of a crowded room, screaming at the top of their lungs, "something is wrong, help me," but no

one notices. "We don't have that cohesion any more. … That's one of my biggest problems. … I have an awesome wife, I have an awesome family, and 99% of the time, I don't think that anyone cares. I don't think anyone really gives a crap about what happened" (P12).

Subtheme 5: Comments and opinions for the way ahead. Veterans with PTSD face a number of challenges after leaving the military, including higher instances of: suicide rates, substance abuse, unemployment, and homelessness (Adamson et al., 2008; Kessler et al., 1995; Litz, 2007; VA, 2010). Yet, it is feasible to surmise that until an honest discussion regarding the mental health care of military members occurs, possibly thinking "outside the box" to create effective treatment policies, the insidious cycle will continue. P12 commented on feeling detached from the cohesion he once knew and P1, P2, and P9 specifically remarked on the value of other veterans on their PTSD journey. Discussed under the subtheme of *Animal-assisted activities in PTSD therapy*, was the recommendation of brining other veterans into the therapeutic process. Reflecting on the fears of reprisal with active military members regarding their PTSD, P1 believes reaching out to employ the veterans to create peer-mentoring communities can assist with problems in active duty forces with addressing PTSD issues and employ more of the veteran population. P9 shared similar sentiments. Working with clients to train their service dog, "I tell them you will never hear me tell you 'I know how you feel, because I don't.' I tell them, 'I get, I understand where you're coming from. But I don't know how you feel because I wasn't there at the exact moment, at the exact second it happened, but

I understand where you're coming from" (P10).

The DoD's categorizing deployment functions as "combat" or "non-combat" (i.e., combat support), and how that determination affects veteran benefits, was another topic raised by participants. One example of how this works is illustrated by P10. P10 has PTSD and a TBI after multiple deployments during his career, yet because his primary duties while deployed were considered "non-combat" as a medical radio technician, he does not receive the full spectrum of benefits that is awarded when disability is categorized as "combat"-related. Participants were also passionate over the politics played with veteran care; after his PTSD diagnosis, P10 was put on the Brady Bill without any previous mental health or legal issues. Aggravation was shared over the knee-jerk reactions from others when trying to discuss their PTSD. After calling the VA's Crisis Hotline and sharing that at times he did not want to live, the telephone counselor contacted the police to do a welfare check on P12 instead of inquiring on his actual intent. "I don't need to worry that if I tell somebody something that I'm *feeling* that they are going to call the cops and do welfare check on me. I don't need that, nobody needs that" (P12). Other comments surrounded the military's handling of active duty suicides, the over-dependency of prescriptions to treat PTSD, and the major disconnects that still exist between active duty and the Reserve Components with taking care of personnel.

Limitations of the Study

Despite the contribution the veterans' experiences add to literature on combat-related PTSD and the human-animal bond, it is not without limitations and caution should be exercised in transferability the findings. Eligibility to participate in the study was not restricted to any type of companion animal; most participants had dogs as their companion animal. Study participants also had cats and a hedgehog; however, the findings predominantly surrounded the interaction with dogs as the companion animal. I discuss the need for further investigation on animals outside of dogs under *Recommendations*.

The primary limitation of the study is the small sample of a narrowly defined group (necessary for a qualitative study): OEF and OIF veterans with combat-related PTSD and owned an animal. The study was opened to all military statuses, yet all the volunteers had separated from the military. It is difficult to suggest a conclusive explanation why the sample did not include active duty participants; one possibility may be the reality of frequent deployment schedules makes pet ownership unfeasible for a large number of military members. However, due to the veteran status of the sample, the findings are not representative of the experiences of active duty armed force members with PTSD. The findings also do not address psychiatric conditions other than symptoms developed from posttraumatic stress resulting from military deployments supporting OEF and OIF. Even with the experiences of P4 and P8, where outside factors compounded the

development of their PTSD, the focus of the discussion surrounded the symptomatology resulting from exposure to the combat environment.

Recommendations

The need to acknowledge and further study the impact of PTSD is a theme that persists through the participants' words. Research on OEF and OIF military members and PTSD in general has grown, but tends to focus on quantifiable topics. I designed this study to understand PTSD and the human-animal bond from the individuals having lived the experiences, to offer a window into the phenomena and the concerns of military members with combat deployment experiences. The "cookie cutter" approach to PTSD is fiscally attractive, but when dealing with a diversity of experiences that cannot fit into a neatly defined package the availability of treatment options reflective of the multiplicity involved in PTSD should be considered. For instance, most of the participants felt that the impact of outside factors on the deployment experience, as well as differences among different military occupational specialties, should not fall under the same therapeutic umbrella for PTSD. "I'm not my grandfather and I did not fight my grandfather's war. My grandfather's therapy will not work for me" (P9).

Another recommendation is for further research into the human-animal bond and combat-related PTSD. The experiences shared in this study accentuated previous anecdotal literature on an animal's ability to reach past the walls of PTSD to provide the emotional and psychological relief unmet by other relationships requires broader investigation for further reaching implications. The experiences shared also indicated a

potential reduction in the reliance of prescriptions to manage PTSD. Larger studies are needed to investigate the therapeutic implications of integrating animals into treatment programs and to assess the feasibility of including other animal-assisted activities as PTSD treatment options. Existing literature on the human-animal bond tends to have dogs as the animal. In addition to furthering research on the human-animal bond with dogs, potential research should also consider lower maintenance animals (i.e., cats, birds, hamsters, etc.) and their influence of their presence on PTSD. Reflecting on this study and wealth of information in understanding the individual perspective on issues, mixed methods research may add the essential aspect of understanding the why behind the statistical results. It is also practical, based on the experiences shared in this study, to extend future research on the human-animal bond to PTSD caused by events other than combat or in persons other than military members (i.e., domestic abuse and natural disaster victims).

The threat of legal reprisal attached to a PTSD diagnosis is real for many veterans. Some of the experiences shared reflect using the care of veterans to support political objectives (e.g., P10's experience with the Brady Bill). Whatever biased spin is placed on PTSD, as indicated by responses during the interviews, veterans feel they are marked – vilified and ostracized – with no voice to speak for them and no real place to turn to for help. The hope of easing the effects of combat-related PTSD and reducing the number of veteran and military suicides, as suggested by participants in this study, needs to begin with countering the social stigma still associated with PTSD. P5's comment,

"You can't say 'thank you for your service' then be afraid of what that service entails or the consequences of that service," identifies where and how an honest discussion about PTSD must begin. However, it is safe to assume this type of discussion will not ensue unless further outreach begins with political figures leading the way.

Dissemination of Findings

These findings will be shared with veterans groups, animal advocacy and rescue organizations, animal-assisted activities and therapy specialists, as well as communities dealing with trauma-related issues. The Senate's Committee of Veterans Affairs expressed interest in pursuing alternative therapies to combat PTSD and requested a copy of the findings (Valenzuela, 2013, personal communication). This report will also be shared with various military departments. Many of the comments and opinions related to experiences that occurred before the DoD instituted changes in handling combat-related PTSD; however, some of the experiences reflect recent events suggesting problems that still exist for military members. The more current experiences may assist policy makers in identifying inconsistencies among current procedures.

Implications

As identified above, and addressed by participants in this study, active duty and veteran suicides continue to rise each year, challenging military leaders and policy makers with finding a solution (DoD, 2013a; Kemp & Bossarte, 2012). The suggestions proposed by the participants interviewed for this study – veterans helping veterans – are relatively new concepts in the discussion of PTSD treatment (Mittal et al, 2013). Many

participants commented on the benefits they experienced talking with veterans of other wars during their PTSD recovery journey, "I found it paramount in the reintegration into garrison life" (P3). Other opinions commented on the "win-win" potential of incorporating veterans into peer-mentoring groups for active duty personnel, "Now you're hiring peer mentors to work with the active duty force, you're getting veterans back to work. Win-win" (P1). Further investigation into large-scale practices across the VA and military installations, as commented by P1 and others, could provide that "cohesion" many lost leaving the military. Who better understand a veteran's experience than another veteran, while at the same time, easing employment issues facing many veterans?

Reflecting on the literature pertaining to the Walter Reed *Dog Tags* and PTSD service-dog training programs (see Chapter 2), and then the participants' responses, another "win-win" scenario using animal-assisted activities in PTSD treatment exists. To review, in the *Dog Tags* program individuals recovering at Walter Reed spend time at the local humane society providing care and obedience training for the animals at the shelter and Warrior Canine Connection teaches service members with PTSD the skill of training service dogs for other physically impaired veterans. The responses from participants of this study about their animals mirrored feelings expressed in Walter Reed's 2012 literature. A subset of the military population where the ownership of an animal may not be feasible is the younger, single individuals living in barracks. Expanding on Walter Reed's programs, the creation of similar animal-assisted activities close to military

installations may provide (a) the access interaction with animals that would otherwise not exist, and (b) provide an economically attractive way to assist with the homeless animal population and the overcrowding of shelters.

Taking the idea a step forward, many of the nonprofit PTSD service dog programs focus on training homeless dogs from animal shelters. Opinions shared by veterans in this study warrant further consideration on the evaluation of shelter dog temperaments prior to service-dog training. Benefits and drawbacks exist on both sides of the discussion. However, additional discussion on the topic is necessary, especially if different types programs use animal-assisted activities involving service members training dogs (i.e., training dogs for basic obedience or to the service level).

Finally, highlighting the veterans participating in the study, one veteran began his journey as a Walden student in the fall of 2013. The exposure to this study and knowledge of the potential influence higher education can have on social issues, prompted P3 to investigate furthering his education. A second veteran, upon learning about PTSD service-dog-training programs through this study, is coordinating with a trainer in hopes of creating a service- dog-training program in her area. P8 is also investigating the use of her veteran education benefits towards a canine training certification. All of the veterans in this study shared some action on their part to further alternative therapy options for PTSD, whether through their involvement in canine training programs, volunteering at ranches like Horses for Heroes, creating of public-

service-announcement type media productions, or furthering their education in areas involving nature.

Conclusion

OEF and OIF in many ways identified how the dynamics of combat have changed for the United States military, but the psychological impact of war has not. Technology continues to reduce the number of deaths in the combat theater, but the result is an increased number of military members returning with psychological issues, over tasking already struggling military and VA healthcare systems. The experiences shared in this study identify problems with OEF and OIF personnel obtaining qualified, timely assistance to address the psychological scars of war. It is important to remember, the VA also manages the psychological issues of veterans from previous conflicts, where PTSD remains the most common psychiatric condition which disability benefits are sought (Arbisi et al., 2004; Marx & Holowka, 2011). The increased number of suicides in the active duty and veterans populations may reflect the ultimate price of not receiving effective and timely treatment for psychological issues, including PTSD.

The therapeutic experiences for the OEF and OIF sample interviewed in this study raise the question of the future of PTSD treatment with military and VA providers. Between an over-dependency on prescriptions to manage PTSD symptoms and the qualifications of civilian providers to deal with the combat-related issues associated PTSD, it is no surprise most of the participants were not involved with a therapeutic program. Yet, with the stories on the positive influence animals have on individuals

managing their PTSD symptoms, inquiry into the phenomenon has largely gone ignored. Observations released by the Army in 2012 and the efforts of many nonprofit organizations to advocate the therapeutic potential of animals on PTSD, and the House of Representatives approval of the 2014 Appropriations Act, suggests that there is promise of further investigation. I have to wonder, echoing the statement made by P2, how do the DoD and policy makers determine what works in the treatment of PTSD? Does Congress simply follow numbers or do they listen to what their Armed Forces need? This study's small sample uncovered many examples where the bonds developed with animals met participants' emotional and psychological "needs" unfulfilled in other areas. The human-animal bond may be a tool that can meet the diverse needs included with combat-related PTSD.

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Appendix A: Recruitment Flyer

Operation Enduring Freedom and Operation Iraqi Freedom Service Members Needed

for a

Study Investigating the Lived Experiences of the Human-Animal Bond and Combat-Related Posttraumatic Stress Symptoms

Looking for OEF and OIF service members who:

- **Have experienced posttraumatic stress symptoms resulting from OEF or OIF deployments**
- **Adopted a companion animal *after* posttraumatic stress symptoms surfaced**
- **Not currently on an 'in-patient' status**

Participation is completely voluntary and confidential. Interviews conducted by telephone.

A $10 gift card or donation to animal rescue will be provided upon completion of the study

Interested individuals please contact Melissa White at melissa.white@waldenu.edu for more information

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Appendix B: Study Participation and Interview Questions

Study Eligibility

The following questions will be used to determine study participation eligibility as interested individuals initially contact the researcher:

1. How long have you been in the military? Which branch did you serve?
    - Is the individual a veteran or still on active status?
2. Did you deploy in support of Operation Enduring Freedom, Operation Iraqi Freedom, or both? How many times have you deployed in support of either campaign?
3. Did you adopt your companion animal after experiencing PTSD symptoms?
4. Will your companion animal be with you during the interview?

Interview Questions

****Review the terms of confidentiality, limits of confidentiality, and disclosure of drug use****

The following questions will be used to guide the individual interviews.

Note: • denotes prompts, if necessary, to enhance the conversation flow.

Interview questions:

1. What have your experiences been since your OEF or OIF deployment?
2. What have your experiences been since adopting your companion animal?

Examples of some possible PTSD related probes:

- What PTSD symptoms have you experienced resulting from OEF or OIF?

- When did you begin noticing symptoms?
- Have you sought treatment or other help for your symptoms?
    - If the participant has received or is receiving treatment, ask about their opinion of the experience.
    - If the participant has not sought treatment, ask participant to explain why.

Examples of some possible companion animals related probes:

- What lead you to get a companion animal?
- When did you get your companion animal?
- How did you pick your companion animal?

Added after interviews began:

3. Do you think PTSD is curable?
4. Is there anything else you would like to mention as part of your story?

Appendix C: Consent Form

Consent Form

You are invited to take part in a research study exploring the lived experiences of the human-animal bond and combat-related posttraumatic stress symptoms. Your selection to participate is based on your reported experience with posttraumatic stress symptoms due to military deployments supporting Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF), and status as a pet owner. This part of the process called "informed consent." This form documents your role and requirements in the study, potential risks associated with this study, and the boundaries of confidentiality. The intent of this process is to provide you ample information regarding the study, to make a well-informed decision whether you wish to proceed to the interview phase of the process.

Background Information:
Melissa White, a doctoral candidate at Walden University, is conducting this study. The goal of this study is to understand the lived experiences of United States military members who served in OEF and OIF, have PTSD symptoms, and adopted a companion animal.

Procedures:
If you agree to be in the study, you will be asked to:

- Participate in a 30-45 minute telephone interview. This interview is recorded for the researcher to transcribe for the data analysis portion of the study.
- The second requirement includes a review of an analyzed narration of your story; this is to ensure the researcher captured your experiences completely and accurately. This review should take no more than 30 minutes and will come to you as a Word document via email, unless you prefer a mailed, paper copy through the United States Postal Service.

Here are some sample inquiries:

1. What have your experiences been since your OEF or OIF deployment?
2. What have your experiences been since adopting your companion animal?

Selected prompts or additional questions may be used to assist with the flow of the conversation. These prompts are meant to help the researcher understand your experiences after the deployment(s) and could include topics such as a brief description of PTSD symptoms experienced, when you started noticing symptoms, and if you pursued treatment. Regarding your companion animal, questions could ask what lead you to adopt a companion animal, how long after experiencing PTSD symptoms did you adopt your animal, and what lead you to deciding on adopting the companion animal you have. There are no right or wrong answers; this is an opportunity for you to share your

experiences. Finally, any prompts inquiring about your experiences with PTSD symptoms are to enhance the description of your experiences, not to provide a diagnosis.

Voluntary Nature of the Study:
Your participation in this research is voluntary. This means that you are free to choose not to participate at this time. This also means if you choose to join now, you can change your mind at any time and remove yourself from the study.

Risks Associated with the Study:
There are minimal risks in this study. The interview questions, as previously presented, inquire about your experiences after your deployment and may ask about your posttraumatic stress symptoms, plus whatever else you wish to share; specific details about the traumatic event(s) are not asked. If you choose to participate, you may want to either have an appointment scheduled with your mental health service provider, if you are enrolled in a treatment or support program, or have a trusted friend available. The National Veteran's Crisis Hotline toll-free number is 1-800-273-8255; the researcher will have this information readily available during the interview process. It is also recommended to have your companion animal with you during the interview, if you had not originally identified as such during the study eligibility screening. If you withdraw after the interview, your interview recording will be destroyed immediately.

Compensation:
For participating in this study, $10 in the form of a Petco or Petsmart gift card or donation to an animal rescue of your choice is awarded. This will occur after you review the analyzed narration of your story. You will also receive a copy of the accepted results, unless you chose otherwise.

Confidentiality:
The records created for this study will be kept confidential and your identity will not be revealed. A pseudonym (false name) will replace your name and assigned prior to conducting the interviews; pseudonyms will follow a Participant 1, Participant 2, etc., theme. The researcher will transcribe and analyze the interviews and will not use your personal information for any purposes outside of this research project. Collected data (i.e., interview recordings, transcriptions) is required to be kept for five years after the study is complete, then destroyed. Items associated with your interview will be maintained in a locked, fireproof, security box where the researcher has sole access.

Limits to Confidentiality:
Again, if the researcher believes you are experiencing emotional difficulties during the interview, the interview will terminate immediately and you will be asked to contact the National Veteran's Crisis Hotline, a counselor, or a trusted friend. However, the researcher has an ethical responsibility to report statements associated with (a) the abuse

or neglect of children and elderly persons, (b) harm to self, and (c) harm to others. In the event of these statements, the interview will end and the researcher will contact the law enforcement agencies in your area, and contact her dissertation chair.

Special Note. Due to various Department of Defense and the Uniform Code of Military Justice requirements surrounding mandatory reporting of known drug use among military members (Active and Reserve Components) and civilian employees of the Federal Government, this study is not interested in collecting experiences relating to drug use. If the researcher feels the conversation is leading to the disclosure of such statements the interview and your participation in this study is terminated. The researcher is required to report any statements disclosing current drug use.

Contacts and Questions:
You may ask questions at any time. The researcher, Melissa White, may be reached at (703) 310-4523 or melissa.white@waldenu.edu. The Research Participant Advocate at Walden University is Leilani Endicott, you may contact her at 1-800-925-3368, extension 1210 or email at irb@waldenu.edu. Walden University's approval number for this study is 04-05-13-0085310 and expires on March 18, 2014.

Statement of Consent:
I have read the above information and feel I understand the study well enough to make a decision about my involvement. My signature below indicates I am agreeing to the terms of described above to participate in this study. If providing consent via email, please reply to the researcher's email with the words "I consent."

Printed Name of Participant _____

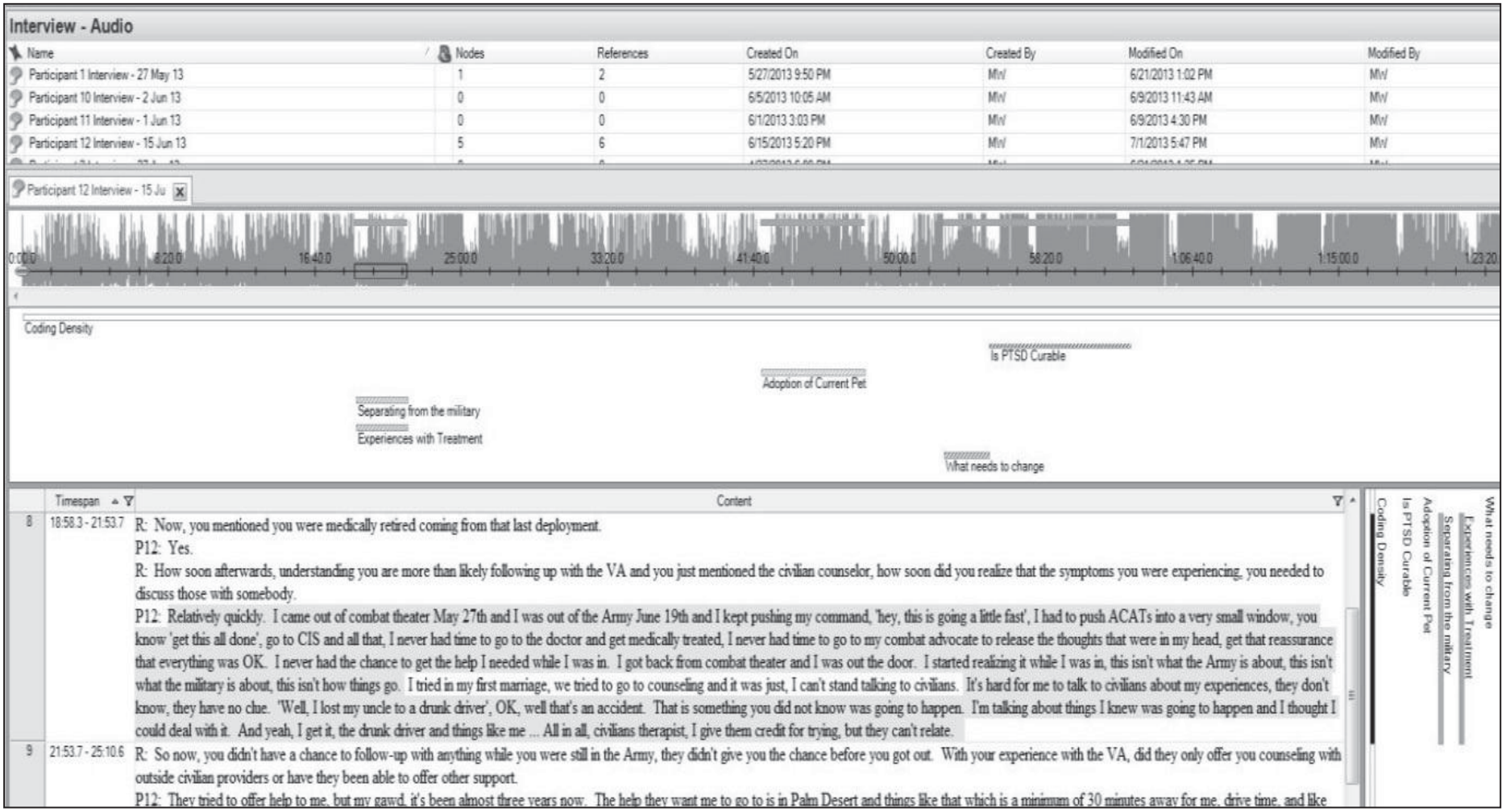
Date of Consent _____

Participant's Written Signature _____

Researcher's Written Signature _____

Researcher contact information:
Melissa White
3206 Collard Street
Alexandria VA 22306
(703) 310-4523
melissa.white@waldenu.edu

Appendix D: NVivo Screenshot of Textural-Structural Development



Appendix E: Themes

Theme	Subtheme	Participant Codes
Deployment		P1, P3, P10, P12
After Deployment		
	Coming home	All
	PTSD	
	PTSD: Screening	P1, P3, P4, P8, P9, P10
	PTSD: Symptoms	All
	PTSD: Guilt	P1, P3, P10, P12
	Separating from the military	P1, P8, P10, P12
	Treatment	
	Treatment: Prescriptions	P1, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12
	Treatment: Groups	P1, P2, P3, P5, P6, P7, P8, P9, P12
	Other treatment	All
	Experiences and the VA	
The Human-Animal Bond		
	Acquiring a companion animal	All
	Pet responses to PTSD symptoms	All
	Other pet benefits	All
	Dog training programs	P1, P2, P4, P10
Additional Findings		
	Is PTSD curable?	P1, P3, P5, P6, P7, P8, P9, P11, P12
	Animal-assisted activities in PTSD treatment	P1, P3, P5, P6, P7, P8, P9, P10
	Restriction on PTSD service animals	P1, P2, P4
	What needs to change	P1, P5, P9, P10, P12
	Way ahead	P1, P2, P9, P10

Appendix F: Participant Textural-Structural Descriptions

Participant 1

Deployment. Retiring as a senior noncommissioned officer (SNCO) in the United States Air Force, Participant 1 (P1) experienced four deployments in the course of his career, two prior to September 11, 2001, and two following. P1's job in the Air Force adds a different essence to the discussion of posttraumatic stress – how do you gauge the impact of war with individuals whose daily responsibilities expose them to traumatic events on a regular basis? A duty executed by services technicians is mortuary affairs, "I was in Saudi Arabia for both deployments during the first conflict [Gulf War I], I was at Khobar Towers, came home, they blew it up, then I was sent back to help move everyone." In his post 9/11 deployments, "I did mortuary affairs for both times, once in 2005 and in 2008."

Setting aside the residual effects following a combat deployment, the physical exposure to the environment causing their PTSD ends when they return home; however, this was not the case for P1, "I was still supporting mortuary duties stateside … in 2006 we did more mortuary cases than any other base, non-combatant deaths." It also may not be the frequency of exposure, but the gruesome details of events, "in my experience, we had minimal casualties in Kuwait (2005), but what I saw was really grievous … total body burns, guys with no eyelids." P1 recalls discussions with warriors who lost both legs and pararescuemen, their reactions to the nature of his experiences, "they were a gasp…the reaction is always the same … they comment having to deal with one or two,

but you dealt with thousands." With no break between from mortuary duties between 2005 and 2009, P1 brought a presence of dignity to each case, giving each situation the keen attention to detail as if it were the only case. "Day one back from my rest and relaxation (R & R) … it didn't stop for a couple years, then I go back to Qatar … I treated every one of the casualties like it was my own family. That took a toll on me."

After deployment. Sometimes the individual does not immediately recognize how the experience changes their demeanor, "from 2005, my wife noticed I was a different person when I got home. Fortunately, I did not suffer from the anger, violent outbursts a lot of the guys do." P1 retreated into the deep depressive states and battled the darkness of nightmares and terrors, "I was screaming in my sleep to the point that I was losing my voice. I didn't know what it was. I failed to recognize it … this couldn't be happening to me, I am Johnny Air Force." As P1 tried convincing himself there was nothing wrong, his wife continued urging P1 to seek help, for three years, "I didn't actually get help until 2009."

The conclusion of P1's last deployment coincided with the increased post-deployment psychological screening; however, the sensitivity of his duties, the emotional strength and energy required, raises the question whether people in his career field go through any standard screening. "Absolutely not. Much like medical [personnel], if a guy goes into surgery and comes out white as a ghost, they go 'what's wrong with you', like the movie, 'you just can't hack it.' It's that Bravado, chest out, '*ahh-haaa* – I can't be affected by this.'" Knowing the stigma that is associated with admitting mental health

problems, it is questioned whether individuals honestly answer post-deployment questionnaires, as they are required prior to members being released on their two week R & R, "once you become a broken egg, the guy with PTSD, the guy with a medical profile … we shun them as a community." The journey known as PTSD treatment was accompanied with many twists and turns, ups and downs, but P1 would ultimately experience the shunning and profession retribution many fear connected with admitting help is needed for the residuals of the combat environment. "I never had a profile until I was diagnosed with PTSD, then I became a dirt bag, especially among my peers"; the highly decorated SNCO with many accolades and awards received a downgraded rating on his last annual performance report "because of my disability, because I suffered from PTSD."

The first leg of P1's treatment journey began shortly after returning from his second deployment, in 2009, "Once I started getting help, my doctor suggested that I start looking for an assignment … avoidance techniques are typically not used, however, every square inch of the base was a constant reminder of what was seen." A challenging element of PTSD is recognizing and dealing with environmental and sensory triggers that stimulate response, but how can one learn adaptation mechanisms when breaks, "safe" periods, are not encountered, "[I couldn't] go through the front base without being reminded of the motorcycle accident that happened … go to this parking lot without remember what happened there." A successful move to a staff job that working for Headquarters Air Force, with an assignment to a new location, working a position with

no chance of encountering mortuary affairs, "it was a good fit." Unfortunately, tackling PTSD is not as simple as a change in scenery; it is only a matter of time before the next trigger:

> I pretty much thought I was cured. I went to the base. Right outside the gate, outside my window, there was a shooting where a guy went into an establishment and shot up everyone and shot himself … I saw the mortuary and the vans come and from that point I just regressed. I had a pretty bad regression. I had super hypervigilance. I would drive 20 miles per hour down the highway; a 30-minute drive, was taking me an hour to get home. It was pretty bad. I had gone to get help before and I wasn't embarrassed that I had … I sought my new leadership and they were really, really instrumental in getting the help I needed and not shunning me.

The potential of regressing is always present. After work began with his service dog Houston, P1 faced an incident, an unknown trigger, setting back his recovery efforts and even created new issues. The following description begins with an incident where an establishment was not welcoming of P1's need for his service dog, Houston:

> I was asked to leave and refused … the cops were called. I had another regression to where I was really kind of scared to go anywhere and I ended up overworking my dog and she got hurt. That's when I started suppressing the symptoms, what I knew was PTSD. I started stressing more and more, trying to work without a dog or any therapy. I started having, the symptomatology in me was olfactory

> hallucinations, when I put my uniform on, I would start smelling decomposing bodies. This is very troubling for me because I knew there were no decomposing bodies. There's no other smell like it on the planet. It was to the point of nauseating me, I would get sick at work and have to leave really early. I would go in at 0730 and be gone by 0800 or 0900. I was running away from having the uniform on; that was becoming a problem, troublesome with my leadership, which I understand … at my request, because I really just wanted to get over this …[I] spent 33 days in an inpatient treatment [October 2011], and they helped me get over that hump. But, once I went to inpatient treatment, that was the mark point to the end of my career … they started the medical evaluation board process and as I was retired in February in 2013.

Many behaviors associated with PTSD are protective responses to symptoms. At times, the brain enters a protective mode, undetected by the individual,

> I think a lot of us suffer from dissociation, which is much like driving home, pulling into your driveway, and having no recollection of driving home. You're functioning on all cylinders, but your brain wanders … we just do it periods of time. I ended up in another city, some hundred miles away and not knowing how I got there.

This dissociation mechanism is the brain protecting itself, much like severe pain commonly causes individuals to "pass out"; the brain is over excited, scared, and enters a protection mode by dissociating. The stimulating characteristics of the environment,

along with the presence of intruding thoughts, often determines the individual's reaction, "if it's a violent situation, the person is going to think they are fighting for their lives, and act accordingly. For me, I will go into a severe depressive state, almost like a zombie, I am not behind my eyes."

Addressing his regression after the homicide scene outside his window at the new location, P1 reaffirmed his commitment to tackle PTSD with alternative, more natural methods:

> I don't like being a zombie; I like having full control of my faculties … I'm not a fan of benzoes or anything … psychotropics, I don't care for them. Anything that alters the brain chemistry … when I found out when I had PTSD in 2009, I hit the books. I needed to know what was going on with me … I know that I'm not having a heart attack … it is anxiety and do some self-talk … work my dog … and hopefully get through it so it doesn't last for days and weeks. So that's why I sought out the educational portion … I learned everything about what PTSD is, what it does to a person.
>
> I met a captain who was really supportive of alternative therapy. They really respected my wishes, never really pushed any medications on me … I tried some antidepressants for a while and it really didn't help and had side effects I really didn't like so I asked to be taken off of those. When I was in the hospital the doc talked me into … he really liked Cymbalta. Because I was also having issues with my back and having pain issues … I went on that for about six

> months. [I] didn't really notice any difference but the big thing, and what really scared me about it when I was graduating off, the side effects coming off were so bad. I'm not talking about withdrawals; I mean I heard my eyeballs moving. I mention this to my doctor and he said, 'yeah, I've heard that before'. That will drive you insane. I mean every time you move your eyes you can hear them moving and I mean loud. It's really unnerving … that just made my point that I didn't want to be on the things. I really haven't talked to the VA doc about it; I told them I had an aversion to psychotropic medication. They just scribble in their notebook and say OK.

The human-animal bond. When Houston and Tech came into P1's life, after which deployment, was not specified, however, the focus of using one of his pets as a therapeutic tool began shortly after arriving to his new duty assignment. P1's favoring of more natural, alternative methods in dealing with his PTSD symptoms led him to research working with a service dog after his hospital stay.

In 2010, P1 started working with Houston, his English bulldog, through a program called Paws and Stripes. Paws and Stripes is a foundation started by a special operations veteran who also suffers from PTSD and TBI [traumatic brain injury]. During his recovering at Walter Reed, the founder soon realized the comforting effect the therapy dogs had and began the foundation. P1 was the first client. "She was at the head of her class. It helped me out tremendously and I didn't have to take pills … my leadership was

really encouraged in the way that I responded to this treatment. Having her at work … they liked that too."

Paws and Stripes trains rescue dogs to be service animals for PTSD and TBI. Using his own dog, "they train the veteran to train their dog; they never 'hold the leash'. We met three times a week … it's a performance-based certification. The good thing, once you're done … you have the ability to train your next service dog … this was helpful to me when Houston got hurt … I was able to train Tech. He's a rock start." Very similar to the methods used to train medical service dogs for epilepsy patients, "when the individual has an [PTSD] attack, the dog is placed next to them … initially the dog gets scared and runs away, because this is happening and they can sense the different cortisol or whatever levels in the brain, whatever receptors … they almost immediately become keen to what is going on." After training Houston to his symptoms, her ability to sense an oncoming attack has helped P1 work through rising PTSD symptoms, "about two minutes prior, I don't even know it's coming …I don't have a definite trigger." Each dog presents in different ways, but Houston will "climb into my lap, jumps into my lap, and licks my ear." Even while driving, Houston will lick P1's ear, letting him know he must pull over and address it." For P1, all it takes is 5 to 10 minutes of loving on his dogs and "he's back. Sometimes I avoid the attack altogether."

The influence Houston, and afterwards Tech, have on P1 go well beyond simply presenting oncoming PTSD symptom attacks, there is a new purpose, a new mission:

> They tell you when you graduate, you have a new mission. That mission is to get better … this is not forever; this is a temporary fix until you can walk without the leash. And for me, now that I am to the point where I am starting to walk without the leash … I still have my days, there are some situation where I may never walk without the leash … but that advocacy, helping the next guy, that kinship, all of that is the biggest healing product I have found … You want more of that, you want to taste it again, and again, and again and that keeps you moving forward and out of your depression. It keeps you moving forward because now you have a purpose that is bigger than yourself.

This advocacy and interaction, vets helping vets, P1 believes is the truth to healing. Differences in opinions exist regarding the appropriateness of this type of therapy for individuals with violent tendencies and severe anger and aggression issues related to their PTSD attacks, however, P1 feels the companionship offered can even reach these individuals. The influence of his service dogs and the desire to reach out to more veterans planted the ambition to begin coordinating for his own foundation, "I want these guys come out to the ranch and start working with rescue dogs, getting [them] rescued, then training the dogs … the whole process of getting out in the community [and] doing things that are helping other people. Seeing the joy in a little girl's eyes when she gets her first dog and it's well trained … that healing is better than anything you put in a bottle … anything you can be prescribed."

One last element critical to the P1's experiences includes his family. First, the differences between the bonds he feels with his service dogs as compared to his children – if the dog's give a point of focus and purpose, what is the difference? "The dog asks nothing of you but unconditional love. They ask nothing of you but for direction. And you're totally responsible for that … much like an infant would be. With your children, you're fearful to share your experiences with your children." P1's children lived his PTSD every day. "You try to shield them … What happens is a lot of these guys get home, they try to shield them by becoming isolated, or drowning in a bottle … they don't understand what they are going through, so they become aggressive, loud, and yelling. It's not dad, it's not husband anymore." Unfortunately, P1 feels a good number of these people end up getting divorced, they are alone, "which makes the nightmare real." Fortunately, for P1, he has a family who has stuck with him, "They call me on my bullshit … they have that ability, being led by my wife, 'this is how we help dad, this is how we get through this to help dad' and when you notice him … this is how we handle. I am very lucky in that aspect."

Additional findings. The goal of Paws and Stripes is to learn to "walk without the leash," but even as indicated by P1, he questions certain environments or events will find him leash-free. "Once your brain is rewired and the chemicals in your brain, as I understand it, are changed, they are changed forever. PTSD super-charges the connection between the fight or flight response; it's like a raw nerve, you go to that response instead of a logical response." P1's opinion is PTSD is not curable, "but you

learn to live with it, you learn to self-talk, self-sooth, or write it down." The stories P1 wrote, as part of the cognitive processing therapy he encountered in the hospital, has a cathartic effect, "it's now on page and not in my head. I can reference it when I want to." However, P1 still deals with intrusive thoughts from time to time; life does not stop for PTSD. What is different now, he chooses to focus on what is ahead of him or how he is going to help the next guy instead of the death and horror associated with the intrusive thoughts. Additionally, P1 and his service dog are a "mouth-piece" advocating and educating about PTSD, "People are naturally inquisitive; the better experience they have meeting you and your service dog, the better chance we have to educate."

P1's duties during his deployments are considered non-combative, a support function. As budgetary constraints begin to direct how military personnel are utilize, along with the growing "Purple Force" feel of multi-service operations, many who typically maintain a support function role may be tasked to fill a combat-related role to fulfill the mission. Many of these individuals may not always receive the acknowledgement of their combat function due to the assignment of their primary career field, whether it is in understanding the development of PTSD or other services and benefits:

> Cooks, fitness managers, as well as the personnelists working with me [were sent] onto provisional reconstitutional teams in Iraq and Afghanistan … I had one troop actually put rounds down range, at the enemy … they actually tried not giving him a combat action medal because they said his career field didn't dictate.

> That's what we have to stop cookie cuttering … any person in a support function that is going out doing convoys every day because they run the motor pool but yet, they are getting flak from leadership and everybody when they come back because they didn't serve in the traditional combatant role. This is crap. This guy … he was the gunner … he put rounds in the car and disabled the car … he didn't kill anybody, but he took enemy aggression and squelched it and he couldn't get a combat action medal because of his career field, because of a number. This has to stop.

Between his experiences after the second regression, leading to inpatient care, and the shared experiences of others he has assisted with service dogs, P1 also feels seeking mental health assistance continues to be vilified and discriminated against. "It's ridiculous, it's bullying." Considering the forced medical evaluation board and the final marks on his annual report, "If this was the civilian world, we would be loaded, because we could sue them for disability discrimination." However, as P1 continued his fight, he was continuously met with replies that "charters did not exist to protect the military member." As disabled military members are being allowed back on active duty, at least with the Army, P1's concerned, "What about these guys they are allowing back on active duty with one leg, are they not disabled? There has to be some protection so leadership does not shun the disabled." " We need to stop treating that PTSD is something to be ashamed of and to get help." The research P1 continues to do on the subject affirms his belief that, "support has to come from the top down … [But] it's not a cookie cutter, you

can't treat me like you treat the next guy" even in the face of budgetary concerns and a taxed system. "We also need to ensure people coming back, there will be no reprisal."

The suicide epidemic with active duty and veterans also weighs heavy on P1's mind, "There was a suicide at the last base I was at … it was an airman and he hung himself." The corresponding displays, honoring the airman's death (i.e., flag at half-mast, etc.) proved troublesome for P1, everybody grieved … why did he do this … I was the guy that had to answer the family … why didn't daddy love me. I had to cut the guy down." P1 questions the base's almost glorifying the act, "it's murder. He just murdered himself." While understanding the influence of depression and desperation that exists out there, P1 believes, at least with active duty, negating the $400,000 life insurance payment may assist in forcing some people to find another way, understanding their family may not be taken care of. "We have to have to change how we look at this … it's not the family's fault, I understand that, but how do we strike a balance? Being the individual responsible for "cutting" people down and facing the family, this is a passionate topic for P1. But what is the balance? As a SNCO, in the face of overly publicized stories of unprofessional relationships and sexual assault, P1 feels supervisors are afraid to know their troops, "then we start blaming SNCOs and the front line leadership, 'why didn't you know,' You can't know by asking somebody, 'do you feel like killing yourself?' They aren't going to answer you. It's about knowing your people and noticing change in their behavioral patterns … but now, supervisors are afraid to do that because now, they are being hit with unprofessional relationships." The discussion

will probably be very unpopular, but P1 feels, “It’s time to treat it for what it really is, a symptom.”

Reflecting on the positive power his interaction with other military personnel has on him, P1 believes veterans, those who have shared similar experiences, are key to helping today’s and future deployed members with dealing with PTSD. “You are not going to find that peer mentorship [in active duty] because they are still too scared to talk about it, because there is a stigma that is still attached to it. Programs such as Veterans to Work and other advocacy outreach programs exist, but the focus P1 has in mind is creating that type of mentoring at active duty bases and posts, “We need to instill peer mentor groups. The guys who have come back and successfully gotten over or guys like me who have been through it … feel like they can talk.” Help for PTSD while discrimination and stigmas are attached; this has been addressed by research from 2004 and 2008, but what is the solution? “Make it [peer mentoring] confidential. Unless they are saying they are going to hurt somebody or myself … that’s what I find when these groups of veterans get together … we really talk, we don’t fear that reprisal anymore, and we really share what we’ve been through.” Sometimes, there are experiences only other veterans can understand, only another veteran “gets it”, and only another veteran can call you out on, when needed. “When we sit around, veterans in groups, we talk about that and they listen to each other … we listen to each other … and I say, ‘hey, knock it off, it’s not your fault,’ they listen, they get it, and they feel better.” The other beauty of this idea, “Now you’re hiring peer mentors to work with the active duty force, you’re getting

veterans back to work. Win-win."

Participant 2

After deployment. Participant 2 (P2) returned from a year deployment to Iraq in 2009. At first, the Army tried to medically separate P2 from active service; however, he was later released from the Army due to personnel downsizing due to military budget cuts. Immediately after returning home from military service, adjusting back to civilian life was hard. Living in a small town, "I didn't have a lot of people to relate to because the town population is really, really small, it's under 100 people." P2 mentioned a number of people from his hometown joined the military; however, few talked about their deployment experiences, "So random people were just constantly blowing off question after question. Not only was it stressful to deal with, it was also dealing with my own things from deployment … it is very irksome when a random stranger comes up to you and asks if you shot someone."

"Relating to people," P2 remarked, "was the main stressful thing. People expect you to be the same person you were when you left to join the military versus coming back from deployment." However, speaking to others who experienced combat and know the life style, at organizations like the American Legion (AL) and Veterans of Foreign Wars (VFW), provided some relief. "I found it paramount in the reintegration into garrison life." Even if similar experiences are shared among a group, the ability to connect may not always exist. After waiting months for VA psychological treatment, the outpatient group program P2 initially entered was not as beneficial as the AL or VFW, "they start you off with a group program. I had a hard time coping with that. Not

everyone has the same experiences. Combat MOSs sitting with different combat MOSs or just different MOSs … it's hard to relate to some of the experiences they went through." Research suggests men in general have difficulties addressing feelings in larger groups; further inquiry into whether men have difficulties sharing feelings, "I actually got out of the group program because it just frustrated me even more." Once P2 entered into one-on-one therapy, "that was fine."

P2 followed-up with the VA the day after returning home, but did not begin treatment until several months later, "it took me several months to get in. I started as soon as I got home; I went to the VA the next day. I got home on a Thursday and went in on a Friday, and they scheduled me for an appointment [counseling] a few months later. I went to psychiatry and they got me in the next month." This was after P2's military medical provider called to coordinate prescription refills, "I was prescribed Prozac before I got out. But my prescription was going to expire shortly before I got out, so the medical center called over to the VA to fast-track my referral program so I could get a refill."

The human-animal bond. The introduction of a companion animal for P2's PTSD symptoms came from the recommendation of his psychiatrist at the VA, "my psychiatrist in the VA recommended a program called PAWS through the VA." The PAWS (PAWS for Veterans, Inc.) program is an interactive approach in developing a companion animal for veterans with PTSD:

> You take your dog, with the help of the psychiatrist, to train your dog so that it becomes your companion animal. Your dog goes through the program. So, I got

> my dog. He was a real small, little puppy, probably about two months old when I got him, and me and Black started going through the program. He was a companion animal at first, later you can have them certified as a service dog for PTSD. So we went through the training courses and because he was a training animal, he was able to be with me 24/7. He helped me a lot, especially since I was in a wheelchair when I first got out and couldn't do too much.

Black is a topic P2 likes to talk about; when asked about the bond between himself and Black, P2's voice shifts, as if you can "hear" his smile. "Black's my buddy. He is my baby. I've had a couple of girlfriends get pissed because I show him more affection than I did them." More than a pleasurable topic, the PTSD symptoms experienced by P2 are part of the bond shared between P2 and Black, "He picks up on my symptoms automatically. He'll start nudging me or hopping on me to get me into a petting session or he'll grab my pants leg and start pulling on me or like my shirt or my arm and start pulling on me to kind of like bring me out of a flashback or anything else like that." In addition to flashbacks, hypervigilance is an issue as P2 startles much easier than prior to his OIF deployment, "He also always, like if I'm standing still, he's always behind me and doesn't let people get close. Unless I'm directly facing the person, he'll bark or whine to let me know someone is coming up behind me or something like." Since adopting Black, P2 is taking lower doses of two prescription drugs prescribed for PTSD symptoms. "He definitely helped me a lot. I just feel that having an animal, a

companion animal or service dog for PTSD it definitely a big factor that can help you recuperate from a lot, a lot sooner and adjust."

Call it fate. Call it chance. The events leading to Black's adoption were unplanned and unexpected. "When I got out, I wanted a job with least amount of responsibility as possible. I was a corporal when I was in the military and always had several subordinates under me; I wanted something with absolutely no responsibility. So one day, I was delivering pizzas and I saw this guy, this little asshole, who had all these puppies in a chicken-wired fence. They were all bloated and had worms and ticks all over them and everything else like that; I stayed there and called the police." After learning the puppies would be taken to the pound by the SPCA until homes were found, "one of the police officers was a buddy, and said I would really appreciate having one of the puppies. He said, 'yeah,' they just were going to go to the pound anyways until they found homes. I said I want this one, right here." The series of events provided P2 with the opportunity to participate in PAWS with puppy Black, versus an older dog.

> Personally, I think that is a lot better to get them as a puppy and train as you go. Most programs out there, give you two or three weeks with an animal before you take them home. You don't really know them all too well. Getting your dog as a puppy and training as you go, it's a lot better. Because you already know the animal's behaviors and he can start recognizing and learning some of your symptoms … not, everyone has the same symptoms.

Additional findings. The DoD and VA recently announced the restriction of PTSD service animals at VA facilities and on DoD property; a sensitive topic for any veteran with a companion or service animal for their PTS symptoms. "I talked with one of my classmates, a former Marine. He had a couple of guys with service animals and had to get base commanders and lawyers to say they could can have the animals go into any facility or you would get turned away. Apparently, it was really, very hard, pretty much like pulling teeth." What P2 feels about the situation, "It's crap. It's just your service animal and you should be able to go wherever you are no matter what. There are other animals in training in the military, where trainers take them home, so what's the difference if it's a service animal or companion animal or that."

P2 is aware of many of the PTSD dog training programs available. He is also aware of the financial issues many face due to cuts in federal funds as well as other options:

> There's a couple different programs like the American Legion, the VFW, and others have grants for service animals. [After] you get your companion animal and you can raise the money yourself or get VFW or the American Legion to help with the process of getting your animal trained for you. Even Petsmart has a training program to help reach Companion Animal certification if you take like 10 classes or so. It's kind of crap that since the VA is hardballing us. So many foundations are losing or lost their funding from the DoD … The Battle Buddy

Foundation is another losing their funding … they specialize with animals for PTSD and TBI. With both programs, that all the do, service vets and PTSD dogs.

Participant 3

Deployment. Participant 3 (P3) experienced one deployment in support of Operation Iraqi Freedom (OIF) in 2004 and retired from the Army in 2007. During his yearlong deployment, P3 described a high combat operational tempo, but that "we were getting things calmed down by the time I left. It got pretty wild there for a while." P3's unit "ended up going all over Iraq" operating out of six forward operating locations during the deployment. Personnel conducting operations out of multiple locations are faced with more than just a change of scenery, "every time [you] changed bases, you would have a totally new scenario; different types of attacks." Strategic and logistical planning for combat is challenging, especially when providing options for stress relief and other concerns. P3 received a short pass to an area of Iraq with little to no combat operations and a mid-tour leave, "but other than that … small bases didn't have rec centers, professional help, or any of that type of thing. All we had was what we had in an organic unit."

After deployment. At the end of the combat portion of the deployment, P3 remained in Iraq for an additional month to ensure the processing and shipping of unit equipment, as others returned home. This was 2005 and post-deployment screening for PTSD and other psychological issues was available, but "very basic at the time." P3 admits to "pretty much checked the blocks and because it was so fresh, I didn't have any time to unwind and get the stuff to actually start popping up," after returning home from Iraq during his screening; he had orders taking him and his family to another Army post

in a few short months. Although not in full swing, P3 recognized residual from Iraq existed, “In Iraq you didn’t let any civilians around you with vehicles and you certainly didn't let them pass you. We get on a bus and all these Germans are going by, and we’re like ‘nope, I'm in Germany, it’s alright.’” The night before leaving for his new assignment, two and a half months after coming home from Iraq, P3 first recognized issues, “a festival opened across the street from our housing development. It opened with fireworks. I was wide-awake when the first one went off and was out of the bed when the second one went off. It was at least three hours before I could go back to bed; I sat in the living room absolutely frozen.”

Literature on combat-related PTSD identifies that the longer individuals are separated from their deployment, larger numbers of individuals experience symptoms:

> I can fully believe that. When we go into survival situations in combat, we see everything; we smell everything; we feel everything. Everything comes in. The card sitting in the middle of your brain is going, “not relevant, nope, no, no, OK this has to go forward right now” the rest is shoved into a filing cabinet. When things start calming down, that card goes “we have to get stuff cleaned out.”

By 2009, anytime P3 drove his car, unfamiliar piles of trash or dead animals along the road sent P3’s mind screaming “IED,” followed by the internal struggle against the instinct to engage in combat-style driving maneuvers. Since retirement, working as a contractor an Army post, “when they fired the tanks, I would literally want to crawl under my desk, ‘where’s my gear’, and just really have a panic attack.” Operating out of

multiple combat locations during his deployment, just exponentially multiplied the number of triggers to his PTSD symptoms, "it did cause me, to have different types of panic attacks when I came back. I had more things that would trigger unwanted memories and trigger me back into survival mode."

Eight months after returning from Iraq, at his new location, P3 was facing another combat deployment, but attending to two "blown shoulders" forced him to watch his men fly out for the next deployment, just days after the first surgery on his shoulders. As he was recovering from a second surgery a few months later, P3 realized the limitations his body then possessed and made the decision to retire, "that fed into the PTSD and all my problems because it made me mad. I was so mad at my body for breaking down and forcing me to abandon my men. My men were going to have to go into combat without me. It was absolutely infuriating." Guilt was also associated with these feelings; guilt over the fact that, "I wasn't there to share with risk and share the danger … my experiences in Iraq were actually very mild for the Army, but to come back and not be able to continue, I think that played a multiplier role."

After retiring from the Army, "it took my wife two years to get me, that there *might* be a problem. Basically at that point with me, it was 'OK, fine, I'll go and talk to them just to shut you up' (to the wife)." Unfortunately, P3's first attempt at counseling was not very successful, "she [P3's wife] went with me on this first talk with a psychologist at the VA … at the end, she [the psychologist] said, 'well, yes, I definitely think you have PTSD, but don't think it is that bad. I'm just going to diagnosis you with

adjustment disorder.'" P3 talked with other veterans with similar, disappointing experiences, "others said they would go in and start talking and the counselor would just get up and leave the room crying."

It was another year before P3 made another attempt at counseling for his PTSD, all the while, his symptoms becoming "incrementally worse." The second attempt was successful with connecting P3 to a doctor who understood the progressive nature of untreated PTSD, ultimately directing P3 to a counselor and group he still attends today, "sometimes we talk about PTSD, sometimes we talk about everything else but … and if I ever have a problem or issue, I just call him [his counselor] up and talk about whatever I need to talk about." P3 continues to follow-up with the VA for his physical issues and disability evaluation:

> The VA is a very interesting experience. Some sections of the VA are very high quality; some sections of the VA will drive you absolutely nuts. I have a primary care doctor with the VA and the only problem I have there is she is so pushed for time. She doesn't have time to really sit there and listen to my non-medical terminology and how I feel and different things, to translate it into medical. Some of the stuff we don't think about because it's become our normal. If the doctor could ask us question, or had the time to ask us in depth questions and dig deep into everything that was going on, it would be a lot better. The VA is really overwhelmed on that side of things. The real frustration come when you go in for disability evaluation. That will really have you pulling your hair out.

The human-animal bond. Kitty's entrance into P3's life was not a preplanned event, just showing up at the house one day in 2009:

> For whatever cat reason, she would just crawl up on my lap and keep butting my hands with her head for me to start petting her. She'd start purring and I would be able to calm down and mellow out. She mellowed me out. How it works, I don't have clue because I'm really a dog person.

Besides chasing P3's troubles away, he believes Kitty is part of his ability to maintain the ability to "control things" and maintain a lower dose of a mild antidepressant, "a new doctor bumped me up to 150 mg twice a day, I started having freaky dreams … they weren't combat … they weren't real. I'd wake up and the entire bed be soaked. Between the counseling, Kitty coming along, and lowering the meds, all that pretty much stopped." P3 still requires pain medications for injuries sustained outside of his deployment and had not experienced any change in dosage requirements with Kitty's presence.

The attractiveness of PTSD companion and service dogs is their ability to sense the oncoming of PTSD symptoms in their owners. Of interest, is a cat also capable of this? Much to P3's surprise, a bond developed and Kitty, indeed, appears to sense on-coming PTSD moments:

> With cats it's always been "yep, that's a cat." She just crawls into my lap and demands I pay attention to her, scratch her ears, and starts purring and all my troubles just disappear. It's really uncanny. You hear about people training dogs to

> sense these different emotions and different circumstances with people. It's really uncanny how she senses this, she'll just be in my lap "scratch my ears and I'll start purring," it's really magical … here's this cat, who has just latched onto me. Whenever, when it's cold, we'll go to bed and she'll come up and demand to be let under the covers and she'll sleep next to me under the covers. It's magical, that's the only way I can really say it.

Additional findings. In describing the balance among the counseling and group sessions, Kitty's presence, and the medicine to keep P3 in a state where he can "control" his PTSD triggers. It has been almost 10 years since his deployment and understanding where he is today, the question was asked, is PTSD curable or does an individual simply learn how to deal with it. Apparently, this is a question regularly raised by new people coming into P3's counseling group:

> They want to know if this [PTSD] is something that they will be dealing with the rest of their life, they hear about different supposed magic cures, the deep immersion type treatment and all this. We're like "no," we can control it. We can get down to the point that "it's a trigger, it's not really happening, I'm safe, I do not need to react in a combat manner."

Thinking to younger troops who may live in apartments which do not allow dogs, or any variety of other situations preventing from dog ownership, and the possibilities of cats providing the same emotional support, "Oh, absolutely! I think the trick with a cat is going to be … a cat, well like Kitty did with me, she chose me. I didn't go choose a cat."

Finally, furthering the thought about animal-assisted activities in PTSD treatment specifically for troops living in on-post dorms, in-patient care, or other animal restrictive environments, should options be open to them? Would alternative programs, where these individuals have some type of interaction with animals (i.e., working with a humane society), be able to provide the reassurance and confidence soldiers described in the presence of animals? "That seems, from my understanding, now you have something, like your soldier, that is relying on what you do and bring back that love and affection and caring in return … you have something saying I don't care, I love you anyway."

Participant 4

After deployment. Participant 4 (P4) experienced one deployment with the Army, deploying mid-2010 for a year, supporting Operation Enduring Freedom. She has since medically separated from military service. P4 commented that most of her symptoms began during her deployment, "When I came home I was in pretty rough shape. I was suicidal. I was depressed. I had a lot of anger, towards what happened during my deployment and then what was going on with my unit and the chain of command." At the time of her return from Afghanistan in 2011, the DoD increased the frequency of post-deployment screening and availability of counselors as the psychological well-being of America's military received a lot of focus in the news, "They recognized that I needed help. They first sent me to an off-post counselor who was horrible, it wasn't helping." P4's needs were not being met and her symptoms worsened:

> I felt I was truly emotionally out of control and I definitely was having a lot of anxiety, nightmares, and flashbacks. Hypervigilance, that kind of stuff … I mean it was to the point where my chain of command from my unit was having somebody call me daily to make sure I wasn't going to kill myself, but that was as far as it went with helping me … I had a hard time getting help.

After P4's second post-deployment screening, around September or October of 2011, she would meet a social worker and begin her therapeutic journey towards finding relief from her struggles, "I went back to be screened and then they called me as I was leaving the building saying, 'come back in, we have to help you.'" An important element to highlight, life beyond PTSD does not stop solely because a military member suffers from symptoms. "I'm not going to say I [experienced] every type of traumatic experience, but a lot of traumatic experiences from deploying, to getting a divorce from an abusive person, getting treated horribly by my chain of command. It was all a big mess…it was just really hard to handle everything at one time." P4's match with a social worker was initially not a replacement for the formal PTSD treatment with the off-post counselor, but "She asked if she could work with me and started doing my counseling. I stopped going to the off-post guy … she was amazing. I always said she saved my life. She was perfect and matched what I needed … she was amazing in her field."

Consistent with literature and other shared experiences, a pharmaceutical regiment accompanied counseling, for P4's PTSD symptoms as well as physical issues. Of concern with P4, was the interaction of medications taken for multiple issues:

> One of the Army's solutions to all of my issues, which they do to everyone, and they had me on so many medications I was afraid to drive my own car. I would drive to work, give my friends the keys, and they would drive me around. A psychiatrist put me on an excessive amount of anti-depressants and of course Klonopin for anxiety. There was stuff for sleeping and after that, I was in a lot of physical pain, so narcotics also.

P4 continues to visit the VA now that she is out of the Army, for both physical and PTSD related issues. When a military member is medically retired or separated from active duty, the evaluation conducted on member's medical or mental health issues is assigned a rating. This rating reflects the dollar amount veterans receive for the specific disability, including PTSD. Disability evaluation occurs annually for five years, "They evaluate me to see if I'm better, if they can lower my rating. Which is honestly pretty *infuriating*."

The human-animal bond. As therapeutic work progressed with her social worker continued, P4 learned of the Train a Dog Save a Warrior (TADSAW) around May of 2012. "My social worker wrote a letter for me, recommending the program. I filled out the TADSAW packet and sent it." Shortly after applying for the program, P4 visited a local shelter and saw Dixie. TADSAW is supposed to evaluate any potential dog coming into the program, but P4 "… couldn't leave this dog in the shelter, there was something about her. They kept saying they would come to look at her but they had not…I sort of went out on my own." After about a week of Dixie staying at a boarding

facility for the TADSAW evaluation, “I took the [service dog] paperwork from my social worker, took it to my apartment complex, and said ‘look, I have a service dog.’ I didn’t meet up with a trainer until August. I think they mean well, maybe they just don’t have the resources.”

A quick description of the TADSAW program; assigned trainers assist veterans with training their dog. TADSAW permits veterans to use their own dog after an evaluation to assess the feasibility of the dog meeting training needs. The primary office is located in San Antonio, Texas, with trainers located in different areas. P4 feels they mean well, but the length of time she waited before beginning the training program and the specialized attention Dixie needed to break through some training issues, P4 was a little disappointed with the experience. However, the program’s manager assisted P4 by providing some training and bonding tips prior to the official training and TADSAWs responds immediately whenever P4 needed help with the verification of Dixie’s service dog status.

Outside of the delay in getting Dixie into the training provided by TADSAW, a bond nevertheless developed, “When I got Dixie, I felt like, there's something having a dog like her that will, it gives you a sense that everything's going to be OK, everything's safe. You can relax a little bit…she's always focused on what I'm doing, from day one.” For P4, there was also a sense that they were recovering together “I rescued her from the shelter and she was in rough shape so it was sort of like we took care of each other.” Dealing with her unit and her chain of command, “They must give Klonopin, I swear, to

every soldier who comes back for anxiety. I was taking it quite a bit because I was so stressed out about being in the Army and going to work … I had enough. She's so soothing and so calming, that [Klonopin] was the first medicine I stopped taking." Dixie's influence on P4 goes beyond just being a calming companion:

> We have to go outside and walk everyday, and play … it got me out of the house. I was sleeping a lot and just laying around in the house … then just having her with me, like going to the store and things like that, I don't focus as much on things going what's on around me, I'm more focused on what she's doing. She distracts me from what I would normally be distracted by.

However, when P4 has a moment, whether it is a flashback or hypervigilance, "If she senses that I feel anything other than calm, she comes up 'what's going on.'"

Dixie has also proven helpful for P4's husband, another combat veteran who suffered a traumatic brain injury, "My husband suffered a TBI when he was deployed to Iraq and he sleeps with a CPAP. When we sleep, she lays in a spot where she can see both of us. If I have a nightmare, she checks on me, if he stops breathing, she checks on him. I also think it makes him feel comfortable that she goes everywhere with me."

Additional findings. The recent DoD and VA decision to restrict service and companion animals will no less be of interest to participants in this study. For P4, this decision came in the middle of her adoption experience of Dixie. "When I got her … I would see people with the service animals all the time. Shortly after, my brigade commander would not allow anyone to bring their service dogs to work with them …

shortly after that I stopped seeing service dogs at the Reset and biofeedback programs, like they kind of banned that on Ft. Hood." P4 admits, the service dog concept may have become a fad for a while, which may had led to the ultimate decision on Ft. Hood. But, this did not erase her need of Dixie, "It wasn't fair to her and it wasn't fair to me, because I had been lower my meds so I could function a little better, but the reason why I could function better wasn't allowed. But they don't agree with it." After further issues with P4's attempts to take Dixie with her to different locations, "It was so frustrating. I just stopped taking her on post with me, everybody has something to say about it everywhere you go."

Participant 5

Deployment. Participant 5 (P5) witnessed the kickoff of both Operation Enduring Freedom in 2001, and Operation Iraqi Freedom in 2003 as a member of the United States Navy. Returning to homeport after the first deployment, the energy and pride behind the United States military members were high as the events of September 11, 2001, were still fresh among Americans, "The experiences were weird. I don't know how else to put it, but [I] felt very cocksure and confident I guess … very gung ho, very immoral feeling and just kind of lived, on reflection, like a terrible frat boy, really. I am very ashamed of that time now that I'm older. But that was just the reaction to what I saw … I don't know...it's weird to think about it." The men and women in military uniforms, for a time, would not encounter the negativity experienced by those returning from the widely unpopular war, Vietnam, "When we got back people really respected us … we even got out of a DUI. I hate to admit it now. Two weeks after we got back, my buddies and I were out drinking and the cop was like 'you guys are in the Navy? Man, that's awesome! I'll follow you guys home.'"

Combat operations include a variety of capabilities. Most people immediately think of the armed infantry units of the Army and Marines or even the bombers and fighter aircraft of the Air Force. Thoughts regarding Naval operations often consist of air carrier, submarine, or SEAL Team operations, but one often-unnoticed capability exists in its electronic warfare technicians. These technicians are responsible with analyzing radar information obtained on missiles, capabilities of aircraft, submarines, ships, surface

to air sites, ships ashore, and other enemy capabilities; their physical exposure to the combat environment is limited, no less witness the impact of their contribution to combat operations. "My real interaction with the war was done through a video screen … the aircraft would come back with information and come to us to help break down the type of radar or the platform the radar was associated to. Sometimes those would include missile sites." P6 shared the typical protocol that followed when their analysis, when it was believed data included information on weapons such as a missile site:

> At the time I thought it was pretty cool, but grosses me out on multiple levels now … they would drop one bomb … a camera-guided bomb on an area, then they would drop another one after that to see what the first one did … and to make sure everything was cool and pull a station of the area. The videos circulated on the secure web or server, people would watch them and share them, or the pilots would come by, "hey check this video out you guys helped us break that down to see what the radar was, it was awesome!" And you watch the tapes and you don't see Taliban, you don't see terrorists … you see little kids, women, and goats and these homes that just happened to live next to some site that they probably didn't even know was a missile to begin with and they would just happened to get obliterated, you know. But, then after that of course, I've watched friends have different kind of experiences, but that was the one thing that was very weird.

After deployment. After launching the war on Iraq, P5 separated from the Navy with the end of his service commitment and came home. Reflecting on his deployment

experiences, P5 pursued as education in media creation. However, accompanied by the academics towards a new, post-military, career, P5 also faced information surrounding the geopolitical history of the regions, challenging the perception he held about his deployment experiences. "I started learning about the history of the region. I never knew anything about the wars with Russia and Afghanistan; I never knew we helped them out. So, when you learn the geopolitical struggle the region had, for like forever, you kind of start to begin question that stuff … I wasn't actively trying to learn about it, it was 'oh shit' kind of moments, then you start … I started feeling guilty." Occurring concurrently, the wane in social focus the wars received also contested P5's original opinions, forcing him to reassess his role as a Naval electronic warfare technician:

> Bush had done the whole carrier thing about 'mission accomplished' and things just kept going on … stories kept coming out about the lack of funding for armor … I started losing some of my buddies … it seemed everybody became apathetic to it. They just stopped caring. Sometimes you'd hear stories here and there...but then progressively '06, '07, '08, people stopped caring. The news stopped covering the stories. Nobody wanted to see people die and no one understood why… the war in Iraq was so fickle. We kind of knew … I had friends in the intel community and they said they were reading what they're getting and we're not seeing these weapons their talking about. We were still gung ho about going to war, but there was still stuff that we're not really sure what we're doing. Then it came out blatantly there was no weapons of mass destruction, the Al Qaeda

> really is a small group of this population, the more we kill the more they recruit to get us out of there. It seemed like was I duped? 9/11 happened and I think Afghanistan was justified for the first couple of years, then we get Bin Laden, but then we're still there. What are we dying for? I think that was what was really getting to me.

There is no cookie cutter explanation for posttraumatic stress, no one theory to justify why some individuals develop symptoms, predict who the next victim is, or determine when complications will start, "The strangest thing actually, 2003,'04, and '05 were not really too bad. It was '05 that it really started … maybe for two months I'd wake up freaking out, with cold sweats, not knowing where I was." Triggers, or events, stimulating the onset of symptoms also differ from one person to the next and can be unpredictable. P5 studied England, exposing him to a different level of media than experienced in the United States, "When I got back home in 2007 and for some reason, when I went back to school, something kind of clicked and the PTSD really hit me hard. Maybe it was a combination of, more exposure of what was going on and different things … I'm not really sure what triggered it."

Seeking assistance with the VA was disappointing and P5's experience with psychotropic medications was almost 'out of body':

> I went in [to the VA], the lady said, "Tell me what's going on," so I told them and she was really curt and abrupt, "Ah-ha, ah-ha, ah-ha" and she's … she was just checking things off. She turned to me and said OK we're going to prescribe you

> "something, something, something;" I don't even know the names. I took them for like four or five days and what would happen is that … it was about a mile walk to school every day and the second day I took them, I was walking, it literally felt like – the best way I can describe it, like a first person camera, then it felt like a third person perspective. The camera was like slightly above me and I was watching my self; I was cold and numb … it just didn't feel right.

Following up after this experience, the VA's remedy was more prescription drugs. P5 did not want more pills, but realized the staff was not interested in talking about his symptoms and the root issues of their triggering effect. He was also offered group therapy, but the experience of a friend quickly closed the door to that option, "when he was in the group it triggered more of his PTSD because of listening to everyone else describe their problems and what happened to them. He said it trigger it so bad that he said 'screw it' and never talked to the VA again." A university counselor offered initial help, but as a student, P5 was only allotted six sessions, forcing him to turn to an alternative means to cope with symptoms, outside the scope of the study.

The human-animal bond. The therapeutic influence of animals on PTSD symptoms first became known to P5 after watching a friend's response to an animal, "He was very aggressive, he did three tours to Iraq, and when he got back he was very short tempered all the time … [his] girlfriend had a puppy. I saw this guy with the puppy and he was a *changed man*. It was amazing!" Determined to put himself in a position where he could experience the human-animal bond, P5's continued education put him in place

where he could consider owning an animal. Visiting a local shelter, Runner's demeanor and style gave P5 a new battle buddy and companion, "I said, 'I like you dog, I like your style. Kind of like come over, hang out and see what's going on, then you go smell around, do your own thing then come back.' We kind of connected and I adopted him." Runner had been in the shelter for nine months, which created some initial concern for P5, he was leaning more towards a puppy, "[He was] a year and a half … I was a little nervous about it, I kind of wished I could have had him as a puppy, but he's turned out to be a great dog."

The two years since adopting Runner has been "amazing," but not without its challenges, none-the-less, remembering those times is with a jovial tone:

> It's like, if he poops in the living room, it's like '*aahhhhhhh what the hell*' ... but then you just gotta go, 'if you poop, I gotta clean it up. Dogs do that, gotta take them out.' Those types of things ... like 'I shouldn't have left those shoes out ... he obviously likes to chew on shoes' ... so he's really helped reestablish my patience and tolerance for certain things like that. He's one hell of a great dog and great presence in my life.

However, regardless of the shoes destroyed or 'presents' left in the living room for P5 to clean up, Runner "keeps tabs" on P5 and assists with the maintenance of PTSD symptoms,

> I started feeling a little stressed out. So Runner will come over and lick my hands ... or come over ... it's nice because he kind of keeps tabs on me. So he'll

> come over once and a while, then he'll go lay down by himself for a while. I think when he feels that I'm stressed out ... he'll come over and sit next to me, put his head in my lap, and want to hang out … he definitely knows, I think, that I need a distraction and I'll turn my attention to him and pet him and stuff. He's very 'pet me know' at all the right moments … I walk Runner every day. I try to take him to the campus lake and do a two mile walk with him every day. So it gets me out of the house because I have to take care of his health as well as mine.

Additional findings. P5's experience since his deployment highlight how group and pharmaceutical treatment plans are not a good fit for every individual suffering from PTSD. Presented with the idea of creating more animal-assisted activities as an alternative option for PTSD treatment:

> I 100% support it, in fact, if there was a way to federally sponsor a program that would be great. Even like the VA, if there was some way to grant veterans who have PTSD some type of waiver for apartments and other places where they don't allow pets. Nothing huge and ridiculous, but like … I think society, people are always trying alternative ways to help deal with these types of things. An animal isn't a person you speak to … it's a responsibility, something you take care of and gives you something back in return. Grant it, not all veterans should have pets. I have friends who have incredible anger issues and I would not want them to have a small animal, as it would be a detriment to both of them. By and large, it just the fact that I have a lot of vet friends who live alone, like I do, and don't have

> anything. They have a couple friends and they just kind of recluse themselves at home, play video games, and drink a lot … If there's any way to convince the VA or Congress to allocate money to do research on this, I think it will be a wealth of goodness.

P5's work and education in media creation provides a great outlet to express his thoughts and opinions, especially those related to his posttraumatic stress. However, society's approach to the issue, or lack thereof, he feels is also a hurdle to cover come when dealing with this issue. P5 expresses himself every descriptively, but there are times where he internalizes thoughts and expression, which has lead his unconscious behavior of clenching and grinding his teeth:

> I do internalize a lot of stuff. That's one of the reasons I'm in the art program I'm in, it gives me an avenue to express things like that. I think my big thing too, a general theme I have notice for some people I talk to … sometimes you feel like you're arguing with talking points and not with real people. It's just … they don't care and so apathetic towards it ... and they don't want to hear, because when they hear about it they get upset and they want to do something [and] it adds more shit to their very full plate. So for me, what I'm trying to do just starts conversation. I don't want to be part of the conversation, I just want to start the conversation. When you're in a group, you're just bouncing around same kind of negative influence off each other ... I think we walk out of there a lot more angry and depressed than when we first walked in, but that's just my opinion on it.

Continuing with this theme and his feelings, it has been after almost a decade since P5 was in the military and asking his opinion whether over the idea of curing PTSD, he shared the following opinion and perspective about deployment experiences, "You can't unsee what you've seen, you can't undo what you've done. There's survivors guilt, there's guilt about killing women and kids and innocent people ... there's all this guilt you feel about different things and there's nothing you can really do besides … if you have to really talk about it, talk about it." However, adding on the original thought of society changing its approach:

> But also, society needs to change. We like to stigmatize the words PTSD and all the psychological terms we have to put people into these categories. They are just categorizing and having these negative stigmatizations and connotations towards people who display these symptoms. They need to understand, look, it's not like PTSD is something I asked for, it was something I developed from the experiences of something everyone says 'hey, thank you' for going to do. So you can't say 'thank you for your service' then be afraid of what that service entails or the consequences of that service … that is what has to change, more than anything else, the human perception of what it is.

P5 is in a unique situation where he encounters ROTC students at his university, where he fields questions about his experiences in the military. What does he tell them? If he tells them the truth, will that create conflict in the upcoming officer cadets, possibly influencing their decision to pursue a military career? Social media names such as John

Stewart and their critical satire of issues facing the military, how can he promote sacrificing an ungrateful nation?

Participant 6

After deployment. Participant 6 (P6) experienced one deployment to Iraq, from 2004-2005, during his enlistment with the Army. As his unit prepared to return to Iraq within the next year, P6 experienced severe back injuries while preparing unit equipment (Bradleys) for the next deployment; "We knew shortly after returning, that we'd be going back to Iraq. I tore back muscles and herniated four discs … they wouldn't let me go back." Leaving Iraq meant returning back to the monotony of typical Army existence, "I volunteered to stay with the incoming unit … the whole Army thing … formations and waiting … doing nothing all day, then leadership finding a task 20 minutes before final formation … it aggravated me. Coming back to that stuff was why I wanted to stay in Iraq…it didn't work out that way." Instead of redeploying with his unit, P6 was medically retired in 2007 because of his back. Mixed feelings filled P6, "In one way, I knew I was going to get out and return here [home], but in another way, I didn't want to return back here … I wanted to stay and go back [to Iraq] with them; that's what I went in for." P6 channeled his disappointment towards higher education, "The only reason I wanted to get out was to go to school. In an infantry unit, we had no chance, no option, to go to school … [but] I wanted to stay in and do what I was trained to do."

Customary for most young, enlisted military members, home life usually meant having a barracks roommate, "After we got back, I was rooming with another guy; we would do stuff and hang out, but I got my own room a bit later." P6 also shared he's a summer person and with the unit's return in May 2005, "I was OK through the summer.

We would travel and do things." The combination of getting his own room and the end of summer gave P6 a chance to seclude, "As it got colder and the days got shorter … and I got my own room, then well …" the isolation began. "That's basically what I did for the next year and a half. I would go to work, then pretty much stay to myself." Isolation became a means of dealing with the experiences of war, albeit, "Looking back on it now, I can see what I was doing was how I was handling things, but I wasn't paying attention." P6 recalls drinking more when he initially came back from Iraq, "quite a bit more." Even with his combat-related duties, P6 often had the opportunity to separate himself from others, "Luckily I worked for the platoon sergeant. I was his driver through Iraq and was his gunner, once we got back … that was what I was training to do … I got to do what I wanted, which gave me the option to pretty much isolate myself."

While the isolation began shortly after returning from Iraq, coming home to the United States after the end of his Army career, although P6 did not drink as much, he still did not do "a whole lot." With his grandmother suffering a stroke, requiring hospitalization and the care of a nursing home facility, P6 moved into her apartment, "I spent a lot of time with her. I knew how much she hated that place and being there. I wasn't working or doing much of anything, so I would visit and stay with her. Having her apartment gave me an opportunity to get away from everybody." Outside of visiting his grandmother before her passing, P6 occasionally interacted with a couple of friends, but that was "pretty much what I did."

The period of P6's return from Iraq was prior to the Department of Defense directed increase of psychological screening of returning deployed members, "We had a short integration, or reintegration period, but that last maybe a week. Then it was back to work." An attempt was made to address the residual effects of the Iraq deployment, "I had a really good social worker with the VA; we wouldn't talk a whole lot about treatment stuff, but she helped come up with things that I wanted to do – ways to get out and do new things. She's the one who sent me to this school I just graduated from." The secluded existence P6 maintained was not restricted to mere physical proximity of people, "Every time I tried to talk to someone about that stuff, it just aggravates me … I've tried stuff like that. I tried talking to this one lady, to discuss my driving issues. She started comparing them with her husband, who has never been in the military." When confronted with group therapy, "They tried pushing me into a group. I am not going to sit in a room where a bunch of people talk about issues; we were all there, I don't need to hear that." Unfortunately, experiences as such further aggravated P6, shutting him down. Fortunately, the inundation of prescriptions medications for his PTSD symptoms was not an experience P6 contended, outside of pain management for his back, "The only thing I told them is occasionally, when I get aggravated, I would like to have valium. They offered Xanax and Ativan; I know how I get if I take Xanax, I get mean. They've offered and I'm like *nooooooooo*."

The human-animal bond. Sometime would elapse before Side-pocket would come into P6's life and not with the specific intention to ease his PTSD symptoms, "my

buddy has a dog, ended up finding her under a dumpster, I always liked he …, but just seeing the puppies, I just had to have one. He was my dog after a day. As soon as he was ready for his shots, we started going to parks and he pretty much went everywhere with me." P6 enjoys his seclusion from people, but he has always liked animals and gardening; nurturing things and watching them grow. Not with him any longer, P6 also rescued kittens and bunnies found, discarded, in his neighborhood, "I think things, especially with my animals, they give me something to focus on and turn my attention. Still, even with them, my desire to talk with people or hang out with people, I just don't do it."

Side-pocket, the little puppy P6 just had to have, has also brought P6 out of his restricted existence, to attend to the canine's care and subsequently, his own, "… we started going to the park and started running. It gave us something to do and get out and both of us could get some exercise. I'm a firm believer exercise keeps you calm, keeps your depression down, keeps you where you don't get as aggravated." General patience, even with driving, has also improved with Side-pocket's presence:

> He's given me something to focus on, with pretty much everything. Especially like with driving, I have issues with driving. I was a combat driver and I don't care for driving at all. I drive fast, I get aggravated. I know, when we get into the car I have something else depending on me not to do something stupid. He's definitely taught me patience, not to get upset and scream and yell too much.

Side-pocket also appears to be able to sense when "a mood" is beginning to surface in P6, "He might be a little more playful or what to play, try to get up close to you. Especially at first, I go 'go away, I don't feel like dealing with you', then I think about it and it's like 'oh, come here, I know.'"

Additional findings. Current PTSD treatment protocols focus heavily on talk or group therapies, along with a strong reliance on prescription medications, not all of which meet the needs of a personality such as P6. Regarding the topic of group therapy, "I think I would have been OK if we were actually out doing something and not just sitting around talking … I mean, if they got a group of guys together to go out, where the focus isn't the whole 'what happened … what were the experiences.'" Some people do not where their hearts on their sleeves, some do not want to talk; for P6, it has been eight years since his deployment and he still does not want to talk. P6 is not a big talker. Approached with the idea of an animal-assisted activity, as part of PTSD treatment, a basic description of a ranch-style environment where veterans were responsible for the rescuing and care of animals, P6's responses were enthusiastic and supportive. Different approaches work for different people; for an introvert, expectations of sharing feelings and experiences may shut them down and turn away from treatment. Even with treatment, as focus is turning to enduring or constant PTSD, realizing the approach to the effects of war may not be erased, but managed much like diabetes, P6 shared, "Yeah. A lot like that. That's what I'm doing. I'm not trying to cure it, I'm just trying to keep it in check. If I feel myself acting a way I shouldn't be acting, I know I have to change that. If

I focus too much on the wrong thing, or I get too aggravated … I try to do something to avoid feeling those feelings and reactions."

Participant 7

After deployment. Participant 7 (P7) deployed to Iraq in 2004 with the United States Army, returning in 2005, and medically discharged that July. P7 suffered from a traumatic brain injury (TBI) as well as PTSD. Returning home, P7 shied away from being around people and going places because it caused a great deal of anxiety and fear. Depression also set in, "Because you're isolating yourself. You don't know why you're doing it; you're kind of on auto."

Following his discharge from the Army, P7 acknowledged some nervousness over his follow-up care with the VA; the stories from other veterans, especially Vietnam, did not paint a pretty picture based off their experiences. "Maybe I was lucky, [I have] had good experiences with the VA. I never had any doctors or nurses make me feel uncomfortable." P7 addresses some issues with the first VA he visited in Arkansas regarding getting specialized care, "I would make an appointment with primary, that would take a month. Then they would refer you to see someone that would take a month. Then, it was probably another month or two out before the [actual] appointment." Since moving, the new VA center he visits has a better system with the assistance of a poly-trauma coordinator, "I can call her, if I need something, and I'll get directly an appointment within a week or two."

P7's treatment experience consisted of groups and prescription medications. As far as the groups, P7 felt some were beneficial while others were redundant, and did not "really get anything out of them." Considering his TBI issues along with the PTSD,

when asked if the VA prescribed P7 any medications, his response was simply, “Oh, yes.” Unfortunately, it would take a couple of years before the doctors could balance the interactions between the medications prescribed by the neurologist and those for the PTSD.

The human-animal bond. Originally adopted for his fiancé, the puppy Stella laid in P7’s lap on the drive home and from that point on, “she chose me.” Stella continued to display her affection by sleeping on shirts just worn by P7, when she could not lie next to him. In the five years since adopting Stella, P7 finds being in crowds are not quite as uncomfortable with Stella by his side, “She’s very protective; sometimes with other people, she doesn’t want them getting close to me. She kind of provides that buffer zone without my having to back away.” Stella also appears to sense when issues arise in her owner, “She also seems to know when I was having a bad day, she'll come over and lay her head on my lap. I have nightmares and she'll go and alert Jan that something's wrong. She's looks after me more, I guess, than I look out after her.”

Additional findings. Considering his experience since Stella came into his life, and the experience of others, P7 believes the number of people turning to animals “shows that it really works.” After returning from war, many commented about relating to others with the help of animals, P7 feels, “The dog ain’t going to judge you about anything, they interact with you without any judgment, you know, that unconditional love.” Although it is hard for P7 to tell if adopting Stella earlier in his recovery would have helped with his symptoms sooner, the thought that it would is there. P7 recalls his inpatient treatment

three years ago; even then, the discussion circulated about bringing therapy dogs into the treatment protocol.

P7 feels the opinion that seeking treatment is still considered a sign of weakness among so many veterans. Even if they do not go through the VA for help, which sometimes takes veterans a year or longer to get in the system and centers vary in ability to provide timely appointments, he feels they need to "get it somewhere"; so many struggling with issues. He points to the Vietnam veterans who, after 40 years, are still having issues with their PTSD. With the increased attention of the mental health issues and also the increased number of options available to day as compared to thirty or forty years ago, P7 hopes that veterans coming home from Iraq and Afghanistan "may not have as many problems as they [Vietnam veterans] did."

Participant 8

After deployment. Participant 8 (P8) deployed to Iraq from 2006-2007 with the United States Army. Predicting the traumatic events military members may face during combat deployments is a challenging aspect of operational planning; however, the death of a sibling, at a different Iraqi location, is an event many would not consider. Aside from dealing with her own deployment related issues, P8 also lost her younger brother, another Armed Force member, "We were 25 miles apart at the time. They think that played a huge impact on the posttraumatic stress (PTS)."

Instead of returning to her Army post with the rest of the unit, P8 went home for 30 days on emergency leave. Returning to her home station, "Emotions ran high … I didn't know where to turn or who to talk to ... it was tough." Interacting with others was far from a priority, "I didn't want to be around anybody, could care less if I saw, heard, or talked to anybody. [I] didn't want to go out to eat ... didn't want to go to public places." The stress mounted. Her post-deployment screening was rushed and abbreviated; completing the required paperwork, when the doctor discussed emotional and psychological issues, "oh normal things, go back to work" was the response P8 received after raising the death of her brother during the deployment. Relating to her unit was difficult and many did not understand what P8 was experiencing, nor did she feel like they cared. The stress mounted higher. "I was requesting to be moved from my unit to a new unit, because I didn't want to face those people any more … I told him 'I have to get out of the unit' … he was nice enough to work with me … [another] unit needed help

getting caught up on legal issues, so I could bury myself in the work." Not leaving herself room for anything but work and training her newly adopted dog, P8 successfully treaded Army life until her separation, approximately four months after returning from Iraq.

The whirlwind of emotions was not enough to push P8 to seek help to manage her deployment experiences and the death of her brother; she managed to bury herself in work and stay under the radar. Leaving the Army was accompanied with mixed emotions, "I went from something I knew every day to 'I don't know what I am going to do for work, I don't know what I am going to do, I don't know where my skill sets fall,' kind of had *no clue* of what to do with the civilian world anymore." Whether the added stress of leaving the military was the "tipping point" for P8 is uncertain, a formal diagnosis of PTSD came two years after leaving the Army, "Admitting I needed help was admitting a weakness, and that's not something you do. I fought it for a long time." An unfortunate evening, highlighted by running from the police and not making a corner at 150 miles per hour, launching her brother's motorcycle into a barb wired fence, was P8's, "Hey, there's something wrong, you need to get some help for it" moment. "I didn't care, I didn't care if … what happened to me. I didn't care if I lived or died at that point in time. That's not me. I would never, in my right mind, do the running from the cops, I would never do over 100 miles per hour on a motorcycle." Her guardian angel was with her that evening, her brother's familiar voice saying, "tuck and roll, sister, tuck and roll" is the only memory P8 has of the accident.

The treatment experience began with a visit to the VA, getting P8 on medications to address her depression, anxiety, eating, and sleeping issues. P8 was never a big fan of public places, yet her deployment experiences sent the issue from uncomfortable, but tolerable to completely unmanageable, "I'll have something ordered and pay more money for delivery than go grocery shopping." Introducing other therapeutic elements to combat her PTSD has not fared well. Directed to the Vet Center for counseling, P8 allowed the staff to assist with filing her service related VA claim, but was not able to tell her story passed the point of her brother deploying. "I've been able to discuss it with some of my friends … my physician's assistant (PA) knows more, she's gotten more out of me, but we've formed the relationship and bond that [she] can kind of drag it out of me." P8 follows up with the VA to refill her prescriptions, but is not enrolled in additional therapy. "The VA is awesome," P8 works with a staff who are understanding of her anxiety with public places and work with her, yet the Vet Center, which P8 has not visited in two years, "They were always nice and friendly, I just didn't quite hit it off with that group." The anxiety tormenting P8 overshadows the potential of considering other group sessions, yet, at her current location, "They don't really offer the groups as much here in Louisiana. It's difficult to get into one of the groups."

The human-animal bond. While still in the Army, P8 encountered a six-week-old puppy "who following me around" even with her best attempts to direct the pup's attention to a group of kids playing with other dogs. Picking the puppy up, "She wrapped her arms around my neck, in a hug, and started snuggling her head underneath my chin,

like a little angel … she named herself and came home with me and has been by my side ever since. I wouldn't trade her for the world." Training Heaven gave P8 the distraction she desperately needed to get through the final months in the Army; "She's trained in French, German, and English, and it's just me going home after work every, because I'm a hermit at this point in time … all I have is Heaven so my concentration went into teach her what I wanted her to know."

In additional to her multilingualism, Heaven "always knows when my mood takes a turn to the south." When the depression deepens, or the anxiety rages, it is Heaven's closeness that P8 relies on; that closeness that says, "Hey mom, I'm here." Sometimes that is it, when an individual cannot relate to the world, when the words and emotions do not fit nicely into another's definition of what 'ought to be', there is always the companionship and protection of Heaven. "When I don't want anybody else around, she is always there." "With nightmares … she just snuggles closer, [and] she'll put her paw over me, it kind of wakes me up and I realize, 'hey, somebody's here and it's her, and she's trying her little heart to comfort me' … if I could take her everywhere with me legally, she'd never leave my side." There is a trust in Heaven. There is a devotion to Heaven. Described as an "old soul," Heaven is getting older, a thought P8 does not like entertaining.

Princess, a six-month pit-bull puppy, keeps Heaven and P8 on their toes. The "yin" to Heaven's "yang," she "gets my mind off everything," sometimes literally, with puppy antics and goofiness. But for P8 it is a constant, they are her balance:

> I really wouldn't have the sense of normalcy that I have … (pause) …it's a skewed normalcy but a normalcy, in my world, that I have with Heaven and now with Princess … Just at night when I wake up from a bad dream, and I have Heaven curled all the way as close to me as possible on one side and Princess cuddled on the other side, with her head thrown across me, just a comfort comes over me and I know that something at least is right in the world and I my girls are here.

Additional findings. P8 has been out of the Army for six years and her PTS has only gotten worse, "I am locked in my head 24-7 and that's the only place I can be. The memories are still there … the triggers are still there and they catch me unaware." Unfortunately, as addressed above, P8's issue with anxiety makes any additional therapeutic option challenging; any suggestions require extreme consideration of the dominance fear of public places continues to reign. Even with the struggles, coming off all the prescriptions has been attempted, with less than "pretty" results. With this experience still fresh, P8 believes PTS can be treated, but not cured. P8's hope is for a service-dog training program to start in her area; the idea of having that sense of security and protection, she feels may permit her an independence currently lacking in her existence",

> I know the VA says it doesn't have funding for this, that, and the other, but they need to put more research into the dogs, in a way the soldiers can relate to the dogs, and it will provide another level of healing to the soldiers. It doesn't have to be a dog; it can be a cat, a horse, a pig.

Participant 9

After deployment. As a United States Marine, Participant 9 (P9) deployed twice to Iraq, the first time from January to June in 2003, then again from February to September in 2004. Coming home from the first deployment, P9 could not release himself from the "lifesaving habits of combat," marked by hypervigilance and jumpiness. A clown's popping of a balloon at a farmer's market triggered his first flashback – tunnel vision, shortness of breath, and a slight need "to get out of here" type of panic – all the typical symptoms of fully-charged, combat adrenaline. However, after his second deployment, P9 did not want to be anywhere with lots of people or in environments he could not control. And there was anger, "Anger was the response whenever something … to uncomfortable feelings. Whether it was in traffic, on the side of the road, or physical environments, the anger, [it was] self-preservation, I guess."

Post-deployment screening for the Marines was nothing more than an obstacle in getting home, "Quite honestly, it was a joke. We were involve in some pretty hefty stuff … it was like 'do you see, hear, or smell anything you found disturbing', (sarcastically) *Ahh, no*." Anyone who goes into a combat zone, especially Iraq during 2003 and 2004, was not coming home the same person, but the stigma attached to admitting help, to admitting a weakness, "We were afraid if we said we were having problems with nightmares, problems sleeps, or having problems with self-medication of over drinking … we all just lied about it. If we don't admit it, it's not there. We're Marines, we'll just push through it." A visit to the Naval Corpsman (doctors) resulted in a prescription of

Zoloft and biweekly follow up with the doctor, “It kept me going. It helped with that will to fight; it kept me grounded, to the point I'm at now … but it wasn't as helpful as it could have been. This was 2005, there wasn't a lot of discussion about PTSD.” Coming to the end of his second service contract, instead of reenlisting, P9 felt if he could put the military behind him and get enough distance, maybe the PTSD and its symptoms go away. P9 filed a VA claim on his way out the door, but did not visit the VA until 2009.

The reality that distance could not put PTSD in his review view mirror became apparent. In 2009, VA counseling helped P9 “get the discussion started, to the point where I can address the issue, and discuss the traumatic moments.” However, the Vet Center proved much more helpful and inspiring. Together with Vietnam veterans, one other Iraqi veteran, and a World War II (WWII) survivor, the groups, relaxation classes, and other counseling appointments taught P9 “a positive way to calm himself down or collect himself.” Reflecting on the WWII survivor, “When you listen to that man, you can see what happened 60 years ago hasn’t … it defined his character but it didn’t define his life.” A seed was planted. Through several moves and job changes, P9 got it and applied it, “I realized that the pace of life, living in the city, and surrounding myself with 10K people, that was *not* good for me. It was a Tom Petty concert when I decided to pull up and get out of southern California.” Now, finally ‘home’ in the quietness of Northern California, on three acres with his two animals, P9 continues to live it:

> I thought, why was I going through the grind and killing myself every day to pay my bills and keep up with the Jones … I'm not trying to keep up, I am trying to

> catch up to begin with because there's that idea that while we're deployed, everything when we come home is going to be the as we left it. We have to process information from our journey as well as try to catch up with the rest of the real world, that's been trucking along every day … It's scary to redefine who we are. We have a strong mental picture of who we are. The PTS changes things … But now I have new insight in this thing called PTSD, that most people won't even attempt, or you know … the PTSD is forcing me to do a lot more analyzing of who I am as an individual, where I am at in my life, and where I want to go with my life, at a much younger age than the majority of my peers will. So, that gives me the tools to live a much happier and fulfilling life in the long run.

The human-animal bond. Coming across Cairo and Egypt is another journey P9 travelled. It all started with seeing a lady with a Dalmatian, curled at her feet, on an airplane, "She was reading a book, so I gathered she wasn't blind. I hear her say, I'm a veterans and this is my service animal … that really piqued my curiosity. I was having a lot of anxiety about flying and watching the dog just curled up at her feet put me at ease." P9's mind raced, "I can have a dog that I can take on an airplane with me, does that mean I can take them to Wal-Mart, [does] that mean I can take it everywhere? It piqued my curiosity a little more … but being responsible for them, it was a little too much, I had a lot of anxiety about it." Even so, time spent volunteering at a local rescue ranch continued to keep the interest piqued for P9, but each time the thought of "ownership," "selection," "adoption process" surfaced, he found himself quickly overwhelmed, then

turned away, “There were some days were I could barely take care of myself and fears of being in a serious relationship. Having the responsibility, it was so overwhelming.”

However, one afternoon a call from a neighbor sent P9 tracking down the river to see a Golden Retriever (Cairo) and Standard Poodle (Egypt), let loose by their owner. Odd how fate works, one minute he found himself turning from the possibility of pet ownership, then the next he’s saying to himself, “You keep talking about it, you obviously want to do it, man up. Step up Marine.” In 2011, P9 came face to face with Cairo, “As soon as I met Cairo, he absolutely dispelled any anxiety I had about having a dog. I said load up, he smiled, and jumped right into the truck.” Life in the new relationship started with a few bumpy roads, identifying some boundary issues; Cairo apparently did not like getting out of P9’s truck. This provided P9 an opportunity with understanding dog behaviors, applying techniques from the Vet Center with controlling his anger with the realization, whatever you are feeling as the lead human, the dog is going to sense, and respond accordingly.

If there were ever two dogs different in temperament, “Egypt is much easier to manage when I go out. Cairo, I don't think was ever on a leash much.” There is a happiness the pair bring him, even with Cairo’s age and physical limitations, “He's happy, he loves being out there” and Egypt, right by his side, “I don't even need a leash with her, she doesn't wander, she's very (pause) I don't know … she's a good dog.” Although, when it comes to a bad day, when symptoms begin to surface, Cairo tends to be the comforter of the two, “He'll come over and give me a nose bump. He looks like,

from the Never Ending Story, Falcor, when he's getting his ears scratched … very relaxing face, he'll come to me and head bump me, 'Hey dude, just another day in paradise.' He's very calming in that aspect." When P9 feels like prospecting, even where encounters with mountain lions and bears occur, he is able to rest his mind, knowing, Cairo and Egypt sound the alert if there is anything requiring his attention.

P9 has cats on his therapeutic team as well. Often sleeping in bed with him, P9 describes nightmares where, "You wake up and you're at 100% and ready to go. [Then] feel the fuzziness of the cat next to me, it's my grounding agent. It reminds me 'you wouldn't have your cat in combat, you're home, you're safe.'" The cats also sense bad days, climbing onto P9's lap or laying at his feet. What may start as an "I'll get annoyed, obnoxious, and angry at the cat because it's loving me," quickly turns into a "You dummy, the cat's trying to tell you to quit being grumpy." Like the dogs, they do not judge, they do not have input or commentary "their undying devotion and love, it's true friendship."

Additional findings. P9 has realized and actualized many of the lessons he learned from the older veterans at the Vet Center. Reaching back to the realization that there were more choices in life than killing himself in attempts to "keep up with the Jones" P9 also highlighted a society "more concerned about Justin Bieber than what's going on overseas" as well as society's approach to the issues such as PTSD. Society and starting the PTSD conversation, how do you start the conversation? Unfortunately, as P9 points out, we are not a very nice society. "Going postal" was the joke about Vietnam

veterans employed by the postal service, who reached their breaking point, “It was easier to make jokes about it and laugh about it than address that there were some people who were really hurting inside.” Even with his attempts at writing on Facebook, he realized the ignorance and oblivion a paid military provides for so many, “so their hands are clean.” In a post about Iraq, he was met with this blinded view, when confronted with a, “Why should I care … my children aren’t being threatened … but you are bombing schools and killing children.”

> It really made me angry, to the point that, “hey, are we blowing up schools, yes, but we're rebuilding them. Because those schools were not schools, they were bomb storage buildings … and you know what, fuck that kid's father who that put that kid in a car and put him in the middle of a combat zone.” And some 19 year old kid has to decide, when a car was speeding towards him, whether or not he was going to protect his friends or you know … it's such a disconnect.

Unfortunately, political agendas and Monday morning commentaries by armchair quarterbacks, it is easier to judge from afar and “satirical comments to make about what went wrong.”

The answer is not all society. One change, like what P9 experienced, is how PTSD is approached may make the difference. In his opinion, PTSD is not curable, but he questions if that should be the focus. Redefining one’s character, albeit scary at any stage in life, provides a chance for serious self-reflection. For the individual with PTSD, the new definition includes “these little quirks we have now.” Most individuals deployed

to a combat zone will not return the same person, but like any other developmental process, it must consider changes in morals and values, who they once were, who they are now, and what they have. This process may need to take the individual back a couple steps to relearn earlier life lessons to move forward, better coping mechanisms, nutrition, and fitness, in a non-threatening, natural environment, possibly an environment where individuals can work with animals.

P9's involvement with a program called Horses Helping Heroes really solidified his opinion of approaching PTSD treatment with a more natural setting, exposing individuals to working with animals, "It's group therapy on horseback." The amazing aspect of Horses Helping Heroes, a veteran maintains the grounds and many of the volunteers are also veterans. Programs where veterans help other veterans, such a service-dog training program, P9 believes can provide the greatest therapeutic impact in dealing with PTSD symptoms than the standard "cookie cutter" approach:

> [It] can be an amazing therapy for the individuals that's doing it. It's good for the people there volunteering … but doing something like training service animals, if you don't keep the animal and you hand it off to another veteran, you are bringing that other veteran into the program as well. Now you're helping two or three people along the way.

Participant 10

Deployment. Participant 10 (P10) dedicated 30 years, 6 months to the United States military; his time includes attachments to active duty Army, the National Guard, and finally the Air National Guard. P10 also experienced a number of deployments during his time, three pre-September 11, 2001 (9/11), deployments between Bosnia and Kosovo, and three post 9/11 deployments between Afghanistan and Iraq. P10 recalled his wife noticing a difference in his personality and demeanor after returning from his second post-9/11 deployment to Iraq; however, P10 feels his last deployment, to the Helmand Providence of Afghanistan, was "the hardest tour" he had experienced. P10's specialization was Medical Air Evacuation (Medevac) operations, trained in radio operations and as a flight medic, with additional civilian volunteer experience. "I also volunteered on the outside, in the civilian world, doing EMS. So I was no stranger to trauma and death … but, *nothing* prepared me for this."

The visions of war leave a lasting imprint on each individual for different reasons. As a father, witnessing the number of wounded and casualties was especially difficult for P10, "I had seen plenty of kids over there, 22, 23, 18 years old … we did 357 Medevacs in 4 months and I carried almost every one of them on a litter up [to] that airplane … I would see their first sergeant or sergeant major sometimes a week or two later asking 'how's so-n-so', 'he died.'" The frustration for P10 was overwhelming at times; doing everything he could, ensuring and talking to the wounded, trying to encourage those under his watchful eye, "don't stop, keep pushing, we're almost there … but sometimes,

they wouldn't listen." Seeing friends injured, being the first person they saw after shrapnel was removed from their eyes, helped P10 push through to the next person who needed him. The dedication military members have to their brothers and sisters in arms can lead individuals to step outside of their original role for deployment, "I went over as a radio operator, but because I was also [trained] as a flight, I would help in any way … That was somebody's son, somebody's brother … somebody loves that person and so whatever I could do, big or small, it didn't matter."

Sometimes, that sense of duty required sitting by, as a soldier took their last breath "so he wouldn't have to die alone." Or knowing your actions allowed a family to be with their son before he died; there were 53 quad-amputees during P10's tour, of which, only one was saved in theater, who later died from complications, "I know he had a chance to have his family there, they sent us a thank you card for what we did to keep their son alive." Duty can even try helping a local Afghan child, "I don't forget the local kids we tried to help, one was burned so bad, black like an inner tube … this kid had his eyes open and this oral pharyngeal in his mouth … I'm carrying this kid in my arms to the doc, what the f...uck am I supposed to do with this kid? The doc said, 'just give him some medication, make him comfortable, that's all we can do.'"

After deployment. Returning from his 2003-2004 deployment to Iraq, P10's wife noticed a change, but it was a comment from a unit member after his 2009 Afghanistan tour before P10 went to speak to professionals. The hitch, as with many

veterans returning from war, they do not want to talk about the horrors. They definitely will not be pushed into it:

> I went to talk to this lady and she kept pushing me and I got mad, I got really mad at her. I told her, I said … "what fucking part don't you understand I don't want to talk about it. If you want to make this two weeks later or something, fine, but for right now leave me the fuck alone and I don't want to talk about it and I definitely don't want to talk about it with you." I wanted to go see my son. My son was coming home. I had seen so many guys with amputations and things. I told you the 53 with the quads, there was a bunch more with both legs blown off or arms, whatever the case, I had to put my hands on my son to make sure he was intact. Rationally, logically, I knew that he was OK because he wasn't subject to that type of environment. But, to still my mind, I had to put my hands on him.

Being an Air National Guard member, typically means medical and mental health assistance is referred to the VA, where his location, an OEF and OIF coordinator assists with members with navigating the process, "His words to me 'how ya feeling, really, buddy? Come on, let's go up and see the doc and get you some drugs.'" Coming from a medical-type background, P10 understands the full story on psychotropic drugs, the longer taken, higher dosages or a change in prescriptions are required to get the therapeutic effect. However, at one point, he did try medication to assist with his sleep issues:

> The neurologist gave me this med … the side effect was it made me angry. Yeah, PTSD and a drug that makes you angry. It was Quanatin …I would get unconscionable … I would take it at 8 or 9 at night, then it was 3 pm the next afternoon before I started feeling like I wasn't in a cloud … The first time I went for CBT, the lady, that medicine, it really made me angry and that is not me, and she said to me, "are you willing to learn" and I said, "are you willing to teach." This lady's jaw hit the floor and my wife said, "Welcome to medicine head."

P10's psychological evaluation consisted of a paper and pencil evaluation, then a long wait until someone contacted him stating his signs and symptoms were not severe enough to warrant care under the VA, he would have to seek his own help. P10 did not really want to talk, but conceded he needed assistance and found it on his own via the Vet Center, "I wasn't right in the head. I had bad flashbacks, I still have bad flashbacks, and the one thing I really hate is when I dream, I dream in color, so it's like it's happening all over again." The hypervigilance and hyperfocus, along with vivid and active dreams, forced P10 and his wife to sleep separately;

> I was so rammy in bed, I hit, her in my sleep. One time she came to go to bed, she said I hit her so hard, she thought I broke her jaw … we weren't fighting; I would never hit a woman. It's not right … one time I was laying on the couch. She bent over to try to kiss me, I came across and hit her right in the head. I knocked her down to the ground. She was crying. I felt like shit because I hurt my wife.

It ultimately took P10 two years to get the VA in line with the opinions of his civilian providers, but not without consequences. P10 was told by the OEF and OIF coordinator to be honest, to get the help he needs, but still they have not officially determined his traumatic brain injury (TBI) and have put him on the Brady Bill, "I never have gotten into a physical altercation with anybody, but I have had verbal arguments, not a lot. I tell them the truth, I tell them these things, they mark my paperwork that I am a threat to myself and others. Then they turn around and put me on the Brady Bill." Through this experience, P10 feels people with PTSD are marked. Any reaction, by an individual, it is considered a normal response to anger. However, a guy with PTSD, "Oh, they're flipping out."

During the process of seeking help, P10 had his career pulled from under him as the Air National Guard began processing medical discharge paperwork behind his back, P10 and four others. "I would give anything to deploy again … the fact they tell you when you claim PTSD is not a career stopper, that is a bold faced lie." After realizing what was about to happen, P10 challenged his commanding officer, receiving an empathetic, "'Noted'. Noted meant shit. Don't give me noted. Noted means, 'I hear you speaking but I'm not going to do anything about it' … The only relief I got after being discharged … was not being screwed with anymore." In the current environment, where seeking treatment is supposed to be encouraged without reprisal, one has to wonder what service members asking for assistance really face, especially with an individual who could have, and would have preferred to, retire. "I did tell them I would rather retire than

be medically discharged. They said there was a time line, but they never gave me an exact date and signed the medical discharge process papers without telling me or giving me a chance to retire." The medical evaluation board process was anything but informative and forth coming. For P10, months passed without word, only to receive a phone call directing him to appear to sign paperwork that "is going to effect the rest of your life" with minimal time to research information provided on the document. If you are lucky, this does not happen during a holiday weekend.

An even more puzzling aspect, the role combat medals have in the determination of compensation, "one of the five guys discharged got a combat ribbon … I spent my time on the ground and didn't get a combat ribbon." A combat ribbon means special compensation. It means getting both VA benefits and military retirement. Then the military and its careful wording per Air Force Form 356 dated July 2010, questions being hurt in a combat zone is not the same as being hurt in combat, "It's a technicality on words." Add on top of this inconsistency are the differences that still exist between active duty and guard units; traditional guardsmen are put on Title 10 orders, making them active duty in order to deploy, but it is not as simple as that. To get anything sorted out, it can end in with "nitpicking," with active duty pointing to the guard and the guard pointing to active duty, to process any documents. The bottom line, men and women volunteer to serve in the military, under the promise they will be taken care of if they are injured. It appears, the fight overseas can follow the member home, only this fight if for their benefits.

The human-animal bond. The Great Dane who would be P10's service dog, was originally slated for another wounded veteran. "Janet wanted to get involved in training service dogs for the guys, and women too, with TBI and PTSD. I didn't feel like I deserved one. I knew that there were a lot worse than I was." The idea of training a dog for other veterans filled P10 with a similar pride he experienced when helping the wounded. However, believe it or not, even Great Danes are small at one time, and during these initial days of training, "Janet said to me, 'don't you get it', I said, 'get what,' 'this is the first time in two years that you've smiled and laughed.' I said, 'he brings me peace." And so it was, DANE stayed with P10, but the idea to assist others in training their service dogs was planted.

Dane has been P10's right-hand paw since May 2011. The list of duties performed by Dane is thorough, and impressive, "He's been trained to help me to take my medicine, because I have short term memory. He's been trained to help me with mobile issues when my legs don't want to work right and he's been trained to lick me in the face when I have flashbacks so they don't become full blown. He [also] patrols the house and he comes back and lays by my side at night." Where P10 was not so comfortable going out, with "J's" presence, a rather large barrier is put in between P10 and others, so they do not come too close.

But Dane is more than an assistant, asking P10 to describe his feelings about Dane results in an instant, melting of in his words:

> I love him with my heart … I was having a really bad day, he can sense when I'm having a bad day … he pops his head up and he's looking at me, he cocks his head all the way back and like looking at me, then his head spins all the way around … I just had to laugh … it was so funny and just that momentary break in the negative feelings.

And what P10 describes as "puppy time", when Dane is able to remove his red working vest, "it is time to play," followed by cuddle time on the floor or play nips to P10's "you are an animal." There is no doubt about the bond and friendship that has developed; "It's so cool. He's just like, he means so much to me. I would give my life for him."

About 6 months after having Dane, P10 and his wife began assisting others in training their dogs, with the objective of returning some normalcy into the lives of men and women suffering from war's invisible wounds, "We had women, guys, we help them train their dogs. We get paid nothing for it. Our mentality is you have already paid the price." But P10 also shows others with PTSD that if he can do it, anyone can do it, "I tell the people I'm working with, it's not right or wrong, it's not pass or fail, it's none of these things. Because your dog is just like you and I, we're two totally different people, so we're going to have to work together. But if I can do it, and I have a brain injury, than you can do it and we'll learn together." The clients train the dog, P10 only shows them how.

But P10's presence may also have another meaningful purpose to the experience, "I know what they've been through. That's where the connect is, if they feel like they

want to talk about it, they can talk; if they don't want to talk about it … I don't push." P10 understands what it feels like not wanting to talk. He understands being pushed and the reactions to feeling cornered. "I tell them you will never hear me tell you 'I know how you feel', because I don't. I tell them I get, I understand where you're coming from. But I don't know how you feel because I wasn't there at the exact moment, at the exact second it happened, but I understand where you're coming from." Unfortunately, even with the dedication P10 continues to show towards those in need, the survivor's guilt experience has not subsided much, "I know you can only do so much … I wish I could have done so much more to help these guys. There were so many of them."

Additional findings. Considering his experiences with both treatment and Dane, P10 feels drugs are not the answer to treating PTSD long term, "Medications have a purpose, they really do. But long-term care, just doping people up to deal with different emotions, it's not good. You're not helping the problem." From what he and his wife have seen and heard, they have to question if this is not exactly what is going on. But P10 admits, dealing with PTSD without medications is "a bitch," but he would not have wanted it any other way.

Reflecting more on Dane, P10 believes the use of animals, in various therapeutic settings, can provide relief for members with PTSD, siting the known literature regarding nursing homes, hospitals, and convalescence homes. He shares this experience of making *that phone call*, telling applicants of their approval into the training program, "You hear either total silence because it is a reaction of happiness, or the ones you hear

the crying and the crying from their spouse, it gives them the chance of hope." P10's program also assists clients in locating a reputable breeder. The program he is affiliated prefers clients get dogs from reputable breeders, "You know the dog's health, its temperament … they have to be calm, can't bite … [going] to a rescue or a shelter … there's nothing against those dogs, but you don't know the background of the dog."

The focus of his experience with the medical discharge process, and his sharing of that experience, shows his concern for all of those who follow in his footsteps, anyone who might endure what he has, "That is some of the behind the scenes stuff folks don't hear about. I hope you get well educated in some of these things, God forbid if something happens to you. You know what to look out for. They don't tell you this stuff." The Temporary Disability Rating List, the length of time without any word or direction, empathetic nature of support personnel, only to have a call for an immediate decision and subsequent signature on paperwork, made P10 and his wife furious;

> You're fighting for what they say are your benefits. And they aren't going to give them to you and you have to know the right questions to ask. That ticks me off … Start taking care of these guys. You promised us, if we got hurt, you'd take care of us, not jerk us around. And that pisses me off.

Participant 11

After deployment. Participant 11 (P11) was a member of the United States Army, with one deployment to Afghanistan from 2003-2004, leaving active duty in 2005, and completing his service commitment in 2009. A common feeling among returning war veterans is that life is different; they are different. Married with a daughter, P11 felt "pretty guarded" initially coming home; P11 is one who felt his changes even prior to leaving Afghanistan, "I even told my buddies, 'I'm going to go back pissed off, I could already feel it." Even then, he knew he was not the same person he was before the deployment.

Besides anger, hypervigilance is another characteristic of this new person, "My wife picked it up when my friends and I went to a mall." Still today, a constant awareness of his surroundings, positioning himself in restaurants to surveillance the door, or sitting next to one for a quick out option, exists as part of his 'modus operandi'. Driving consists of techniques learned when driving convoys, "In traffic, I stop a good car length behind the person in front of me, just like we were trained to do in convoys. It's a constant alertness." His sleep even suffers, "I just stay awake for some times days, just being awake, not being able to go to sleep because of it."

However, the anger is what P11 focuses on, as it is still an issue he deals with, "I've been violent too, against property; I tend to break stuff or throw things, if it's around. I don't like that. I don't like being that person." Relating to others is another common theme shared among returning veterans; how can you share, find a common

ground, with those who have not experience the horrors associated with combat? "I fight every day not to get into a rage about something. If I hear someone complaining about their day, I want to explode, 'what do you know about bad days?" For P11, this can be a daily struggle, often having to rely on self-talk and breathing techniques to cope:

> I literally, if I can, have to step away from the situation, if it's an argument. In traffic, road rage (laughs) I have to really maintain it. I can feel my body, my blood pressure, my breathing gets heavier, faster, it's almost like a panic attack. More breathing, taking deep breaths, and calming myself down. Reminding myself it's not worth getting that upset over.

Logistical challenges make it hard for P11 to follow-up with the VA; he has asked for medications to address his sleep, depression, and anxiety issues, but without a car, it is difficult to make appointments. He finds himself dealing with issues on his own. Recently, the VA has sent a representative to visit, which P11 finds "cool" and shares that his overall experience with the VA has been good. "All of them, more or less, are willing to help out and do what they need to do."

The human-animal bond. P11 claims the special place in his heart for animals was influenced by his mother's love for animals. Leaving active duty in 2005, P11 was in an apartment unable to afford the money for an animal. However, P11 would stumble across, what most would call a "most unlikely," companion animal during a visit to a local pet store, a hedgehog:

> They aren't the most cuddly animals, but I got him when he was small enough where I could handle him and he actually helped me with my depression, a lot … just having something to take care of, I guess, and looking forward to coming home to him after school, coming home and taking him out of his cage and playing with him. It would get my mind off a lot of things.

Henry, the hedgehog, was P11's companion for almost six years. It is understandable, the bond that develops with a hedgehog is not comparable to that with a dog or a cat, but never-the-less, a bond developed for P11, "When I would go to pet him, or go to mess with him, he would come out. He knew when I was going to take him out and let him run around and stuff like that. He liked it. He seemed aware of it. He would come and sit with me on his own. That was cool." Granted, Henry is not the picture most people would think of when they hear the term "companion animal," but provided the interaction and non-judgmental nature of even a hedgehog, it provided the companionship P11 needed, within the restrictions his life presented to him at that time.

Fortunately, the experience of having a companion animal would not end with Henry's passing; shortly before his death, a little kitten stumbled into P11's life, "After Henry passed, I was pretty devastated actually, she pulled me out of it. I focused my energies towards her again, something else to focus on, to take care of." There are currently two cats in P11's life, Rock and Roll, and tend to behave more like dogs than cats, "My wife even gets jealous, kind of, she's like 'they are even at the door waiting for you when you leave.' [I] come home and they are there, right by the door, like dogs.

They are really cool cats." Even when P11 begins to feel a little "blue" Rock focuses her attention on her owner, "When I'm feeling down, I don't know if she notices or not, but she tends to spend more time with me than normal." Even still with the two, coming home from a bad day at work, "They'll jump on my lap. I have to calm down as I'm petting the cats, it draws my attention on them; I know they help that way."

Additional findings. P11 experienced one deployment to Afghanistan, almost 10 years ago, but still suffers from the experience today. Can you cure PTSD? P11 doesn't believe so, "The few experiences I had were enough, there is no amount of therapy, I don't think I could talk about it or recount the events enough to wash those memories away or how I feel about it. It's just ... literally every day is coping with it." The anger and rage he continues to contend with, finding ways to relate to others without exploding; self-talk helps, breathing helps, his animals help.

Participant 12

Deployment. If there were one word to sum up Participant 12's (P12) military career, it would be Iraq. Entering the United States Army approximately five months before his first combat deployment, if P12 was not in the Iraqi theater, he was in combat simulations, training and preparing, for the next deployment or alert call. "I was a member of a small kill team … It was constantly, we were on 24 hour call. They'd call us and we had two hours to get to post, get our gear and armament, and ready to leave on an AC-130." On constant alert, always considering how his decisions and actions affect those around him, direct combat is an experience few in this country understand, even within the military community. "There were many days me and my buddies would sit in our barrack rooms with bottles and bottles of alcohol, but it was fun for us … they [society] don't realize that we did things in our minds that kept us out of society, that kept us away from people that wasn't like us."

Certain military career skills create a brotherhood, a bond, where shared experiences sound more like a sensational Hollywood movie than real life, "I was over all the harassment and interdiction … that show the insurgent forces that 'we are over here and we have the fire power to obliterate you, if you give us a reason to. We're not going to do it, but let us show you what we have so that way, if you think about doing something, you may think twice now'. That was my primary job during my last deployment." How does that compare to closing a stock option deal or worrying about the person who is working behind the scenes for your position at work? P12 experienced

five deployments to Iraq in the five years he served in the Army. P12 came home from his last Operation Iraqi Freedom deployment March 27th and was separated from the Army June 19th, of the same year, "I never had time to go to my combat advocate to release the thoughts that were in my head, get that reassurance that everything was OK. I never had the chance to get the help I needed while I was in."

After deployment. Deployments often mean missing important family events; first birthdays, first spoken words. Coming home, making up for lost time with his 11 month old daughter was forefront in P12's mind, "I got home I just made it where it was all about her … I didn't realize it at first, but I was really overprotective, overbearing … It took me awhile to even drive with her in the car. I never couldn't get it out of my mind that 'pot holes in the road were just pot holes in the road and not IEDs and things that could hurt me.'" Intrusive thoughts, flashbacks, and hypervigilance are words that come quite familiar to anyone with posttraumatic stress; however, going through the symptoms is a journey that is unique for each individual. "Flashbacks … it felt like it was getting worse and worse and worse … watching people and everything get blown up, people lying on the side of the road suffer, doing a sniper drive, 'you've got to slow down, you've got to slow down, switch sides of the lane I was on,' things like that."

Surroundings. Watch your surroundings. Survey your surroundings. Combat is all about your surroundings and constant vigilance; simply coming home, separating from the military does not "stop" the need to check your surroundings:

If she [daughter] was laying down on the couch watching cartoons and I went to

> the bathroom, I knew where everything was, so when I got back I could see if anything was disturbed … I go out and make rake lines in the yard, the sand. Every time I go out in the morning, I check my rake lines to see if someone's walked in my yard and things like that. I know, to watch to see if anyone's trying to do something to my house, my vehicles.
>
> I'm really overprotective of my surroundings. It bugs me to sit in a restaurant with my back to the door where I can't see at least 80% of the people, because I don't know who's coming around and stuff like that … I go out in public sometimes, I'm always watching around, scanning, assessing people, assessing situations. And people get annoyed, and it's like 'so what'. I know this person is unarmed, I know this person is disabled, I know all of this, and I'm comfortable, so I don't really care [who is annoyed].

A person's upbringing, reinforced by their military experience, is the heart and soul of that person, their values and ethics; outside opinions, challenging those values, is not a topic open for discussion without expecting some level of a defensive reaction. But as P12 points out, is an issue with PTSD is learning how to handle those emotions, and not simply explode. How to relate to people without going "overboard."

> There's points in time that I just want to explode. I want to scream. I want to punch things. I want to do whatever. I want to get on my Harley and I want to go. I want to leave everything behind. I'm angry …and then there are times I don't want to get out of bed.

Life can be a roller coaster of emotions, for any individual, but add the added "twist" of PTSD into the equation, harnessing the feelings and thoughts running wild is not that simple. Often, individuals will create coping strategies to provide a sense of "good job" or help manage the impulses. However, as with any good plan, if they do not execute accordingly, chaos can result, "All I want is to get drunk, have sex, and go to sleep, surprisingly, my wife allows it a couple times … it comes at a pretty big risk in a marriage." When plans do not go accordingly, feelings of inadequacy can surface, feelings like "I did something wrong." Then, the floodgates open:

> We start to think about "how did we start feeling this way', then we start thinking about what we did wrong. That triggers, 'OK I was on the Syrian border one day and dropped my LPD and you know, I wonder if I did that, dropping that, then a rocket came through and hit a tent. And if I wouldn't have dropped that, it wouldn't have happened.' Kind of that same emotion, like, one act that was nobody else's fault triggers our thought process and it's not going to be cheerful … PTSD opens your eyes to a lot of things you've done in your life that you, you second guess yourself, you are always going to second guess yourself.
>
> With PTSD, you always think about what you've done, what your actions were that caused something. Even though, that insurgent dropped a mortar round down the chute, I couldn't have really prevented it, I know that I couldn't, but still it happened. I did something then, that I should have been more aware of, I should have had a better grip on my canteen, instead of dropping it and bending

over to pick it up, if I would have had it on my person, maybe I could saw it, or I could have helped that person and pushed that person out of the way.

P12 is a protector. He protects his daughter; he protects his brothers in arms. Despite the number of deployments to Iraq, it was the last deployment where P12 did not maintain an active "boots in the combat element" role, and where the stress culminated. Responsible for the oversight of troop movement, P12 admittedly was "overzealous and cynical" to the point that pre-operational checklists were accomplished two or three times. And sometimes it takes stepping back, getting out of an active role, when experiences have the chance to catch up with the individual. "I didn't notice it then, but looking back now, a lot of things I go through today are things I didn't think about then. Things I didn't take the time to actually analyze and go through in my head, 'OK, this happened, why' or 'this happened because [of] this or this' is what I'm going through now."

Survivor's guilt. That is what they call it, the civilian counselors, survivor's guilt. When someone else dies and you did not, that guilty feeling afterwards, they call it survivor's guilt. "I do agree that people on my team died instead of me, it should have been me. *It should have been me*." The protector role surfacing during operations and falling back to help a teammate, then witnessing the person die who filled his spot, "… if I would have just picked somebody else to go help the person I was helping, that would have been me." How can a civilian provider to understand, the simple action of picking up a dropped canteen and not focused on the surroundings, "… I should have been more

aware. I should have had a better grip on my canteen … maybe I would have saw it or I could have helped that person and pushed them out of the way." How does a civilian provider connect, comparing these deaths to the loss of a relative to a drunk driver? "I give them credit for trying, but they can't relate." It's been three years since his deployment and not much has changed with PTSD treatment, "Anytime I get a call from a therapist, the first thing I hear is 'I'm a civilian contractor' and I pretty much shut them down. It's a waste of time." Yet, the VA continues to expect P12 to go out of his way for therapy appointments that he is already close-minded to, "… seven miles from my house, I know a therapist there. He's a civilian contractor, but he's a veteran … why can't they cover that …" The experience with the VA Crisis Hotline was a fiasco. "I told the person on the other end of the line 'I just don't want to live' and 30 minutes later, I had the cops at my house … I don't need to worry that if I tell somebody something that I'm *feeling* that they are going to call the cops." There is definitely a fine line between expressing feelings and requiring a welfare check by law enforcement. How are veterans supposed to express those emotions without the authorities getting involved?

The human-animal bond. Having owned a dog while they were dating, P12 and his wife had gone some time before Harley became part of the family. "One day me and my wife decided were going to look at dogs … then we came across Harley. She looks more like a scrub brush." Harley is a colorful spirit, a "playful puppy that likes to be funny and makes you laugh." Talent and charm are among Harley's wonderful qualities, getting up on her hind legs to "box" with a "hey, you're back, let me show you how much

I've missed you by being stupid." The Staff Sergeant loosens his bearings talking about Harley, giving her human-like qualities, "I'll go to bed and she'll jump in bed and just lay on me like, 'hold me', you know, 'let me love on you and you love on me, let's do this', she doesn't give you the option to say 'no.'" Harley smiles. "Her bottom teeth come out, like she's smiling at you." Whatever the mood in the house, Harley appears to respond accordingly, whether that is being silly, "You can't be mad, you can't be upset at that point in time because you watch this dumb dog do this stuff and it lightens up the mood."

Harley can be supportive, "It's great because whenever I'm sad, she'll kinda look up at me or just lay in my lap or lay her head on my shoulder like, "hey, I'm here." Harley knows when P12's happy; she knows when he needs his space, but keeps a careful eye on him, ever vigilant for when a "let me love on you, you love on me" moment. She is also that non-judgmental ear P12 needs from time to time, "I feel like I can say what I want to say, whatever is going through my head, that I want to get out, my dog will come up to me and just, 'do whatever you need to do, say whatever you need to say', that's where dogs are great." "I catch myself talking to my dog. I talk to her and she gives me a retarded look and I just lose it."

Harley is a bit naughty sometimes;

> I get mad, she does something bad and I get onto her and I scold her, then 5 or 10 minutes passed, she's coming right back to love on me like, "Hey, I forgot already about it already, let me love on you, let me be a part of you." That unconditional – regardless of what I do, that my dog is always going to be there, she's always in

my life, regardless.

Harley is P12's light, playful spirit; however, P12 is very interested in also getting a service dog, a working, grounded spirit. "There's always going to be the reassurance factor, that's what I am looking for."

Additional findings. Flexibility, that is what the VA needs, to be more flexible with the circumstances in veteran's lives. Money is tight for many veterans, spending $60 in gas for an appointment the veteran has no interest in participating in is not the answer; especially when other options are available. "We voluntarily signed an oath to everyone in the United States and coalition forces. We were flexible enough to go anywhere and everywhere they needed us. Why can't they return the same thing we did." The VA has a big bill on its hands; OEF and OIF service members are waiting to receive treatment, veterans from past wars and conflicts need assistance:

> Each individual war has had something happen to us service members to where we can no longer functionally live with ourselves. We're always fighting a battle to present the facts. We know the end result of us losing this battle with PTSD is death. Whether it is because we had an accident or because we took our own lives, I've lost five in the last year to suicide … They do not see a light at the end of the tunnel. Neither do I, I don't see a light. I don't see me coming on top of this … We see that, yes have a family now, yes we have things that we never had before, but we're always waiting for that end. We're waiting for us to explode that one last time, that our spouses are going to leave us. And we're going to lose

everything we worked so hard for.

It does not end at flexibility. The cookie cutter approach to PTSD treatment, P12 is another who, considering the level of intensity of his combat exposure, is tired of being treated just like the next person. "The VA sees every PTSD case as the same … Me and my brothers that hit IEDs and were blown up, we have a compounding factor." Expecting the same treatment to help every situation does not work. An excessive pharmaceutical protocol does not work. Hiring civilian providers who cannot related does not work. If an option exists for a veteran to receive help from a provider they feel they can connect with, that option should be considered. In P12's opinion, there is not cure for PTSD; however, learning how to deal with the intensity when emotions strike, that can help;

> I've been blown up, I've been shot, I've had a vehicle turn over and I'm two inches shorter than when I joined the military because of my because of an IED blast. It's hard to think positive whenever you wake up in the morning and you literally have to get your adrenaline going to get out of bed.

Posttraumatic stress will never be erased from combat and often, the military family developed as brothers and sisters in arms, often scatter to the wind when one separates or retires, "That's the main problem with our PTSD … we were in the military together. We were always, every day, almost every day we breathed, we were together … We don't have that cohesion any more. Once we get out we look for that cohesion that we once had." Even when a veteran has a supportive family, sometimes they feel

like a stranger in their own home:

> I have an awesome family and 99% of the time I don't think that anyone cares. I don't think anyone really gives a crap about what happened … And then we look outside of that, and that's the problem a lot of us have, we will look into the situation, 'I'm having one horrible day and I can't get these thoughts out of my head about what I went through' and I am living with it day by day, minute by minute, second by second, and nobody is picking up on it.

The sense of indifference extends outside the home. Society, really, you do not stand at the Pledge of Allegiance and National Anthem? The youth of today, 16 and 18 year old American citizens, your ambition in life is living with your parents and getting on welfare? You are willing to jeopardize every American freedom and right because handouts sound better? The lack of empathy does not stop there. Having PTSD also means having strikes against them; an audition for the SWAT team was terminated, based off a civilian therapists input "well, we don't know if you're going to shoot an innocent person," without the opportunity of proving himself.

A parting opinion by P12 really sums up much of the frustration heard in the voices of all the participants interviewed, as gun rights are threatened, federal agencies not adhering to the American Disabilities Act with allowing veterans bring their PTSD service dogs, and the hosts of other experiences and opinions shared in this study:

> A big thing with veterans, we feel like we don't have a voice … look at our needs and our opinions and experiences and actually put them into a voice to where the

VA, the Senate, the Congress, even the President, would see how, forces upon them to see, 'hey look, we have people that make up about 10% of the population, that they need help from what we defended' … We need the reassurance that we're OK … we were the golden child when we wore the uniform, you had nothing but good things to say about us, you had nothing but good things to give us … now that we're not wearing the uniform, you brush us to the side. We don't have that voice that says, "Hey, look we're still here. Help us." That voice pertains to everything, guns, financial, mental facilities things like that ... we need that voice we don't have any more.

Appendix G: Sample Interview Transcript

	Time	Content	Subtheme	Theme
1	0:51.2 - 1:40.0	R: What were your experiences after coming back from deployment? P2: Yep, I found it was very hard to adjust after I got out. I live, well I lived in a real small, rural town so I didn't have a lot of people to relate to because the town population is really, really small, and it's under 100 people. And uh, there was some issue with going back and forth with the VA and then, I heard about a PTSD study that my psychiatrist in the VA recommended, and um also recommend that there was some, a program called PAWS through the VA, that, I kind of researched along with everything else.	Coming home The VA Dog training programs	After deployment After deployment Human-animal bond (HAB)
2	1:40.0 - 3:06.0	(P2: continued) You take your dog, with the help of the psychiatrist, to train your dog so that it becomes your companion animal. Your dog goes through the program. So, I got my dog. He was a real small, little puppy, probably about two months old when I got him, and me and Black started going through the program. He was a companion animal at first, and later on you can have them certified as a service dog for PTSD. So we went through the training courses and because he was a training animal, he was able to be with me 24/7. So he started being with me 24/7, I took him to work, to school, and everything. I feel that he helped me a lot, especially since I was in a wheelchair when I first got out and couldn't do too much. He definitely helped me a lot. I just feel that having a companion or service animal for PTSD is definitely a big factor that can help you recuperate from a lot, a lot sooner and adjust.	Dog training programs Pet benefits	HAB HAB
3	3:30.1 - 4:08.5	R: You mentioned having difficulties when you first came back with adjusting when you first came back. Are you comfortable with giving basic descriptions of the distress you experienced? P2: Since like I said, I live in a rural town, a lot people went and joined the military but not a lot of people really talked about so much so people were just constantly blowing off questions after questions after question. Not only was it kind of stressful dealing with it, it was also deal with my own things from my deployment. So I guess, the main stressful thing is how I would relate to people. People expect you to be the same person that you were when you left to join the military versus come back from deployment. Trying to	Coming home PTSD symptoms	After deployment After deployment

	Time	Content	Subtheme	Theme
		adjust to that life yet.		
4	4:17.5 - 4:43.2	R: So really, a lack of feeling like you could talk with somebody? P2: Yes. However, I knew there were American Legions and VFWs there everywhere speaking to people who had gone through the same experiences as you was really helpful. "I found it paramount in the reintegration into garrison life" (from email).	Way ahead	Additional findings
5	4:42.4 - 4:58.2	R: How soon after coming home from your deployment did you start experiencing symptoms or was it while you were still deployed? P2: When I was still deployed. Yes.	PTSD symptoms	After deployment
6	5:13.3 - 6:20.3	R: It sounds like your psychologist recommended the PAWS program, but that you had issues with the VA getting into treatment? P2: Yes, it took me several months to get in. I started as soon as I got home, I went to the VA the next day, I got home on a Thursday and went in on a Friday, and they scheduled me for an appointment a few months later. I went to psychiatry right away, and they got me in the next month. R: If you don't mind me asking, was that at least to get you onto some type of pharmaceutical treatment plan before you started counseling? P2: Yes, I was prescribed Prozac before I got out. But my prescription was going to expire right before I got out, so the medical center called over to the VA to fast track my referral program so I could get a refill.	The VA	After deployment
7	6:21.1 - 6:58.7	R: In your opinion, once you got into psychological counseling, what was your opinion of that? P2: Well, it's kind of weird, because they start you off with like a group program. It's like I had a really hard time coping with that. Not everyone had the same experiences. Combat MOSs and you're sitting them with different combat MOSs or just different MOSs, and it's hard to relate to some of the same experiences they went through.	Groups	After deployment
8	7:20.5 - 7:54.4	R: A lot of the research I did for this project, it showed men in general have difficulties with talking. Did you find that with the group experience? P2: Yeah. I got out of the group program because it just frustrated me even more.	Groups	After

	Time	Content	Subtheme	Theme
		Definitely talking one-on-one was kind of fine. R: Talking one-on-one was OK, it was more the group therapy. P2: Yes.		deployment
9	8:51.7 - 9:31.6	R: Since you got Black as a puppy and trained him yourself, how did you find actually training your own dog, how did you find that experience? P2: Personally, I think that is a lot better to get them as a puppy and training as you go. Versus someone sticking you with…most programs out there, are have two or three weeks with an animal before you take them home. And you don't really know them all too well. So, you getting your dog as a puppy and training as you go, it's a lot better. Because you already know the animal's behaviors and he cans start recognizing and learning some of your symptoms; not everyone has the same symptoms.	AAA in PTSD treatment	Additional findings
10	9:37.6 - 10:58.2	R: How does the bond between you and Black, how does that work for you? P2: Black's my buddy. He's my baby. I've had a couple of girlfriends get pissed because I show him more affection than I did them. But he picks up on my symptoms automatically, like he'll start nudging me or hopping on me to get me into a petting session or he'll grab my pants leg and start pulling on me or like my shirt or my arm and start pulling on me to kind of like bring me out of a flashback or anything else like that. He also always, like if I'm standing still, he's always behind me and doesn't let people get close. Unless I'm directly facing the person, he'll bark or whine to let me know someone is coming up behind me or something like.	Other pet benefits Pet response to PTSD symptoms	HAB HAB
11	10:59.7 - 11:09.5	R: Is one of the PTS symptoms you experience is that you easily startle? P2: Yes, I am very easily startled.	PTSD Symptoms	After deployment
12	11:17.8 - 12:34.4	What lead you to adopt Black specifically? P2: Black specifically? When I got out, I wanted a job with least amount of responsibility as possible. I was a corporal when I was in the military and always had several subordinates under me and I wanted something with absolutely no responsibility. So one day, I was delivering pizza and one day I seen this guy, this little asshole, who had all these puppies in a chicken wired fence and they were all bloated and had worms and ticks all over them and everything else like that. I stayed there and called the police. They	Acquiring pet	HAB

	Time	Content	Subtheme	Theme
		called the SPCA and then they confiscated the puppies, and one of the police officers was one of my buddies, and said I would really appreciate having one of the puppies and he said yeah, they just going to go to the pound anyways until they found homes for them. I said I want this one, right here.	Saving	HAB
13	13:07.0 - 14:12.5	R: The news has recently covered the VA and DoD restricting PTSD service animals on DoD property and in VA facilities, how do you feel about that? P2: Yes, from what I understand…I talked with one of my classmates and he was a former Marine. He had a couple of guys who had service animals and had to get the first commander of your base, your base commander, and had to find lawyers say you can have him to go into any facility or you would get turned away. Apparently, it was really very hard, pretty much like pulling teeth. R: I know this has been recent. How do you feel about that? P2: Personally, I think its crap. It's just your service animal and you should be able to go wherever you are no matter what. They have other animals in the military and who are training them all the time and take them home, so what's the difference if it's a service animal or companion animal than that.	Restriction on PTSD service animals	Additional findings
14	14:29.8 - 16:18.2	R: Is there any topic I have not addressed that you would like to bring up? P2: There's a couple different programs like the American Legion and the VFW and others that do have grants for service animals. Yes. So. You get your companion animal and you can raise the money yourself or get the grant from the VFW or the American Legion and help with the process of getting your animal trained for you. I mean, like even now Petsmart has a training program that if you take so many classes, like 10 classes or so, and they get a certification towards being a service animal. R: Yes, there's different levels, but can't remember who they get their certification through. P2: Black is in there now. And then it's kind of crap that since the VA is hardballing us so that so many foundations are losing or lost their funding from the DoD. Stiggy's Dogs is one of them. The Battle Buddy Foundation is another losing their funding for…specialize with animals for PTSD and TBI. With both programs, that all the do, service vets and	AAA in PTSD treatment	Additional findings

	Time	Content	Subtheme	Theme
		PTSD dogs. R: Walter Reed had a program when they were still in DC. P2: I know Bethesda had a program that used retired military working dogs and trained them to be service dogs, but they did away with that too because of funding.		
15	18:02.2 - 21:02.1	R: You've hit all the questions I have, is there anything you want to discuss, comment on, or anything? P2: Yes, I do. How is the DoD measuring what works for a veteran with a service dog? Like what kind of scale do they use, what methods are they using to determine that it doesn't help? R: How do they measure if a service dog is not helping them? P2: Or helping. From what I understand, from what I've read, the DoD doesn't seem to think that PTSD service dogs help at all. I can't see how. R: From what I understand, the DoD and VA base their decisions on studies and there are really no studies behind it. That is one of the things that I have read and unfortunately when it comes to the DoD and the VA is empirical evidence is needed behind any decisions they make. Due to the legality behind that. P2: OK. R: That's one of the reasons why I wanted to do this study, to help start building on information to turn to. And a copy of the Senate's Committee of Veterans Affairs after I am finished with this project and it's been approved by the university. Hopefully that will help change those types of decisions. P2: That will be great, honestly. I have written my senior congressman, a couple different people. To different commanders at different military offices and organizations that lost their funding. R: So you have contacted representatives and military offices regarding this issue? P2: Yes.	AAA in PTSD treatment	Additional findings

Appendix H: Curriculum Vitae

MELISSA WHITE
3206 Collard Street
Alexandria VA 22306

EDUCATION

Walden University
Doctoral in Psychology — Expected Graduation Fall 2013
Research and Evaluation Track

Masters of Science in Psychology — February 2010
Crisis Management and Response Track

Park University — May 2008
Bachelor of Science in Social Psychology

PROFESSIONAL EXPERIENCE

United States Air Force — **1990 - Present**
Headquarters Air Force,
Pentagon, Washington, DC

Manpower, Resources, and Organization — **2005 - Present**

Developed, implemented, and managed Air Force technical and functional requirements utilized to build the department-level software system, Manpower Programming and Execution System (MPES). The MPES program is responsible for translating Department of Defense appropriated personnel funds into executable positions for use by units at all Air Force levels and interfaces with other Department of Defense and Air Force programs responsible for pay, health care, and other personnel programs required to meet the overall goal of fly, fight, and win.

Served as the primary manpower readiness and contingency planner for Air Force Forces assigned to the United States Southern Command. Duties included developing organizational structure and associated personnel requirements for numerous

humanitarian, counter terrorism, counter narcotics, medical, and intelligence missions, as well as Presidential movements conducted in Central and South America.

Air Traffic Control **1990-2005**

Provided duties as supervisor and line controller in the control, separation, and sequence of air traffic and ground vehicular movements in four control towers and five radar approach control facilities for some of the busiest airspaces governed by the Air Force. Supervisory duties included the overall management of four to eight position facilities, coordination with Federal Aviation Association (FAA) and other base and local agencies. Held positions as Assistant Chief, Air Traffic Control Training and Standardization at four different locations, charged with creating efficient training programs and base-lined evaluation procedures. Finally, lead liaison efforts with flying units consisting of multiple airframes within the Air Force inventory at stateside bases as well as forward position locations supporting combat operations.

Air Force duties for both occupations were executed at the following locations, over 20 years: England Air Force Base (AFB), Louisiana; Selfridge AFB, Michigan; Cairo, Egypt; Reese AFB, Texas; Incirlik, Turkey; Prince Sultan Air Base, Saudi Arabia; Eagle Base, Bosnia; McGuire AFB, New Jersey; Osan, South Korea; Soto Cano Air Base, Honduras; Hurlburt Field, Florida; Davis-Monthan AFB, Arizona; Headquarters Air Force, Pentagon; and a number of non-disclosure locations.

PROFESSIONAL ORGANIZATIONS

American Psychological Association, current member
International Society for Traumatic Stress Studies, current member
Air Force Association, current member
Non-Commissioned Officers Association, current member