MILITARY SERVICE MEMBERS

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WHAT DO MILITARY SERVICE MEMBERS NEED TR FOR?

Top 5 Ailments:
1. Sleep Conditions
2. Post-Traumatic Stress Disorder (PTSD)
3. Back, Neck, Shoulder Problems
4. Depression
5. Anxiety

http://www.woundedwarriorproject.org/survey?utm_source=wwporg&utm_medium=home-image&utm_campaign=survey-results

HOW IS PTSD DIAGNOSED?

Diagnosis requires a thorough psychological evaluation and the presence of the following criteria. The individual being diagnosed must also have had exposure to an event that involved threat of death, violence, or serious injury which include:

- Experienced event
- Witnessed in person
- Learned of close relation experiencing event
- Repeatedly exposed to graphic details of events

WHAT ARE THE SYMPTOMS OF PTSD?

The symptoms of PTSD usually occur within the first three months after the traumatic event. However, they can show years later. The symptoms of PTSD have three categories: re-experiencing, avoidance, and hyperarousal.

RE-EXPERIENCING

- Relive experiences of the event, such as images or memories
- Upsetting dreams about event
- Flashback as if experiencing again
- Severe emotional distress

AVOIDANCE

- Try avoiding situations that remind of event
- Not remember important parts of event
- Lose interest in previously enjoyable activities

HYPERAROUSAL

- View yourself, the world, and others negatively
- Feel emotional numbness, irritable, or have angry/violent outbursts
- Engage in dangerous or self-destructive behavior
- Easily startled and always on guard for signs of danger
- Trouble sleeping or concentrating

Hyperarousal symptoms can also lead a person to physical symptoms such as increased breathing rate, heart rate, and blood pressure. They may also have muscle tension, nausea, and diarrhea.
http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/tests-diagnosis/con-20022540
http://www.webmd.com/anxiety-panic/guide/post-traumatic-stress-disorder?page=1#1

WHAT RESOURCES ARE AVAILABLE?

Resources for Military

- BBB

Since 2004, BBB Military Line has provided free resources to our military communities in the areas of financial literacy and consumer protection through the efforts of 112 BBBs across the U.S.

The five main components of the program are:

1. Education - Many Local BBBs on and around military installations teach financial readiness classes to service members.

2. Outreach - We attend and support community fairs, conferences and other events, speaking with service members and distributing information.

3. Information - Our website provides a one stop shop for articles, links and consumer alerts for each branch of service. Check out our resources page for free consumer guides written just for military members and find us on Facebook and Twitter.

4. Data Collection - We analyze BBB data to help identify the threats and needs of our military community in the marketplace.

5. Complaint and Dispute Resolution - Filing a complaint with BBB helps military consumers resolve disputes and alert us to issues affecting the military community at large.

- Website for military resources (jobs, education, therapy, family ed) http://milvetsrc.org/

- Dog TAGS provides service dogs to War Vets and little to no charge. http://www.dogtagsprogram.org/

THE ROLE OF SERVICE ANIMALS IN RECOVERY

BY KIM PUCHIR, NAMI COMMUNICATIONS COORDINATOR

When General Patton met a soldier hospitalized for "shellshock" in 1942, he called him a coward. Anxiety, nightmares and anger—which can affect anyone who has experienced a traumatic event—are now known to be symptoms of posttraumatic stress disorder, or PTSD, which affects an estimated 15-20 percent of veterans. The military is finally starting to take PTSD seriously—in fact, the chairman of the House Veterans Affairs Committee recently asked Pentagon and Veteran's Administration officials why they have been slow to try out alternative treatments for the disorder. Service dogs, one of the treatments under investigation, are already being used by veterans as a unique way to cope with symptoms of PTSD.
A person living with PTSD is overwhelmed by stimuli. Something as simple as walking from one aisle to the next in the grocery store can put all senses on red alert for someone like Jim Stanek, a retired staff sergeant with the U.S. Army who completed three tours in Iraq. "That space you can't see between the aisles, in the army we call that dead space. It's a potential threat."

Brain regions like the amygdala and the hippocampus that deal with fear and memory seem to function differently in people living with PTSD. One of the researchers studying brain functions and PTSD, Dr. Jasmeet Pannu Hayes of Boston University, said that the overactive fear response in someone living with PTSD "is not permanent. It can change with treatment."
Brain imaging studies have shown that people living with PTSD are more distractible—both by neutral stimuli and those that remind them of the trauma they suffered. This contributes to the hypervigilance that many people living with PTSD report experiencing. Barry Morgan, who retired from the Navy in 1995, says that what started out as adaptive behavior—being in tune with the changing noises in his submarine—has turned into a problem for him as a civilian. "I have a big problem with paying attention to every little thing that's going on around me," he said.

Cognitive behavioral therapy has long been the first line of treatment for PTSD, but Dr. Yehuda, professor of psychiatry and director of the Traumatic Stress Studies Division at the Mount Sinai School of Medicine in New York City, has suggested that PTSD arising from repeated exposure to something like combat trauma may need a different approach.

This is where service animals come in. Unlike a therapist, a dog is by the veteran's side 24 hours a day, helping him or her navigate daily stressors.

Stanek says his wife has noticed changes since he acquired his service dog a year ago. "Recently we were out at a restaurant and for the first time I had my back to the entranceway. My dog,

Sarge, was watching the door for me. And my wife looked at me and she said, 'This is so nice. I finally got my husband back.'"

Dr. Joan Esnayra, founder of the Psychiatric Service Dog Society, is a biologist who has performed research about the efficacy of psychiatric service dogs, or PSDs. She calls the feedback loop between owner and animal a "cognitive intervention." Angela Peacock, a former U.S. Army sergeant and Iraq veteran, uses a dog trained first by the American Service Dog Association. She and her dog, G.I. Joe, have developed a sense of trust together, "I look at his instincts. I can trust him in the situations where I'm thinking the worst."
The high cost (up to $20,000) and long waiting list for a trained service dog put them out of reach for many people. "Currently, the VA is providing service dogs for everything but psychiatric conditions," said Esnayra. In response, the recently enacted Service Dogs for Veterans Act will provide 200 service dogs to veterans with physical and psychiatric disabilities as part of a pilot study.

Several organizations have also stepped up to try and fill the demand. Stanek founded Paws and Stripes to connect veterans with service animals so that they can be in charge of the training process themselves. "You can't tell someone with PTSD, especially out of a combat zone 'okay, we know this might help you, but you have to wait a year to five years before we can get you help,'" he said. Stanek, like Esnayra, favors the self-training model because it is cheaper and encourages handlers to customize their commands.

For more information on service dogs:

Psychiatric Service Dog Society
Information on self-training for handlers living with a variety of mental illnesses
(571) 216-1589

Puppies Behind Bars
Service dogs trained by inmates and matched with owners
(212) 680-9562

Paws and Stripes
Started by a veteran with PTSD, provides a veteran with a shelter dog and interactive training at no cost.

Acquiring a service dog means going public about being someone living with a disability—and dealing with some of the public misconceptions about PTSD. Morgan, who lives with non-combat PTSD, has had some discussions with veterans who developed PTSD from combat. He often chooses to say that his dog, Katsu, helps him with physical symptoms.

Peacock prefers to say, "my disability is on the inside" when challenged about bringing her dog, G.I. Joe, into public places. She said that many people don't realize that women veterans come back with PTSD, too. "They think we sit behind desks. That's not true. I drove convoys in Baghdad with no armor on my truck. I could have died any day." Stanek, on the other hand, feels like it is his duty to answer questions and educate people about mental illness and PTSD.
The one occasion in which service dog owners are required to disclose their diagnosis is when they produce a letter from a doctor so that they can bring the dog on an airplane. The Air Carrier

Access Act makes this requirement applicable only to psychiatric service dog owners, who must also call ahead when flying, unlike those who use service dogs for other conditions.

Esnayra pointed out that air travel is not the only area where double standards exist. “No other disability group has been required to conduct peer-reviewed research in order to prove that their service dogs work for them, beyond their own credible testimony,” she said. Psychiatric service dogs fall under more scrutiny “because our testimony is not viewed as credible because we are mentally ill.”
Posttraumatic stress disorder is not the only psychiatric condition that can be helped by service dogs. To hear the list of activities that Warren Gillis is involved with—volunteering at hospitals and homeless shelters, visiting people in the hospital, working part time as a mental health support worker—it is hard to believe that 10 years ago he had a hard time leaving the house because of schizophrenia and bipolar disorder. Like people living with PTSD, Gillis says of his service dog, Lurch, “The biggest thing is he helps me focus on the external and not the internal, what’s going on inside my head, hearing voices and racing thoughts.”

Services for veterans have come a long way since 1995, the year Morgan left the military. At that time, he was discouraged from talking about his psychiatric symptoms. Still, not every veteran living with PTSD even knows about service dogs or any of the other supports that might improve their outlook. Recovery from PTSD is possible. As Gillis says with his dog at his side, “My definition of recovery is that you’re comfortable with yourself again.”

WHAT ARE THE TR IMPLICATIONS?

THERAPY THROUGH YOGA: URTA CONFERENCE PRESENTATION 2015

https://mail.google.com/mail/u/1/?ui=2&ik=04db5a5518&view=att&th=14c34d8fe2823c6d&attid=0.1&disp=inline&realattid=f_i7gz5o980&safe=1&zw

THE WORLD WARS

Human service administrators during World War I and World War II could not help but discover the benefits of play and recreation for the morale and rehabilitation of wounded soldiers. Even before the twentieth century, nurses like Florence Nightingale applied recreation to rehabilitation. Having written Notes on Nursing in 1873, she referred to pet therapy, as well as the use of music, to address rehabilitation needs of the soldiers. Nightingale was also concerned about the moral fiber of the healthy soldiers. She stated, "Give them schools and lectures and they will come to them. Give them books and games and amusements and they will leave off drinking" (Woodham-Smith, 1983, p. 165). Nightingale's philosophy about recreation and leisure remained with the military and became an integral part of treatment and diversional programs contributing to recovery and morale of the soldiers.

In the United States, prior to June 1918, all "recreation" programs for soldiers were conducted only on wards and corridors. With the approval of the War and Navy Departments, the American Red Cross built 52 convalescent houses, or recreation huts, costing $1,069,385 for recreation and amusement to facilitate the soldiers' recovery. These homelike structures provided convalescing soldiers with libraries, movies, entertainment, tables, games, and pianos. Each recreation hut served 2,000 beds and was staffed by four to five women. Ironically, although one of the responsibilities of these nurses included entertainment and fun, they were also charged with the contradictory duty of leading searches to find casualties and notify the families.

Recreation services were assumed to be performed almost exclusively by women. A typical job description for military nurses in 1918 suggested that appropriate applicants would be "women of cheerful disposition to staff recreation huts at each hospital" and "...should be those who are keen on entertainment, lots of music, reading aloud, and all that sort of thing to help make the recovery of wounded and sick soldier boys much quicker than otherwise would be the case" (American Red Cross Bulletin, 1918, p. 5).

In the years after World War I, Margaret Lower, a Red Cross worker, founded the ray Ladies, named for their gray uniforms. These women volunteers assumed the primary role of providing recreation services to wounded soldiers. Recreation services provided by nurses and the Gray Ladies were successful in hospitals and later became part of the Hospitals and Recreation Corps volunteers in 1947. In addition to their regular duties these workers helped organize dances, conduct classes to encourage amputees to function better, provide speech and penmanship, operate ward movies and book projectors, and encourage bedside gardening and handicrafts.

Planned treatments using recreation were also being implemented and having positive effects on the rehabilitation goals of the soldiers. Maxim and Stolz (1946) noted how recreation (play) was now clearly recognized by the military to be essential to the soldiers' rehabilitation. They stated, "Adults, no less than children, need to play if their physical and mental capacities are to function freely" (p. 75).

CHILDREN'S HOSPITALS

Perhaps the term "play ladies" found its real home in pediatric hospitals where nurses, teachers, and recreation workers helped demonstrate the benefits of play in the rehabilitation of hospitalized children. One of the pioneers of pediatric hospital recreation came from Massachusetts General Hospital in Boston in the early 1920s. Isabelle Whittier, trained in kindergarten and Montessori with practical experience in settlement houses, was referred to in the hospital as the "Play Lady" ("Children's Play in Hospitals," 1923). At that time, recreation work in hospitals was considered "undeveloped." Whittier, however, proved from a medical standpoint that recreation and play for hospitalized children had a "real value and has hastened the care of the child" ("Children's Play," 1923, p. 489).

The next decade offered more acknowledgment of the benefits of play, especially within nurse training programs. Mabel W. Binner (1935), superintendent at Children's Memorial Hospital in Chicago described how morning hours with the children were staffed by three school teachers and a kindergarten teacher in the afternoon. She noted how nurses were taught how to play so

that they could pick up the work of the "Play Lady." By 1941, the education staff for instruction of the psychiatric nurses consisted of the psychiatrist, education director, occupational therapy director, and recreation therapy director. The last three weeks of the nurses' training was spent in occupational therapy and recreational therapy, one week each, with the remaining week being a choice between the two (Bradshaw & Davis, 1941).

At the School of Pediatric Nursing at Children's Memorial Hospital in Chicago in the mid-1930s, nurses were required to take introductory and advanced courses in play as a fundamental method of care. Since nurses seemed to lack knowledge in children's play and were self-conscious, the beginner's course in play was established in 1932 and included lessons in presenting games, stories, poetry, rhymes, drama, and puzzles. The subsequent advanced course in play included more theory and practice, skills in making one's own equipment, and additional information in children's literature, music, and art. Between 1932 and 1938, 1,004 student nurses and 77 graduate nurses were given courses in play as a fundamental method of care for hospitalized children. Additionally, 232 voluntary workers helped in the Department of Play between 1932 and 1937 (Smith, 1941).

The "play ladies" did not limit themselves to direct service in hospitals or schools, however. Many women addressed the play and recreation needs of people with disabilities through their writings. For example, as early as 1916, Hilda Wrightson wrote a book entitled, Games and Exercises for Mental Defectives. A year later in 1917, Abbie Condit wrote an article titled, "Recreation for Crippled Children" in which she described Blanche Van Leuven-Brown of the Van Leuven Brown Hospital School for Crippled Boys and Girls in Detroit, who supported recreation for "crippled children" and worked with child welfare.

Empirical literature surfaced from these programs as well. Anne-Marie Smith (1941) wrote a six-year summary of the effects of play preceding operations for children under treatment at the Children's Memorial Hospital in Chicago. According to her notes, the nursing program treated 4,000 children each of the six years. Smith, a staff instructor at the leader's training school in Chicago, found that the benefits of play for the children included relaxation, satisfaction, diversion, prevention of homesickness, and constructive use of energy. These experiments in preoperative play also proved that therapeutic play had direct benefits in terms of improved recovery and compliance of post-operative children. During this time, Smith also noted how play served as preventative medicine for the children.

The effects of recreation and play in meeting rehabilitation needs seemed to take hold in the late 1940s. For example, New York installed recreation departments with recreation workers in each of its 29 institutions for care of the state's mentally ill, "mentally deficient," and "epileptic." Additionally by 1951 the recreational department at Lincoln State School and Colony in Nebraska demonstrated the progress that can be made by a supervised recreational program to help alleviate the problem of overcrowded wards for the acutely disturbed and assist in bringing about a better social adjustment of patients.

IMPACT ON THE THERAPEUTIC RECREATION PROFESSION

Many women from disciplines such as nursing, social work, and elementary education helped shape the field of therapeutic recreation as it is today. The foundation built by these women through recreation and play programs for people with disabilities in special schools, military hospitals, and children's hospitals prior to World War II set a framework from which therapeutic recreation could root and grow as a formal and autonomous profession.

As therapeutic recreation professionals (still primarily women) became more organized, standards, credentials, and curricula also were established. Although women like Neva Boyd were providing education in recreation and group work as early as the 1930s at Northwestern University, specific professional training in hospital recreation and recreation for the "ill and handicapped" began to formalize in the 1950s. Some of the first formal curricula in hospital recreation education were established because of the work of dedicated women.

The impact of the work of the "founding mothers" on teaching and applying the importance of play and recreation for people with disabilities is evident in therapeutic recreation education and in practice today. Currently, there are over 100 professional preparation programs and two professional associations for therapeutic recreation in the United States, boasting strong leadership by women. Approximately 50 percent of therapeutic recreation educators are women (SPRE, 1989/90). Also, 50 percent of the presidents of the American Therapeutic Recreation Association have been women. In practice, 80 percent of the more than 13,000 individuals certified with the National Council on Therapeutic Recreation Certification (NCTRC) are women.

Through the work of the women identified, as well as many more women and men who saw the importance of play and recreation for people with disabilities of all ages, credibility was given to the possibilities that play could be therapeutic and beneficial in meeting the rehabilitation needs of various populations. Beginning almost concurrently in public and private sectors of the community, medicine, and education, people from many disciplines found it important to use and establish recreation and play programs as forms of treatment and education.

While the name "play lady" has officially given way to the title "therapeutic recreation specialist," the hard work and exploration of women throughout the twentieth century has brought recognition to the field of therapeutic recreation. Thanks to these women, recreation as a therapeutic intervention exists in most human and educational services today.

http://search.proquest.com.erl.lib.byu.edu/docview/215769885?OpenUrlRefId=info:xri/sid:primo&accountid=4488

WHAT TREATMENT IS AVAILABLE?

http://search.alexanderstreet.com.erl.lib.byu.edu/view/work/536872
http://search.alexanderstreet.com.erl.lib.byu.edu/view/work/1778961
http://search.alexanderstreet.com.erl.lib.byu.edu/view/work/1831707

TR ARTICLES

ZABRISKIE ARTICLE

(Follow link for full results and tests)
The intent of this study was to examine the outcomes of an adaptive sports program on veterans with PTSD and their significant others' marital satisfaction, symptoms of posttraumatic stress disorder, posttraumatic growth, perceived competence in sports, and leisure satisfaction. There were three key findings from this study. First, couple leisure participation had positive impacts and reduced the negative impacts of a traumatic military experience. Second, these findings started to provide evidence for the four functions of leisure to transcend negative life events (Kleiber et al., 2002). Finally, the findings provided evidence that couple leisure participation improves marital satisfaction for veterans with PTSD and their significant others.

The first key finding was couple leisure participation reduced the negative impacts of a traumatic military experience and had positive impacts for both the veterans with PTSD and their significant others. The reductions in negative impacts were indicated by the significant decrease in the symptoms of PTSD, while the Control Group, though not significant, increased. The positive impacts were indicated by the significant increase in marital satisfaction, a significant increase in leisure satisfaction, and the trend of increased perceived competence in sports while the Control Group's perceived competence in sports decreased. Veterans with PTSD from OIF/OEF could use recreation with their significant others to reduce the symptoms of PTSD, improve their relationships, and in the long run should improve their overall quality of life. This is critical for OIF/OEF veterans and their significant others when approximately 300,000 veterans are returning with PTSD or depression, and only slightly more than half are receiving minimally adequate treatment (Tanielian & Jaycox, 2008), and PTSD impacts veterans' and their significant others' relationship in negative ways (Beckham et al., 1996; Card, 1987; Carroll et al., 1985; Jordan et al., 1992; Lasko et al., 1994; Riggs et al., 1998; Waysman et al., 1993; Zoroya, 2005). Hundreds of recreation programs around the country are being developed for OIF/OEF veterans with the purpose of helping wounded veterans heal (National Recreation and Park Association, 2008; "Recreation & Sports," n.d.). This study helps to provide empirical evidence that recreation participation improves the lives of veterans with PTSD and their significant others by reducing the symptoms of PTSD and increasing marital satisfaction. Kleiber et al. (2002) discussed how recreation participation assists on multiple levels with traumatic experiences.

The second key finding from this study was starting to provide evidence for Kleiber et al.'s (2002) four functions of leisure to transcend negative life events. The four functions are distraction, increased optimism about the future, aide in the reconstruction of a life story, and a vehicle for personal transformation (Kleiber et al.). Distraction from negative emotions was indicated in this study by the significant decrease in the overall posttraumatic stress scale and in particular the reduction in re-experiencing symptoms. Re-experiencing symptoms includes flashbacks, traumatic day dreams, or nightmares about the traumatic experience (American

Psychiatric Association, 1994). The positive experience of couple recreation participation, indicated by the high satisfaction with the program scores in this study, appears to indicate a distraction from the negative emotions associated with re-experiencing negative military events.

Veterans with PTSD and their significant others need to be distracted from their negative emotions with positive experiences together to give them the opportunity to rebuild a positive relationship. Findings from this study suggest joint participation in adaptive sports distracts veterans and their significant others from their negative emotions, allowing them to begin to rebuild a positive relationship. Rebuilding of a positive relationship was indicated by the avoidance/emotional numbing subscale's significant decrease while the overall marital satisfaction increased in this study. The distraction created by participation in the adaptive sports program may have produced the space necessary for optimism about the future to occur.

The second function, increased optimism about the future, was observed in this study by increased leisure satisfaction, increased marital satisfaction, and high satisfaction with the program, as well as decreased hyperarousal and avoidance/emotional numbing scores. Hyperarousal symptoms include hypervigilance, extreme startle response, and always being on alert. Avoidance/emotional numbing symptoms include feelings of disconnection from people, avoidance of places or people and numbing of emotions (American Psychiatric Association, 1994). The positive experience of the adaptive sports participation reduced the stress of hyperarousal and avoidance/emotional numbing for both the veterans and their significant others and in turn made it possible for them to enjoy their recreation experience, enjoy each other more, and increase optimism about the future (Johnson et al., 2006; Kleiber et al., 2002). Findings from this study support recreation as a tool to reduce stress (Iwasaki & Smale, 1998), increase positive emotion (Bennett et al., 2009; Chun & Lee, 2007; Iwasaki, 2001), and increase marital satisfaction (Crawford et al., 2002; Holman & Epperson, 1989; Holman & Jacquart, 1988; Johnson et al., 2006; Orthner, 1975; Orthner & Mancini, 1990). The findings also support recreation as a way to improve connectedness between couples (Chun & Lee, 2007) as evidenced by the reduced feelings of avoidance/emotional numbing. Increased optimism about the future is an important function for veterans' relationship with their significant others because the divorce rates have steadily increased over the course of OIF/OEF wars (Zoroya, 2005). Kleiber et al.'s second function of leisure, increased optimism about the future, was accomplished by these veterans and their significant others by participating in the adaptive sports program.

The third function, reconstruction of life story, was determined through the Perceived Competence Scale. Individuals have a need to feel competent before they can pursue life goals (Deci & Ryan, 2000). Before soldiers leave for war they are highly trained and good at their job; when injured soldiers come home they are not able to pursue their military career in the way they had planned (Friedman, 2006). They lose their sense of self and have a need to feel competent in something again (Deci & Ryan; Friedman). Even though there was not a significant difference between the pretest and the posttest, the Control Group's average mean score decreased while Group A's and B's increased. The length of the program could help explain why competence did not significantly change. Most people may not feel completely competent in a recreation activity after only one week of lessons. If the veterans and their significant others continued to participate in adaptive sports they could increase their competence over time and start to reconstruct their life story through recreation (Kleiber et al., 2002; Deci & Ryan; Williams & Deci, 1996;

Williams, Freedman, & Deci, 1998). Leisure could provide an avenue for veterans and their significant others to experience success, achievement, and regain confidence when other aspects of their lives were not succeeding (Chun & Lee, 2007).

If the four functions are looked at as sequential, it is not surprising the fourth function of personal transformation was also not significant. The findings indicated posttraumatic growth had not occurred yet for these veterans; again this could be due to the length of the program and not having feelings of competence yet. This program was set up to be an introductory experience for winter adaptive sports to show the veterans and their significant others activities they could do together, with the intention for them to continue pursuing activities together when they return home. Posttraumatic growth is a lifelong process and not usually realized until years after a veteran's traumatic military experience. Vietnam veterans experienced PTG 20 years after the war (Jennings et al., 2006). If the veterans and their significant others in this study continue to participate in adaptive sports together they may experience PTG sooner. Findings from this study support Kleiber et al.'s four functions of leisure transcending negative life events. The other main focus of this study was marital satisfaction.

The final key finding from this study was couple leisure participation improves marital satisfaction for veterans with PTSD and their significant others. This finding was indicated by the significant increase in marital satisfaction for Group B. The main interest of this study was the impact of adaptive sports programs on veterans with PTSD and their significant others, but this study was two-fold. The other piece of the study was a program evaluation. Sun Valley Adaptive Sports modified their program between the experimental groups. The experimental groups were different because Group A was more focused on the recreation experience for the couples while Group B added a focus on communication skills and improving relationships through recreation. The finding that Group B increased their marital satisfaction and Group A did not, supports findings from previous research. Baldwin et al. (1999) and Holman and Jacquart (1988) both examined the relationship between joint leisure participation, communication, and marital satisfaction. They came to the conclusion that communication was needed in joint leisure activities to increase marital satisfaction. Communication skills are a key component for martial satisfaction and joint leisure participation can be used as a tool to teach positive communication skills. The findings from this study could be used by recreation professionals to improve the outcomes of programs intended to enhance relationships. http://scholarsarchive.byu.edu/cgi/viewcontent.cgi?article=3549&context=etd

WAR NARRATIVES: VETERAN STORIES, PTSD EFFECTS, AND THERAPEUTIC FLY-FISHING

Mowatt, R. A., & Bennett, J. (2011). War narratives: Veteran stories, PTSD effects, and therapeutic fly-fishing. *Therapeutic Recreation Journal*, *45*(4), 286-308. Retrieved from http://search.proquest.com/docview/926823022?accountid=4488

Working within a framework of narratology (narrative theory), this study is a gathering and analysis of 67 letters of veterans as they concluded their participation in a therapeutic fly-fishing program in Dutch John, Utah along the Green River. The program worked with veterans with confirmed diagnoses of Posttraumatic Stress Disorder who served overseas in each branch of the Armed Forces (except the Coast Guard) during Operation New Dawn, Operation Iraqi Freedom, Operation Enduring Freedom, Operation Desert Storm, Operation Desert Shield, and Vietnam. The collected narratives were analyzed based on a three-part process of reading: explication, explanation, and exploration. This analysis approach presented a uniquely constructed perspective of veterans as they participated in treatment. Researchers systematically analyzed the stories to present a narrative and set of themes that would inform and guide future empirical studies on the realities of veterans, program experiences, and perspective on treatment.

Keywords: Nanatology, narrative analysis, effects of war, PTSD treatment, outdoor recreation

As the United States has engaged in continuous conflicts overseas for over a decade, the physical and psychological trauma facing returning veterans and enlisted personnel between deployments is steadily increasing as advancement in military equipment and strategies have resulted in a higher number of survivors than in previous wars (Fisher, 2010; Meagher, 2007). Researchers took a stance that there are three unique roles that the field of recreational therapy can take in response to this trend:

1) The offering of service provision with an engaged recreational treatment in direct response to the need of veterans or enlisted personnel.

2) The study of those programs of treatment to educate and assess the nuanced ways to address issues associated with physical and psychological trauma.

3) The presentation of the experiences of those receiving treatment, and possibly, those providing treatment to ensure that not only a human or person-first approach is always present but to also ensure that the details contained in those experiences are considered for future service provision and study.

Working within a framework of narratology (narrative theory; Culler, 2001), this study is a gathering and analysis of 67 letters of veterans as they concluded their participation in a therapeutic fly-fishing program in Dutch John, Utah along the Green River. The program services female and male veterans with confirmed diagnoses of posttraumatic stress disorder (PTSD) who served overseas in each branch of the Armed Forces (except the Coast Guard) during Operation New Dawn (OND or Iraq), Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF or Afghanistan), Operation Desert Storm (Desert Storm or Gulf War 1), Operation Desert Shield (Desert Shield or Gulf War 2), and Vietnam (Viet Nam or Nam). The collected stories were analyzed based on a three-part process of reading: (a) explication (What do the letters say?); (b) explanation (How do the letters say what they say?); and (c) exploration (What is the reaction/response to the letters to readers and ourselves as researchers?) (Czarniawska, 2004).

This analysis approach presented a uniquely constructed narrative perspective of veterans as they participated in treatment. The analysis also presented a brief opportunity to view and compare

stories between those engaged in each of the wars, in particular OIF, OEF with Desert Storm and Vietnam but also those who have been deployed multiple times across campaigns. The study systematically analyzed the veterans' stories to present a narrative and set of themes that would inform and guide future empirical studies on the realities of veterans, their experiences within programming, and perspective on treatment outcomes from therapeutic recreation programs. The stories of veterans that are constructed into this narrative do not seek to present a set of universal truths but more an exploration of what the traumatic and post-traumatic stories are "telling [that] reveals about how the past affects the present" (Sturken, 1997a, p. 2).

Review of Literature: Veterans with PTSD and Treatment

PTSD as defined by the Diagnostic Statistical Manual, Fourth Edition (DSM-IV) states that a person has to experience or witness a traumatic event that puts the person's life in actual or threatened danger, or a situation that poses a threat to others. Symptoms of PTSD cluster into three areas: (a) re-experiencing; (b) hyperarousal; and (c) avoidance/emotional numbing. Re-experiencing a traumatic event can include nightmares, flashbacks, or hallucinations. Hyperarousal symptoms can include difficulty concentrating, hypervigilance, high startle response, or difficulty falling asleep. Avoidance/ emotional numbing symptoms include avoiding thoughts, feelings, places, or people that are reminiscent of the trauma or reduced interest in activities. These symptoms must be occurring for over a month and cause significant impairment to occupational, social, or other areas of functioning. Acute PTSD symptoms occur for less than three months and chronic PTSD symptoms occur for more than three months (American Psychiatric Association, 2000). Due to the nature of warfare, combat experiences are a traumatic event that has been known to cause PTSD symptoms.

Veterans with PTSD

Combat-related PTSD symptoms were recognized as far back as the Civil War. PTSD symptoms from the Civil War were known as "soldier's heart." Soldiers experiencing PTSD symptoms from World War I were known as "combat fatigue" or "shell shock" and after World War II it was known as "battle fatigue" or "gross stress reaction" (Hyams, Wignall, & Roswell, 1996). However, PTSD was not recognized as an official diagnosis until 1980 when the American Psychiatric Association added it to the DSM (Hyams, et al., 1996). Most individuals in upper-level positions in the military or the medical field thought that these returning military enlisted personnel were just cowardly or were weak (Hyams, et al., 1996). Even today, PTSD has a negative stigma of personal weakness and only about half of the soldiers experiencing PTSD symptoms seek professional treatment (Johnson et al., 2007; Tanielian & Jaycox, 2008).

Since October 2001, over 1.6 million men and women have been deployed to OIF, OEF, and OND (Tanielian & Jaycox, 2008). The wars in Iraq and Afghanistan are said to be the most psychiatrically and physically damaging wars the United States has ever experienced (Aronson, 2005; Warden, 2006). Also, veterans with PTSD are four times more likely to commit suicide (Hendin & Haas, 1991). According to a report for the Department of Defense, more troops in 2009 committed suicide than were killed in Iraq and Afghanistan combined (Kinn, Luxton, Reger, Gahm, Skopp, & Bush, 2011). Being physically wounded in war has a positive relationship with experiencing symptoms of PTSD (C W Hoge et al., 2004; Klein, Caspi, & Gil, 2003). PTSD is being called one of the 'signature wounds' of OIF/OEF. The prevalence of PTSD

among OIF/OEF is estimated to be 18.5% (approximately 300,000 veterans) (Tanielian & Jaycox, 2008). PTSD symptoms can negatively affect veterans' quality of life (Schnurr, Lunney, Bovin, & Marx, 2009).

The negative effects of PTSD are numerous and impact a variety of important life domains including social life, family life, and work life (Schiraldl, 2009). Veterans with PTSD have lower family functioning and more conflict in their relationships than veterans without PTSD (Evans, Cowlishaw, Forbes, Parslow, & Lewis, 2010; Friedman, 2006; Jordan et al., 1992). Veterans with PTSD are less expressive, less cohesive, more violent, and twice as likely to be divorced then veterans without PTSD (Carroll, Rueger, Foy, & Donahoe, 1985; Jordan et al., 1992; Kulka et al., 1990; Solomon et al., 1992). Divorce rates for OIF/OEF troops has increased 28% from 2003 and 53% from 2000 (Zoroya, 2005). However, veterans are not the only ones affected by PTSD symptoms.

Significant others of veterans with PTSD also report more issues compared to significant others of veterans without PTSD. They mentioned less satisfaction with their lives, more relationship distress, intimacy difficulties, psychiatric symptoms, impaired social relations, and problems with their relationships resulting in more steps toward separation (Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). According to this research, veterans with PTSD and their significant others experience significant negative side effects from PTSD symptoms. Treatments for PTSD mostly focus on reducing the symptoms of PTSD in the veteran or active duty personnel.

Treatments for PTSD

The main treatments for PTSD are cognitive behavioral therapy (CBT) and anti-depressants (Foa, Keane, Friedman, & Cohen, 2009; Hoge, 2011). CBT helps veterans deal with distressing thoughts about the traumatic event and gain understanding of the traumatic event (Follette & Ruzek, 2006; Tarrier, 2010). There are several types of CBT, including cognitive-processing therapy (Hassija & Gray, 2010), exposure therapy (Taylor, Thordarson, Maxfield, Fedoroff, Lovell, & Ogrodniczuk, 2003), and stress-inoculation training (Hoge, 201 1). Exposure therapy is used to reduce levels of anxiety and fear connected with triggers for the traumatic event (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). In exposure therapy, veterans confront the triggers by exposing them to pictures of the traumatic event or having them imagine the traumatic event (Foa et al., 2009; Taylor et al., 2003). This technique helps the veteran deal with anxiety and fear by teaching them that anxiety and fear will decrease over time (Tarrier, 2010). Relaxation techniques are also taught to help veterans manage anxiety and fear (Tarrier, 2010; Taylor et al., 2003). Another CBT therapy is cognitive-processing therapy (CPT).

CPT is a 12-session therapy that combines cognitive therapy with exposure therapy (Harvey, Bryant, & Tarrier, 2003). CPT uses cognitive therapy to help veterans deal with the conflict between post-trauma beliefs and pre-trauma beliefs (Fao et al., 2009; Hassija & Gray, 2010). A common pre-trauma belief is that the world is a good place. A common post-trauma belief is that it is not safe. Next, CPT uses exposure therapy to have the veteran write a detailed account of the traumatic event often in the form of a story (Buckley, Blanchard, Neill, 2000; Resick & Schnicke, 1996). This story is then repeatedly read, out loud, by the veteran. Errors in thinking are identified and addressed with the therapist to help facilitate cognitive restructuring (Resick &

Schnicke, 1996). Another commonly used CBT therapy is called stress-inoculation therapy (SIT).

SIT is used to help veterans increase confidence in coping with anxiety and fear from traumatic triggers (Foa et al., 1999; Tarrier, 2010). SIT helps veterans become aware of what triggers anxiety and fear (Foa et al, 2009). Also, veterans are taught a variety of coping skills to manage anxiety, including deep breathing and muscle relaxation (Hoge, 2011; Tarrier, 2010). The SIT therapist helps veterans identify triggers as soon as they occur so each veteran can implement coping skills immediately (Foa et al., 1999). This helps veterans deal with anxiety earlier before it gets out of control (Tarrier, 2010). PTSD is also treated with antidepressants.

Antidepressants used for veterans with PTSD are called selective serotonin reuptake inhibitors (SSRIs; Hoge, 2011; Marshell, Beebe, Oldham, & Zanielli, 2001). SSRIs help the veteran feel less worried and sad. SSRIs do this by raising the level of serotonin being absorbed by the brain (Marshall, et al., 2001). SSRIs have several side effects including upset stomach, diarrhea, appetite suppression, feeling anxious, problem sleeping, and/or headaches (Hoge, 2011; Masand & Gupa, 2002). The worst side effect of SSRIs is thoughts or attempts of suicide (Ferguson, 2001; Lane, 1998). SSRIs reduce symptoms of PTSD for about 20% to 30% of veterans (Marshall et al., 2001; Stein, Kline, & Matloff, 2002). No one form of therapy works for everyone with PTSD thus professionals are in need of multiple approaches to treat veterans (Hoge, 2011). Veterans may need to go through several different types of therapies before they find the one or combination of therapies that works best for their condition and needs (Foa et al., 1999; Tarrier, 2010).

An Example of Activity as Treatment

Many veteran-focused recreational therapy programs are dedicated to designing and implementing rehabilitation interventions in the outdoors (Hawn, December 2008). The goal of the therapeutic fly-fishing program used in this narratological study is to provide an intervention that can improve veterans' quality of life including: (a) rediscovering a purpose in life; (b) improve interpersonal relationships; (c) achieve success; (d) ease transition to civilian life; (e) improve functional ability; and (f) progress toward recovery. The program is experienced in Northeastern Utah on the Green River. Each trip consists of six veterans or active duty participants who engage in fly-fishing for two days with a professional guide. The program covers the cost of meals, transportation, lodging, and fly-fishing guides through donations and sponsorship.

Study context. It is important to differentiate between the use of letter writing within the fly-fishing program and this narratological study of participant letters from the fly-fishing program. Veterans either voluntarily seek the program or are recommended by another veteran or a Veteran Administration Hospital. The fly-fishing program is not designed with intentions of conducting research nor are the activities (such as letter writing) developed and implemented for any other purpose than treatment. Following the guidelines of the university's Institutional Review Board (IRB), a narratological study of participants' letters was approved pending veteran's consent to reproduce letters for research purposes. In addition, names on the letters were blocked out as per the specification of the IRB approval. Each veteran was asked if his or her letters to sponsors could be copied and used for this study. It was explained that the letters

were to be reviewed and analyzed for a potentially published study on their stories in dealing with PTSD and their experiences with fly-fishing as a treatment. The explanation was preceded with an opportunity to refuse the use of their letters. However, all 67 veterans from the summer of 2010 program gave permission for the use of their letters. The content of any CPT letters written by the veterans or experiences observed by the researchers were not utilized as part of this study.

Program letters. On the last night of the program, the participants are asked to hand write a letter to the individual or organization who donated money for the veteran's trip. Although the letters are not mandatory, all of the participants are typically very willing to write a letter after their .experiences. These letters are then scanned and saved by the program's staff. The original handwritten letter, along with a photo of the participant holding a fish, is sent to the sponsor. The content of the letter is determined by each veteran and stands separate from a CPT letter intended to discuss the veterans' war experiences and traumatic event (Tarrier, 2010). Thus, the content of the letter presented an unscripted format of what is on the mind of the veterans, as they addressed the sponsors, which could range from general appreciation for the opportunity of the trip, general enjoyment of the fly-fishing experience, or a restatement of their experiences with PTSD.

Methodology: Narratology and the Value of Stories

Within a narratological framework, 67 program letters were read, analyzed, and constructed into a narrative on the effects and treatment of veterans with PTSD (Culler, 2001). Each letter was read a total of three times to ensure that content, sequence, and handwriting was understood before progressing to the actual analysis. In doing so, this study utilized techniques to address similar concepts to validity and reliability in qualitative inquiry, often referred to as trustworthiness and verification (Merriam, 2009). The techniques focused on establishing a dual process for: a) trustworthiness through the use of credible methods for narrative analysis; b) verification in presenting evidence of the proper use of the letters and analysis of their content; and, c) that both trustworthiness and verification achieved a respect to the personal nature of the letters and the experiences they described.

The first level of trustworthiness was achieved through the design of the study with one co-investigator serving as staff for the program during the period in which the 67 veterans participated. This allowed the investigator to receive direct permission from participants on the use of their letters for the purposes of this study (Merriam, 2009). In working as staff for the program, a relationship was established that allowed the veterans to see and value the opportunity to share their letters with a larger audience than just the donors. While the first level of verification was through the actual interpretation of the letters that was conducted away from the program site by the second co-investigator who did not have a formal relationship with the fly-fishing program in order to create a distance from the veterans' experiences. This provided an opportunity to prevent an assumption of meaning based on familiarity and to establish a clean audit trail during analysis and thematic coding. The audit trail was based on an analysis and interpretation of all 67 available letters for maximum variation rather than an analysis based on a saturation of responses of a select sub-set of letters (Merriam, 2009).

This was followed by a second level of trustworthiness, with a solicitation of two colleagues unaffiliated with the study and familiar with narrative analysis. They reviewed and examined the

letters and tables to verify that the emerging themes were plausible. Further, their review also sought to ensure that the interpretations reflected a cautious attempt to be free of political stances on PTSD, war, patriotism, or specific veterans' comments that reflected "the worlds [and views] of the veterans." The first co-investigator provided a second level of verification by reviewing the second co-investigator's interpretations of letters. This information was then placed in a table format so that the accuracy of content could be conferred and compared directly with the written text (see Table 1) (Merriam, 2009).

The unscripted content of the program letters provided researchers an opportunity to read the qualitative aftereffects of treatment, ongoing struggles with PTSD, and perceived benefits of the program. Although there are varying perspectives on narrative theory (Coles, 1989; Mishler, 1991; Reissman, 1993), all perspectives agree that the stories that are given to us as researchers from respondents, participants, and people representing unique experiences are of value in sociological research on the linguistic accounts of the human experience (BaI, 1990; Clandinin & Conelly, 2000; Franzosi, 1998).

Importance of Narratives

A survey or questionnaire may yield responses to specific questions that offers us data on the numbers of clients that "think" or "feel" but stories offers us detailed accounts of those "thoughts" and "feelings" and any nuances that cannot be found from surveys and questionnaires. The chief aim of empirical studies in recreational therapy is to improve best practices. Narratology, narrative analysis, and narrative construction are additional ways that those empirical studies could be informed. For example: (a) as the evidence and importance of social support in narrative description interviews with campers (Roberson, 2010); (b) the scripting of a personal narrative of personal choice and freedom while undergoing rehabilitation (Lawson, Delamere & Hutchinson, 2008; Voelkl, 2008); (c) uncovering cross-cultural issues in receiving treatment and care (Dieser, 2002); (d) countering unrealistic portrayals of post-injury or event with realistic narratives of recovery (Hutchinson & Kleiber/ 2000); and (e) the role that narrative can have in assisting future clients in constructing their own stories and establishing new ways of learning post-treatment (Luckner & Nadler, 1995).

Narratives serve as a skeleton of life events that are given a logical and chronological order to present knowledge and convey an understanding (Chatman, 1978; Cohan & Shires, 1988; Toolan, 1988). BaI (1990) provides those utilizing narratology with a hierarchy of: (a) story; (b) text; and (c) narration as the crucial aspects of a narrative. Narratology presents two key distinctions in structure:

1) That the story that is comprised of events, people, and locations.

2) That the discourse that is given a context by the format of the presentation (e.g., this manuscript, a conference presentation or a documentary), the manner the story is being told, and the purpose for retelling the story (Chatman, 1978).

Methods: Narrative Analysis

As Chatman (1978) stated, "for many narratives, what is crucial is the tenuous complexity of actual analysis rather than the powerful simplicity of reduction" (p. 94). In analysis we are not simply restating what has been said to us as researchers but asking, "Why was it said to us?" With this in mind, the first step in analysis is creating a chronological table for each story (in this case each letter from a veteran in the program) of: (a) finite verbs; and, (b) dynamic verbs that depict the conveyed events (see Figure 1 for an example of a veteran's letter as recommended by Franzosi, 1998).

The collected narratives were then analyzed based on a three-part process of reading: (a) explication (see Figure 1: "What do the letters say?"); (b) explanation (see examples within Table 1: "How do the letters say what they say?"); and (c) exploration (Conclusory findings and statements: "What is the reaction/response to the letters to readers and ourselves as researchers?") (Czarniawska, 2004).

This analysis approach presented a uniquely constructed perspective of a recreational therapy program for veterans from the actual stories of the participants as they participated in treatment for PTSD. The analysis also presented a comparison of the stories between those engaged in various campaigns OIF, OEF, OND, Gulf War 1 and 2, and Vietnam. Further, the narrative of this manuscript on the stories of veterans sought to present their unique identity as they struggle with, seek treatment for, and overcome PTSD (Schiffrin, 1996) to influence and broaden our understanding of how individuals articulate their struggles with PTSD (Simmons, 2011). The biography of the veterans' lives that is told in narration is given meaning to elicit action within the field of recreational therapy (Arendt, 1998).

Thematic Findings

Because of this, as Barthes (1966) stated, "narratives of the world are numberless" and represent a number of discourses of a phenomenon (p. T). What are narratives? The stories of people are "representations of a set of events or a series of events" (Abott, 2002, p. 12) that are given a certain context or depiction by the narrator (researcher) in their recounting (Cobley, 2001). Stories never have innocently placed sequences or sets of events but have implied casual sequences that are presented with a reason. Things happen because of some other "thing" or only after some other "thing." Thus, when the storyteller explains them, their intention in giving an order to those events or occurrences, is an entryway to a narrative thematic analysis (Halliwell, 1987). In analyzing 67 veterans letters post-treatment, four distinct themes emerged:

1) The necessity of camaraderie while undergoing treatment.

2) The ongoing presence of regret.

3) The process of reflection in reconciling memory.

4) The benefits from outdoor recreational activity participation.

Necessity of camaraderie. As all 67 letters were read three times, it was abundantly clear that veterans and enlisted personnel sought or responded to interaction with other veterans or enlisted personnel. A Desert Storm veteran stated,

Due to my service in Desert Storm, I have become very withdrawn from family, friends, and life over the years since my war ended ... spending time with other vets that have went through the same things I have at different times has helped me understand more that I am not the only one and I can have my guard down and few hours in the day that I can act and be like I was before I was injured.

The branch of the armed forces that they were enlisted in, the war of engagement, the location that they were deployed to, or their respective age did not seem to be important or the basis for this interaction. In fact, others who never have served were accepted into group activities when there was also the presence of other veterans or enlisted personnel. An OIF veteran commented, "just being around other vets, the staff, and guides has made me feel alive for the 1st time since... 2004." The valuation of these new relationships increased if the veteran or enlisted personnel were also diagnosed with PTSD but it was not a necessary component to friendship or bonding. Participation in a recreational activity only enhanced the line of communication and other benefits associated with the interaction rather than "just sitting around in a circle" discussing their problems. However, this desire or appreciation for interacting with others who served should not be surprising as most began training or operated within some form of a group (unit, platoon, battalion, company, etc.). For example, a recently returning National Guardsman disclosed,

In the beginning of the weekend, it was a group of strangers. As the weekend progressed, we all become closer through the common bond of fishing together. Sometimes it's hard to pick fishing buddies. But you look for some qualities . . . most importantly is reliability. Someone who you can count on to be there and go fishing with when life stresses you out. These are qualities ... that vets already possess so they become natural fishing buddies.

Thus how they went into war may be thought of as crucial approach of how they could come out of it, within some formal grouping.

Presence of regret. As we are aware that one significant aspect of PTSD is the recurring psychological effects associated with a war-related event, several veterans seemed to compound their mental stress with perceptions of post-war "regrettable" events. These events consisted of regrets about: (a) not being a good spouse or parent (b) leaving their family or job, and (c) missing a range of opportunities.

As mentioned earlier, tied to the presence of regret, spouses of veterans with PTSD reported experiencing significantly more issues (Riggs, Byrne, Weathers, & Litz, 1998; Zoroya, 2005). A Vietnam veteran discussed,

I am trying to deal with PTSD ... for my family's sake. I have made it very hard on them for a very long time now. This very short weekend has done more for me than all the doctors and shrinks have since my return home. Hopefully it helps my family also.

As they struggled with treatment for PTSD, they also struggled with coping with "perceived" failure. This repeated sentiment of regret only reinforces the important notion of treatment that emphasizes functionality in the "real-world" and the "now" while processing how the "now" is

based on war-related trauma (Kilshaw, 2006). A Naval Fleet Marine Corpsman and medical personnel from OIF wrote,

During one of those missions we sustained gunfire, and two of my Marines were shot. I was devastated that having to choose to save one over the other and my inadequacies of not being to save both of them haunts me to this day. I tried to find solace ... [but] to no avail. While the physical injuries have healed, my memories - PTSD leaves me with stress, pain, anxiety, anger, irritability, and frustration I deal with on a daily basis ... [while] getting frustrated over hooking everything [for fishing] ... I never noticed the stress and frustration had been replaced by fun, happiness, and relaxation.

However, despite the anger or sadness that was associated with regret, the regret was based on a desire to have a better life. A few of the veterans found a new sense of achievement as they promoted, recruited, or volunteered for the treatment agency as opposed to just being recipients of care. One Desert Storm veteran concluded his letter, "I believe I have been able to convince local veterans from Utah to also seek help."

Process of reflection. As Hynes (1997) stated, "war narratives by their nature are retrospective," thus, the memory of the war given to a researcher for narrative construction automatically requires a recollection (p. 4). This retrospective recollection is coupled with the "reliving" of a traumatic event that has led to PTSD. The storytelling attempted to make sense of these two types of memories. Within the letters, reflection enabled the veterans to differentiate the two memories. Their anger about their condition (or the effects of PTSD or failed treatment for it) was not transferred to their service and enlistment even if they were deployed multiple times. One U.S. Army veteran, wounded in his first four hours for OEF, stated that they had proudly served since 1978 with "several conflicts, six tours/campaigns."

While a 14-year veteran of the Army with two deployments to Iraq reconciled,

I have been with my moods, dreams, and depression for the first 7 years. I have been hospitalized for suicidal thoughts twice and suffer from chronic pain. During this spectacular 2-day excursion, I have not felt distressed or sad. I even went without my medication and had the best 2 days of my last 7 years. So that I may get my fellow solider up here for remedy and experiencing the life changing benefits.

However, the ability to reflect on themselves is dependent on "the passage of time and establishment of distance from the remembered self" (p. 4). Another Vietnam veteran reflected,

I know I should not have made it home in one piece. But somehow I did. I should have died at least 10 times in the 12 months I was in Vietnam. I am pretty sure I had an angel on my side.

Those who served in Vietnam, Desert Storm, or were in their fifth deployment seemed to be able to process the war, their injuries, the effects, etc. at a greater level than those who served in the most recent wars for less than five deployments.

Outdoor activity participation. The combination of nature and physical activity seem to be the most salient experience from the treatment at the program. As one Marine from a 2008 tour in Afghanistan stated,

After suffering major back and leg injuries. Ever since then doing physical and outdoor activities has been a rare thing for me. Coming to Utah has really given me an awesome opportunity to be outside enjoying my natural surroundings and to learn how to fly fish... thanks to these trips I can now go back home and continue to build on what I learned here. There is no better feeling than fishing and relaxing once again.

To fish, fly-fish, sit in a boat in the river, see the fish, and "take in" the overall scenery had a lasting impact on their overall perceptions of treatment, the positive nature of their interaction with other veterans and treatment staff, as well as their outlook on life post-treatment. An Iraq veteran remarked that the program's activity gave him "the best night [of] sleep in 8 years... [as he] slept an uninterrupted 5 hours." Another National Guardsman who served in Afghanistan mentioned,

I know I will continue to fly fish (even more than I do now) when I get home ... and I will always have great fishing buddy to go with, share our common experiences with and enjoy the healing powers of water and fish.

Conclusion: Searching for Social Meaning in PTSD Research

The development and use of narrative in recreational therapy and the Therapeutic Recreation Journal are rare. The use of qualitative forms of inquiry that presents descriptive experiences such as narratology and ethnography can provide researchers and professionals with windows into how people are impacted by disease, illness, injury, care, and navigating through care treatment (Sutherland & Stroot, 2009). One major limitation within the study and program, is the lack of gender, gay, or racially-based narratives as all 67 participants were white and male. The role of serving as a woman and person of color is necessary to understanding a potential relationship with gendered and cultural experiences with dealing with PTSD. However, serving as a non-heterosexual, pre- and post- "Don't Ask, Don't Tell," may provide us with additional nuances to the effects of the disorder in identity, social relationships, and response in treatment. Although the program serves all veterans regardless of background, enrollment tends to be overly represented by those who identify themselves as white, male, and straight. In agreement with Dieser (2002), cross-cultural representation is highly important in providing cross-cultural competence for disorders that clearly do not discriminate. With the need for a wider representation mind, these forms of inquiry can provide: (a) a significance of narrative to practice; (b) emphasize the importance of recreation in therapy through narrative; and (c) raise the awareness of counter Hollywood war narratives.

For sociologists rather than historians, we are looking for the meaning of an experience as opposed to historical fact (Hynes, 1997; Rowe, 1986). In particular for leisure researchers, we are looking for the meaning of the unique experience of recreation in the lives of participants. In regard to this study, the aim is to give context to the impact of PTSD and the role of a program in assisting those with the disorder in overcoming or alleviating the impact. Further, the study advances an understanding of the role of warfare on developing PTSD, the memories contained

in the stories, and the basis for the veterans in pursuing a recreational therapy program for assistance (Zur, 1987). This intent of presenting a narrative is ours as researchers as opposed to those of the soldiers who wrote the letters (and told their stories). Most veterans minimally desire to educate or make aware those beyond the program (O'Brien, 1998). The construction of narratives by researchers enable these stories to gain an audience, albeit not the initial intention of the veterans, that can affect professionals and treatment providers.

The General Significance of Narratives in Treatment

A 20-year old Marine veteran commented that he

> Spent [his] 18th birthday in boot camp ... after returning home [from Iraq] ... things started slipping from my grasp and I sought help from many different sources from family to the Veterans Affairs. My treatment from the VA system was not what would be expected from an organization who has that much experience with troubles vets face returning. I was able to meet a great group of friends from the support group but that is about the extent of the "therapy" I received and gave up on the VA all together. I looked anywhere... [this] program has been the most effective attempt at treating PTSD.

Care provision, in particular PTSD treatment, is a highly personal and human endeavor that cannot be overlooked in the practice of health care systems. The process of letter writing and storytelling is a useful form of therapy that empowers those dealing with trauma to confront their past events in a supportive environment (Etherington, 2003). While the process of constructing narratives from those stories allows researchers and practitioners an opportunity to "view" recurring themes and make adjustments based on the input contained in the solicited stories. For programs that utilize story writing and telling, it may be useful to begin two processes: (a) allowing veterans returning to the program to reread their previous letters; and (b) allowing new program participants to read letters from previous program participants. By allowing the letters from previous visits and previous program participants to be read by current program participants, the creation of a personal process of reconstructing their views of their own perspectives could be achieved through the comparison with other experiences like their own. A collective and multilevel consciousness of PTSD's event initiation, effects, and progression to recovery may begin to override the unconscious effects of PTSD (Gentry, 2005; Jung, 1980).

Emphasizing the Role of Recreational Narratives in Treatment

Several letters highlighted the duplication of the recreational interaction in nature with veteran-peers in their hometown while other veterans planned on self-funded return trips to the fly-fishing program. The environment as much as the actual structure of the care (activity-based) were components that deserve further attention in future studies. Following the outdoor experience, providing time and space for those dealing with PTSD to create stories of their experiences pre-, during, and post-event also allows for the active integration of self-reconciliation of past events due to the "healing" nature of the outdoor environment (Lawson, Delamere & Hutchinson, 2008; Voelkl, 2008). This program utilized fly-fishing as its principle activity but there have been other forms of recreation that have also been noted with a similar positive effect, such as: sand play (Boik & Goodwin, 2000; Moon, 2006); outdoor adventure (Sutherland & Stroot, 2009); and the engagement in sports for fitness and not competition

(Camahan, August 2008). Through some form of recreation, the processing of their past events enables the veteran to be an active partner in their care along with practitioners (Luckner & Nadler, 1995). In addition, the use of narratives within treatments that incorporates recreation allows the development of a therapy that lessens the emphasis of PTSD and the direct recollection of the traumatic event but increases the emphasis of the restoration of a healthy lifestyle.

Countering and Continuing Discussions on War Narratives in Research

Major or significant life events become stories that are products of repeated memories that could often be painful, vivid, and hidden in regards to experiences associated with warfare (Hoffman, 2005). The influence of memory in the delivery of a story that will be used for narration can also impact the manner of the analysis by directing the researcher to points and contexts that alter perceptions of time and location by making the story seem local as opposed to distant (Boyarín, 1994; Thelan, 1989). The stories of veterans with PTSD become less remote from our own experiences without PTSD through the construction of narrative. The reconstruction of memory by the veterans as stories told to researchers may yield some altering of facts but their recollections still have meanings that directly or indirectly provide researchers understanding of an overall experience, especially experiences tied to warfare (Lomsky-Feder, 2004). However, there ought to be consideration of how media sources, such as Hollywood films, have also influenced the storyteller as much as the analysis conducted by the researcher and development of the subsequent narrative (Lindner, 2009; Sturken, 1991; Sturken, 2004; Sturken, 1997a; Swofford, 2003). War veterans' memory and recollection can be different even if they were deployed within the same area or group. This increases the importance of the individual analysis of each story and the identification of the value of each story as a stand-alone story prior to developing a collective narrative.

War stories from past wars that involved the U.S. armed forces have been noted in regard to Vietnam (Ringnalda, 1994; Spade, 1975; Stacewicz, 1997; Sturken, 1997b; Wolff, 1994). Further, there are a multitude of stories and narratives on the comparison of experiences of veterans from World War II and Vietnam (Ashplant, Dawson & Roper, 2004; Seaton, 2006). Some sources have compared Vietnam to the wars in Iraq (Apply, 2007). However, there continues to be a paucity of studies on more recent wars. Yet due to the familiarity and growing concern of illness (Gulf War Syndrome) and disorder (war-related PTSD), the study of these wars and their psychosocial impacts are increasing (Kilshaw, 2006). Lastly, the salience of OIF and OEF in our current psyche has been fueled by an overabundance of popular films coupled with the scarcity of narratives that have been studied. This disparity, the ending of certain wars with the recent announcement concerning Iraq, and the subsequent return of veterans provides the importance for this continued discussion to take place within leisure research, and specifically recreational therapy circles (Apply, 2007; Augustin & Kubena, 2006; Lindner, 2009; Swofford, 2003).