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I Tie Flies in My Sleep: An Autoethnographic Examination of Recreation and Reintegration  
for a Veteran with Posttraumatic Stress Disorder

Warren David Price

A thesis submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of  
Master of Science

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## ABSTRACT

I Tie Flies in My Sleep: An Autoethnographic Examination of Recreation and Reintegration for a Veteran with Posttraumatic Stress Disorder

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This autoethnographic account details the author's ongoing struggle with combat-related posttraumatic stress disorder (PTSD) and how leisure was integral to his journey toward recovery. By showing the mental and emotional struggles of life with the disorder, this paper offers an alternative viewpoint from the traditional scientific studies of PTSD which bury soldier's voices under layers of analysis. The purpose of this paper is to deepen and expand an understanding of both combat-related PTSD and the power of leisure in an individual's recovery from combat trauma.

Keywords: Posttraumatic stress disorder (PTSD), autoethnography, therapeutic recreation, leisure, stress, and coping, veteran, families, OIF/OEF, reintegration.

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Most especially, I thank my Heavenly Father for bringing me to this point in my education and life. It has not been a comfortable path, but I chose it, and the Lord has brought me through it. In retrospect, I realize He has purged me as a refiner of silver and increased my understanding. I

thank Him for imbuing me with a passion for building stronger families through wholesome recreation.

## Table of Contents

I Tie Flies in my Sleep: An Autoethnographic Examination of Recreation and

Reintegration for a Veteran with Posttraumatic Stress Disorder

Introduction.....	1
Review of Literature.....	2
Methods.....	12
Narrative.....	17
Discussion.....	42
Conclusions.....	44
References.....	48
Appendix A: Prospectus.....	56
Author Bias.....	57
Chapter 1: Introduction.....	58
Chapter 2: Review of Literature.....	66
Chapter 3: Methodology.....	76
References.....	93

I Tie Flies in My Sleep: An Autoethnographic Examination of Recreation and Reintegration  
for a Veteran with Posttraumatic Stress Disorder

More than a decade following the terrorist attacks in New York, Washington, D.C., and Pennsylvania, there are still American soldiers fighting and dying on foreign soil in the “War on Terror.” More than two million women and men have left their families and lives behind to serve their country. Hundreds of thousands have come home with an acquired disability. I am one of those. This is my experience with posttraumatic stress disorder (PTSD) and the role leisure has played in my quasi-recovery.

There is a wealth of literature concerning PTSD, leisure, and stress; however, there is a dearth of research concerning PTSD from the individual’s perspective, and very few connections between leisure and coping with war-related traumatic stress. This paper will provide a personal perspective of PTSD while simultaneously describing how leisure became a coping mechanism for my symptoms of war-related trauma.

Posttraumatic stress disorder is an anxiety disorder associated with exposure to trauma (Feczer & Bjorklund, 2009), and it is not experienced in a vacuum. The memories of combat experiences expand from the veteran’s mind outward, like ripples on a pond at the drop of a stone, infringing on the lives of those closest to the affected veteran (Demers, 2009). The effects of PTSD are pervasive; they affect physiologically and psychologically how a veteran reacts to every social situation, including family interaction (Lester et al., 2010).

The majority of literature on leisure, stress, and coping deals primarily with the typical stress experienced on a daily basis, as well as an increase in stress related to short durations of overly trying situations (Arai, Griffin, Miatello, & Greig, 2008; Iwasaki, Mackay, Mactavish, Ristock, & Bartlett, 2006; Iwasaki & Schneider, 2003). More chronic types of stress, such as

combat-related trauma are only superficially mentioned (Iwasaki et al., 2006). Given the recent influx of war veterans into society from the decade-long wars in Iraq and Afghanistan, the study of PTSD is timely. This study seeks to draw a connection between existing leisure, stress, and coping literature as a possible framework for finding answers to pressing questions concerning combat-related PTSD.

Despite the breadth of research into PTSD and leisure, most studies examine the symptoms and causes of PTSD with a focus on pathology as opposed to the experience of individuals living with these symptoms. Traditional quantitative research methods often understate or ignore the individual experiences of a person living with PTSD. For these reasons, an autoethnographic approach was selected for this research study.

Autoethnography is the act of telling a personal story about a given phenomenon (Axlesen, 2009). Researchers who have used forms of autoethnography to explore PTSD or leisure include Feczer and Bjorklund (2009) and Axlesen (2009). Feczer reflected on her own experience as a nurse in Iraq and her development of PTSD symptoms. Axlesen discusses the way in which triathlon training aided her recovery from anorexia-nervosa. Autoethnography highlights the emotional struggles and paradoxical situations experienced by people who live with, and often suffer from, disabling situations (Axlesen, 2009).

### **Review of Literature**

Many soldiers return from war with physical wounds. Far more return without any visible reminder of combat but carrying the unseen baggage associated with war-trauma indelibly etched into their psyche (Alici et al., 2010; Demers, 2009; Manos, 2010; Zoroya, 2005). Radical improvements in body armor technology and battlefield medicine have prevented many fatalities (Jaycox & Tanielian, 2008), therefore increasing the number of individuals and families



who must now learn to live with the lingering effects of war (Benedict, 2009). According to a Department of the Army demography report (2010) the signature wounds of the wars in Iraq and Afghanistan are traumatic brain injury (TBI) and posttraumatic stress disorder. Numerically speaking, these wounds represent the highest incidence (Tanielian & Jaycox, 2008). Both TBI and PTSD disrupt family life and can produce potentially devastating conditions within family functioning. Much research has been dedicated to understanding the effects of disability on the veterans (Nunnink et al., 2010; Stefcio, 2009; Feczer & Bjorklund, 2009). We are all connected to one another, and no person truly experiences life, or war, in a vacuum. In this manner, the families of veterans are affected, which, in turn, creates a ripple effect beyond the family and throughout society by virtue of the family's interactions within society.

### **Challenges Facing Veterans and Their Families**

Since October 2001, approximately two million women and men have deployed to war, either to Iraq or Afghanistan (Price & Stevens, 2011), and an additional three million Americans have had a parent or spouse deploy (Tanielian & Jaycox, 2008). The Research and Development (RAND) Center for Military Health Policy Research found that 18.5% of returning service members (approximately 300,000 veterans) from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) meet the criteria for PTSD (Price & Stevens, 2011) and only slightly more than half of those have sought and received "minimally adequate treatment" (Tanielian & Jaycox, 2008, p. 108). According to the Office of Army Demographics, 45% of National Guard, 46% of Reservists, and 59% of Active Duty personnel are married, implying that combat stressors may potentially impact roughly half of all military families.

The global war on terror has introduced many unique challenges into the lives of veterans and their families. Those challenges include the increased likelihood that soldiers will deploy to

a war zone, extended separation from family for training and assignments, short reprieves between multiple deployments, and waning public support. While the vast majority of service members who deploy do not experience injury or disability (Price & Stevens, 2011), those who are exposed to trauma are increasingly likely to develop signs and symptoms of PTSD in a compounding way with successive deployments (Stefco, 2009).

**Reintegration.** Once the deployment is over and the family is reunited, soldiers face the challenge of reintegration. While the service member is gone, families pick up the slack left by their vacancy, each member taking over a different aspect of the service member's household role, such as taking out the trash or paying the bills (Yano et al., 2010). Once home, the veteran and family must redefine their roles in the family "in many instances, a traumatized soldier is greeted by a traumatized family, and neither one is 'recognizing' the other" (Hutchinson & Banks-Williams, 2006, p. 67). In addition to reporting increased anxiety, difficulty connecting with others, trouble falling and staying asleep, and remorse over the absence of military structure and camaraderie; the returning soldier often struggles to understand and define where he or she fits in (Feczer & Bjorklund, 2009).

As service members return from deployment, many struggle to reintegrate into society. This struggle is frequently manifested first within the family, as service members often report feeling as though the family doesn't need them or has replaced them (Benedict, 2009; Bowling & Sherman, 2008; Alici et al., 2010; MacDermid-Wadsworth, 2010; Demers, 2009).

**Divorce.** Multiple deployments also seem to especially strain intimate relationships. Between 2001 and 2004, divorce rates among Army officers tripled, and rates among Army enlisted service members increased by 50%. Rates of divorce for enlisted personnel, returning from combat in Iraq and Afghanistan, increased from 28% in 2000 to an astounding 53% in 2003

(Zoroya, 2005). Shea, Vujanovic, Mansfield, Sevin, and Liu (2010) connected combat-related PTSD to functional impairment in family relationships, which is a contributing factor to the rise in divorce among veterans of OIF/OEF. Divorce has been well documented as a negative influence on parent-child relationships and certainly does not affect the veteran only (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011). Divorce causes chaos in the life of veterans and their families and can lead to other challenges such as substance abuse, depression, or suicide (Koenen et al., 2003).

**Suicide.** Kang and Bullman (2009) explored whether there was an epidemic of suicides among current and former members of the U.S. military. Between 2003 and 2009 there was a trend of increasing suicides among OIF/OEF veterans to 20.2 per 100,000 (Kang & Bullman, 2009, p. 759). In fact, every passing year marks record numbers of suicides among veterans and their families (Briggs, 2013). It is unclear why there was an increase in suicides of veterans from the most recent conflicts in comparison to previous wars. In their Health Promotion Risk Reduction Suicide Prevention Report (2010), the Army stressed the need for additional services to facilitate reintegration into civilian life once veterans return from war. These programs are intended to reestablish healthy marital and family relationships and reduce the risk of suicide among returning veterans. Suicide is a considerable public health concern within the U.S. military because it often results in additional risk to family members (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Guerra and Calhoun (2011) indicate that “exposure to wartime stressors” is compellingly linked to an elevated risk of suicide; however, an increase in reported PTSD symptoms are blamed for the increase in suicidal ideation (p. 17). In the same study we learn that PTSD is often experienced simultaneously with other diagnoses, such as major depressive disorder (MDD) or alcohol use disorder (AUD), which may explain an increase

in suicidal ideation (Guerra & Calhoun, 2011, p. 13). Another troubling trend is that veterans with PTSD are four times more likely to succumb to suicidal ideation than veterans without the disorder (Jakupcak et al., 2009).

**Substance abuse.** When veterans face disruptions in life, many turn to drugs or alcohol as a means of escape (Nunnink et al., 2010). Families that have a member struggling with substance abuse have demonstrated how addiction can permeate every domain of family life (Malkin, Phillips, & Chumbler, 1991). The comorbidity of substance abuse and PTSD among OIF/OEF veterans is the subject of much discussion (Brown, Recupero, & Stout, 1995; Nunnink et al., 2010; Guerra & Calhoun, 2011). Since 2008, military sources report a reduction in tobacco and illicit drug use, while prescription drug misuse and alcohol abuse are on the rise among OIF/OEF veterans (Bray et al., 2010). Trauma related to wartime stressors can lead to substance abuse, which in turn has a negative impact on relationship satisfaction in the form of sleep problems, disassociation, and severe sexual difficulties (Goff, Crow, Reisbig, & Hamilton, 2007).

**Dealing with disability.** In previous wars, soldiers who experienced mental or physical trauma often did not survive long enough to deal with the long-term ramifications of their wounds (Benedict, 2009). With the improvements in battlefield medicine, more veterans survive after acquiring a disability. Acquired disability can come in the form of amputation, paralysis, and reduced mobility due to shrapnel or enemy bullets. There are, however, disabling conditions that are not readily recognizable on visual inspection. Traumatic brain injury (TBI) is more prevalent in OIF/OEF veterans due to improvements in body armor (Jaycox & Tanielian, 2008) and has become one of the most frequently diagnosed disabilities since the onset of these wars. Veterans with TBI often experience a comorbidity of psychiatric disorders like PTSD (Rogers &

Read, 2007). OIF/OEF veterans report symptoms of PTSD so frequently it has come to be called the signature wound of the wars in Iraq and Afghanistan (Alici et al., 2010; Manos, 2010; Zoroya, 2005). Any time veterans acquire a disability; it represents a disruption in their life pattern and may present unique challenges to their families. While TBI and PTSD are intricately connected, this paper will primarily focus on the effects of PTSD.

## **PTSD**

PTSD is an anxiety disorder characterized by a triad of symptoms resulting from exposure to trauma (Feczner & Bjorklund, 2009). This triad of symptoms includes persistent re-experiencing of trauma, avoidance of reminders of trauma and/or emotional numbing, and a high level of general anxiety and psychological arousal (Rourke, Hobbie, Schwartz, & Kazak, 2006). Estimates of OIF/OEF veterans reporting symptoms of PTSD are between 20 and 40% (Bowling & Sherman, 2008; Benedict, 2009; Price & Stevens, 2011). Additional psychological symptoms are connected to combat and may be experienced simultaneously with PTSD. These symptoms include anti-social behavior and/or social isolation (Alici et al., 2010), depression (Demers, 2009), and hypersensitivity to crowds or loud noises (Evans, Cowlishaw, Forbes, Parslow, & Lewis, 2010). The continual exposure to stress-inducing situations can cause an emotional overload for veterans with PTSD. Seeking an escape from the near-constant negative emotional state, veterans may engage in negative leisure activities such as alcohol or drug abuse (Jakupcak et al., 2009; Nunnink et al., 2010), unprotected sex (Cameron et al., 2011), thrill-seeking, which can be dangerous or self-injurious (Strom et al., 2012), and, in extreme cases, even criminal behavior (Aprilakis, 2005). Any of these activities can lead to illness, injury, and possibly death. These activities can also have a negative impact on veterans' families; when a veteran's

frustration spills over, it can sometimes lead to domestic violence (Agaibi & Wilson, 2005; Manos, 2010).

Domestic violence among OIF/OEF veterans is often attributable to substance or alcohol abuse (Goff et al., 2007). Each of the aforementioned symptoms can be associated with lower levels of family satisfaction and functioning (Evans, McHugh, Hopwood, & Watt, 2003; Friedman, 2006). Veterans with PTSD are less emotionally expressive, less cohesive, more violent, and more inclined to divorce than their counterparts without PTSD (Carroll, Rueger, Foy, & Donahoe, 1985; Solomon, Mikulincer, Fried, & Wosner, 1987). As PTSD disrupts the life of the service member, the family is typically first to feel the effects and experiences the brunt of negative emotions and symptoms. Parental disability and behavior can also affect children's lives in the form of increased levels of substance abuse, divorce, and suicide rates among children of veterans with PTSD (Rosenheck & Nathan, 1985; Demers, 2009; MacDermid-Wadsworth, 2010; Briggs, 2013). Lester et al. (2010) call this the "wear and tear effect" of combat deployment (p. 317).

Because PTSD is commonly associated with a tendency toward emotional numbing and avoiding reminders of the trauma, veterans with PTSD often report a loss of interest in pursuits they previously enjoyed (Feeny, Zoellner, Fitzgibbons, & Foa, 2005). This loss of interest is expressed outwardly as veterans participate less actively in family-related leisure activities, even avoiding healthy individual leisure pursuits. This may explain lower levels of family life satisfaction (Evans et al., 2003; Friedman, 2006) as veterans with PTSD distance themselves from family members physically and emotionally.

Positive leisure activities can reduce risk to the veterans and their families. Introducing leisure as a means of coping with stress provides what Patry, Blanchard, and Mask (2007)

describe as “planned breathers,” giving veterans enough of a break from negative emotions to allow them to regroup and move forward through challenging circumstances.

### **Leisure, Stress, and Coping**

Leisure has long been recognized as a potent force for both its individual benefits and potential for improving family cohesion, adaptability, and communication (Freeman & Zabriskie, 2003; Shaw & Dawson, 2001). The rejuvenative, diversionary, and therapeutic benefits of leisure have been alluded to for some time (Caldwell, 2005; Hutchinson, Loy, Kleiber, & Dattilo, 2003). In addition to these advantages, leisure is effectively used as a coping mechanism for myriad ailments. Kleiber, Hutchinson, and Williams (2002) assert leisure can be used to transcend negative life experiences, including stress. Hutchinson, Bland, and Kleiber (2008) contend that leisure can be an important resource for coping with chronic stress (p. 10), although they don’t make the connection to war-related stress or PTSD. Leisure has been shown to be effective in mitigating symptoms of stress (Hood & Carruthers, 2002; Juniper, 2005; Iwasaki et al., 2006) and can be a powerful coping tool for veterans adjusting to an acquired disability.

The majority of literature on leisure, stress, and coping, however, does not directly mention war trauma or combat-related stress, although some applications have been suggested (Arai et al., 2008). Living with any disability is likely to have an impact on personal, social, and economic aspects of life (Iwasaki et al., 2006). Iwasaki et al. (2006) do not mention PTSD specifically; however, it is a disabling condition, and further research should be done in order to understand the benefits of leisure for combat-related veterans specifically.

Wartime trauma leaves a lasting impression on individuals and negatively influences thinking, feeling, and behavior that can be mediated through leisure (Arai et al., 2008). Stress

related to trauma is emotionally overwhelming and beyond the normal human experience, and war-related trauma is experienced by far fewer people than any other traumatic event. As such, it only is parenthetically mentioned in the discussion of using leisure and recreation for healing from trauma (Arai et al., 2008, p. 38). Recovery from trauma is not a clearly defined destination; rather, it is a “long journey an individual embarks on in search of a deeper understanding of self” (Arai et al., 2008, p. 38). Trauma can also impact leisure behavior as veterans fall into patterns of isolation and avoidance (p. 40). This is important in understanding the most effective ways for treating veterans with PTSD, because symptoms of the disorder can be alleviated by primary benefits of leisure participation such as empowerment, emotional support, and palliative coping (Iwasaki & Mannell, 2000).

When considering the PTSD symptoms of emotional avoidance and social isolation, Arai et al. (2008) suggested the potency of leisure and recreation involvement in healing from trauma by providing positive social support that improves issues of trust, intimacy, and boundaries (p. 40). This assertion is further supported by Iwasaki and Mannell (2000). They describe how building leisure friendships improves personal relationships (p. 164). Leisure participation can also serve as a respite from the negative emotional states brought on by PTSD symptoms (Patry et al., 2007). In this way leisure serves as a buffer between individuals and their negative emotion, allowing the individuals to regroup and move forward (Iwasaki & Mannell, 2000, p. 164). While connections to combat-related PTSD can be drawn, there is no existing literature that draws these conclusions. More research is needed to illustrate the possible benefits for pertinent social issues related to wartime trauma.



## Summary

We are uniquely poised in history to study the effects of war on veterans and their families and to examine how leisure can ameliorate negative life stressors. These negative situations include greater likelihood of divorce, increased risk of suicide, higher levels of alcohol and substance abuse, and rising numbers of veterans dealing with disabilities, including PTSD. These conditions represent a timely need to provide viable solutions.

Existing literature affirms the potential for leisure to provide possible improvement for conditions associated with disability. Given the recent surge in veteran disability issues, far too few studies have been published addressing the potential benefits of leisure on combat-related PTSD. The limited research concerning the connection between combat-related PTSD and the potential use of leisure in treating veterans is presented from an outsider's perspective looking in.

There is a gaping hole in the literature representing an intimate understanding of PTSD from the perspective of the patient. Many recreation programs exist and are offering recreation-based programming to help disabled veterans (Carnahan, 2008; Lundberg, Bennett, & Smith, 2011); however, those programs are involved primarily in research as a means of program evaluation, as opposed to addressing the issues from the veteran's vantage point. Until recently, there has been a lack of concrete connections between combat-related PTSD and the therapeutic benefits of leisure as a means of managing stress and coping (Hawn, 2008; Mowatt & Bennett, 2011). There is, indeed, a developing effort to address war-related issues through leisure, although publication of these findings is sparse. While Howatt and Bennett (2011) began to explore the veteran's voice, or the personal perspective of the veteran, the concept of *veteran as researcher* has not been utilized.

This study will examine PTSD from a personal, inside-looking-out perspective while simultaneously examining the palliative nature of leisure participation in the healing process. Rather than seeking to portray leisure as a magic bullet or cure-all for disability, this study recognizes that there may not be a total healing from the effects of wartime PTSD and will examine leisure in the light of ameliorating symptoms and improving quality of life in order to cope and move forward.

### **Methods**

The purpose of the study is to deepen our understanding of Posttraumatic Stress Disorder (PTSD) by exploring the relationship between leisure and its effects on symptoms of PTSD from a first-person perspective and provide a basis for future research concerning leisure as a coping mechanism for combat-related PTSD. As a combat veteran who is diagnosed with PTSD, I identify the role leisure played in ameliorating my chronic mental health symptoms. Additionally, I examine the role leisure played in stabilizing my family relationships. This section outlines the methods of the study, including an introduction to me as the subject, and an overview of the autoethnographic process used, which includes data-gathering procedures and analysis.

### **Subject**

I am Warren Price, a 43-year-old white male who is married with four children. I was an Army medic in the Utah National Guard from 1995 to 2008. I was 34 years old when I volunteered to go to Iraq. At the time of my deployment, my wife was 30, and our four children were ages nine, seven, four, and one. As a member of the armed forces, I experienced firsthand the horrors of war, the inherent anxiety, the frequent firefights and attacks, and the confrontation of my own mortality that are all common to soldiers who serve in combat. I returned home after

12 months and tried to return to a normal life. Instead, I had difficulty in keeping a job, as well as trouble adjusting at home, and I felt as though I didn't fit in with my family anymore.

Family members and other soldiers noticed changes in my behavior, such as angry outbursts, suspicion of others, and general paranoia. Loud noises startled me, and crowds made me uncomfortable. I also became resistant to authority figures. Following an incident at home, I was ordered by my company commander to seek treatment at the VA hospital in Salt Lake City, Utah. I was diagnosed with PTSD and began treatment, which included individual and group therapy coupled with significant doses of several anti-anxiety, anti-depression, and anti-psychotic medications. I fell into a pattern of abusing Xanax and Ambien, leading to greater difficulties at home and work. Eventually I was also hospitalized multiple times for suicidal ideations. I spent two years in a chemically induced haze of confusion, depression, anger, and personal darkness. Amongst a host of other therapies, I was eventually introduced to fly fishing as a means of coping with PTSD symptoms and embarked on a transformative journey to where I am today.

### **Autoethnographic Process**

Ellis and Bochner (2000) describe autoethnography as a systematic sociological introspection process of gazing at the data of the researcher's life through a wide angle lens and examining the social and cultural aspects of a formative experience (p. 739). Chang (2008) suggests a semi-structured format for writing an autoethnography; however, the method is still organic and fluid in nature. Following an intensive study of the autoethnographic process, the following seven steps served as a guide in creating my narrative: (a) conceptual preparation, (b) personal memory collection, (c) self-observation/reflection, (d) collecting external data, (e) managing data, (f) analyzing data, and (g) writing the autoethnography.

**Conceptual preparation.** Chang (2008) explains that a researcher must explore topics with particular meaning for the researcher. This step is typically completed during the proposal phase of a research project and is represented as part of the introduction and review of literature. I feel this topic chose me, as PTSD has become a defining factor in my life since 2006. It has proven to disrupt even the most basic functions, challenge my belief system, interrupt relationships, while also strengthening me. A study of social behaviors and recreation has deepened my understanding of PTSD and how it affects those around me.

**Personal memory collection.** Personal memory collection can take many forms, such as journaling, reflective and analytical writing, as well as notes from external auditors, which offer insight into the phenomena you are researching. I not only gathered personal journals, but also collected treatment notes from my therapist contained in my medical records. After reviewing these accounts, I wrote reflectively concerning each event in an effort to add details and provide continuity of ideas. I kept a consistent journal during my deployment to Iraq, and these journals served as documentation of the sources of my PTSD. Documents from my medical records also provided insight into symptoms of PTSD. These recollections are important in understanding how I learned to manage PTSD symptoms.

**Self-observation and self-reflection.** Self-reflection is a naturally occurring process as we seek to make sense of traumatic experiences. Formalizing the process requires one to designate specific time to ponder events and their implications and write specifically concerning insights the researcher and external auditors gain into behaviors or attitudes. My experience with prolonged exposure therapy (PET) and group and individual treatment naturally pushed me to reflect on observations concerning traumatic events. While writing and re-writing about these events, I relived emotions, felt discomfort, and faced personal fears concerning traumatic events

while gaining insight into their effects on my life. These insights are provided in the discussion section of this paper.

**Collecting external data.** External data refers to items not found within the researcher and typically occurring prior to the onset of the research. They include official documentation of events, unofficial correspondence between the researcher and external auditors, as well as any concrete record of events to be evaluated. Also included are accounts of the event by outside persons who experienced the same event from a different perspective. In addition to transcribing my personal journals from handwritten to electronic format, I gathered medical records from the VA hospital and compared those accounts to what I wrote in other stages of the process. I shared these accounts with family members and asked them to compare their recollection to mine in order to check my memory work for accuracy.

**Managing data.** This step formalizes the gathering processes and combines all data into a central location. This occurs when data is organized into similar sections and compared. Previously this process took place on index cards, loose leaf papers, or white boards. However, I employed research software NVivo 9 to help categorize events and organize them chronologically. Every effort was made to formalize a process that previously seemed unorganized. Attempts were made to apply traditional qualitative research methods to a more fluid research format. Each section of my narrative was entered electronically into NVivo 9 software and categorized, then coded for similarities and themes. NVivo 9 software proved to be useful in the autoethnographic process primarily as an organization tool.

**Analyzing data.** During analysis, I engaged in the process of axial and open coding and comparative analysis as described by Corbin & Strauss (2008), identifying (a) situational narratives, which are personal descriptions, (b) re-episodes, or reoccurring situations or themes,

(c) metaphors, a term or phrase used to represent something else, (d) subjective definitions, which are personal perceptions of the researcher, and (e) argumentative-theoretical statements, which are explanation of concepts (Flick, 2008). Coding is an analytical method for building theory and helping analysts consider alternative meanings of phenomenon (Corbin & Strauss, 2008).

A predetermined list of 13 codes from Corbin & Strauss (p. 192) was used during the proposal process. After both open and axial coding processes were complete, categorizations were discussed with my committee chair and external auditors to determine connections and emerging themes. We saw a connection to events that occurred during and after the war, as well as associated leisure patterns that had an impact on symptoms. The expressions of PTSD symptoms, both during and after the war, were represented most in the data. Three themes became apparent as explaining the cause, manifestation, and treatment of symptoms. I chose these three themes because they offered a comprehensive look at how symptoms were observed in my life, as well as their impact on my family relationships. Also impactful was a connection to unique leisure pursuits that helped to ameliorate those symptoms and negative effects.

To ensure my personal narrative offers an honest account and that my interpretations of those experiences provide accurate explanations, this narrative and associated interpretations have progressed through several iterations, reviews, and edits. Data was triangulated by sharing narrative data with three groups of external auditors; veterans who were in treatment with me for PTSD, members of my immediate family who were directly involved in the incident being reviewed; and members of my committee and research colleagues who were familiar with my narrative. The analysis of data also occurred through the self-reflection and member checking processes.

**Writing the autoethnography.** The final step in the autoethnographic process is constructing the written thesis for this project in a narrative format that blends my account with literature concerning autoethnography, PTSD, leisure, stress, and coping in a flowing and engaging manner. While I followed a semi-structured format for writing an autoethnography, it is important to note the method is still organic and fluid in nature (Chang, 2008). This fluidity has been evident during the process of discovery and evolution as I, and my research collaborators, have determined steps to follow while allowing for naturally occurring events to shape topics of interest. After themes were identified, research notes taken into consideration, and insight for external auditors gathered, the process of telling the story began.

I juxtapose my personal experiences with my academic and personal interpretations of the story (Caldwell, 2005; Rourke et al., 2006; Alici et al., 2010). The purposes for providing personal and academic interpretation are dual: to try and make sense of my experiences by examining the role recreation has played in my relief of PTSD symptoms, and to acknowledge the transformational power of leisure. The form of autoethnography employed in this paper seeks to fuse personal interpretations, social science, and literature by exploiting personal vulnerabilities, ambiguities, ongoing struggles, and the nature of the phenomenon (Ellis, 1999).

## **Narrative**

### **An Autoethnographic View of Combat and Coming Home**

When I returned from Iraq, I was invited to speak to various school and church groups about my year in combat. Wherever I went the question “what was it like?” invariably was asked. Each time it was asked, I struggled to answer; often oversimplifying by saying “it was hot!” The war experience is so dissimilar to what may be considered normal. One author of autoethnography invites the reader to “come close and experience this world for yourself”

(Tillman-Healy, 1996). I extend the same invitation as you read the account of some of my life since I returned home from combat in Iraq. The focus is on my journey to recovery and the essential role leisure pursuits played in inspiring this journey.

This autoethnographic narrative is told through a collection of stories reflecting three interconnected themes in my life with PTSD. Each theme represents symptoms found in the existing literature and was identifiable as either a possible impetus for symptoms, the expression of symptoms, or the relief of symptoms. Each theme contains a wartime traumatic experience, a related post-war traumatic interaction with a family member, and a leisure experience that helped minimize the impact of symptoms in my life. There were many experiences to choose from, but as this project is not intended to be an exhaustive review of all my traumatic experiences. Every effort was made to keep it from becoming exceedingly long. The autoethnographic process helped me to select three themes to connect the dots.

While my narrative offers lessons that may provoke potential conversations concerning the use of leisure in treating PTSD, my observations are not intended to question advice provided by the medical profession, nor are they intended to make positivist claims concerning leisure that can be generalized to all sufferers of combat-related PTSD. They are my own discernment based on my experiences as a Caucasian male suffering from combat-related PTSD, living in middle-class American society. I do not claim to be an “expert” on PTSD; however, I can offer a view of the disorder that many professionals cannot. I experience how a person with PTSD lives and feels. I can also provide an example of a journey toward recovery that is not generally recognized by medical experts. This journey embraces a commitment to individual and family leisure as well as leisure rituals as a means of finding improved health, quality of life, and relief from symptoms of combat-related PTSD. In telling this story, I accept the emotional and



professional risk of sharing the darkest and most painful secrets of my life. I expose my vulnerable self (Ellis, 2000) by revealing the complexities of combat-related PTSD and hope to encourage open dialogues regarding alternate viewpoints of combat-related PTSD and the possibility of its treatment by means of leisure.

### **Prologue**

In an effort to understand and gain some control over the symptoms of PTSD that were disrupting my life, I embarked on a program of study on the topic hoping education might relieve the sense of chaos I felt. I devoured academic articles, books, and popular media about both the characteristics of PTSD and the events that could cause it (Demers, 2009; Evans et al., 2003; Feczner & Bjorklund, 2009; Guerra & Calhoun, 2011; Ciaglo, 2013). While reading about characteristics of the disorder, I felt many of these authors were describing my life exactly. This is what I found myself thinking:

*These articles and books describe an illness that is typified by persistent re-experiencing of trauma. Check. They describe a condition characterized by, avoidance or reminders of trauma through isolation. Check. They describe an illness where sufferers demonstrate a high level of anxiety, psychological arousal, and emotional numbing. Check, check, and check. They describe an illness where sufferers' abuse substances, exhibit suicidal ideations, engage in domestic abuse, thrill seeking, and anti-social behavior. Check for all of the above.*

It was like staring at myself in the mirror.

### **Episode 1: Firefight on the Freeway**

Near the end of 2004, my company was transferred to southeast Iraq, requiring a great deal of personnel and equipment be moved across country in several convoys. Due

to increased attacks against American troops during the day, those in higher command had mandated all convoys be conducted at night under strict black out conditions (using no running lights, only infrared markers, and night vision goggles, or NVGs).

As a large company, we provided our own required convoy security. The first and last vehicle in each convoy were designated “gun trucks” and were fitted with either a semi-automatic grenade launcher or fully automatic, belt-fed machine guns. Every third vehicle was also similarly armed. Additionally, all personnel were required to carry personal weapons and keep them pointed out of the window, to remain awake and alert, and to scan the surrounding environment within their firing sector.

Attached to our helmets, we wore night vision goggles that folded down in front of our eyes. With NVGs, outside light is gathered by two ports and projected onto a single small green screen directly in front of your eyes. It feels like putting your nose against a television on static. The strain on the eyes, added to the wind from the open window and constant whine of the engine, make it difficult to stay awake and alert. I became tired and bored.

Approximately 90 minutes into our journey we approached a brilliantly illuminated complex called the Umm al-Qura ("Mother of All Cities") mosque in Baghdad. We saw tracers streaking across the highway and could hear gunfire coming from both sides of the road. The mosque was blazing bright green in my NVGs when I heard over the radio someone shouting “Contact right! Contact right!” to signal the convoy was receiving incoming fire from the right. This declaration was echoed by multiple voices over the radio as we drove into the line of fire.

I felt a knot in the pit of my stomach as I turned to scan my firing sector. A car pulled parallel to mine, matching our speed, and it seemed as though time slowed to a crawl. I remember thinking how bizarre it was that this car was driving backward as a man stuck his whole upper body out of the rear window with a rifle in his hands. I simultaneously saw the muzzle flash and heard the sound of an automatic weapon as he opened fire on our vehicle. My first thought was *“That’s a hell of a lot louder than I thought it would be.”* Instantly, I was awake and alert, and definitely not bored anymore.

Every muscle in my body seemed to contract as I began screaming “CONTACT LEFT! CONTACT LEFT!”

Pandemonium ensued as a cacophony of voices battled to be heard over the radio. The convoy commander unleashed a stream of obscenities as he struggled to gain control of the radio chatter and calm his troops. My heart racing, I held my breath as I stared down the barrel of my M-16; scanning the faces in the vehicle firing on us; I took aim. I could clearly make out the faces of the driver and the shooter. However, I identified a third person in the front passenger seat who was unclear.

I was terrified. At some point I began breathing again, but not regularly. I tried to make sense of the figure in the passenger seat, but could not clearly view their face. The passenger’s face was obscured by what appeared to be a burka, which Iraqi women wear to hide their faces. With my finger on the trigger a disturbing thought flashed through my mind; *“If I shoot her, CNN & Al Jazeera will plaster the headline all over TV and the internet ‘Army medic kills carload of innocent women.’”*

Never mind that men in the car were shooting at us, threatening our lives. I was paralyzed by fear. Not a fear of dying or being wounded; not a fear of the enemy; but

fear that the press in my own country would crucify me for defending my life. I was frozen. Target acquired, finger on the trigger, and I could not shoot.

Our driver made a hard right turn out of the firefight and continued our journey to the south of the country. Just like that, it was over. My veins were flushed with adrenaline, my heart still racing, muscles contracting, my breath shallow and rapid, and my mind still burned with the ghostlike image of that man shooting at me.

When we were out of the line of fire, I began shouting at the driver “Did you see that? Did that just happen? Was that guy really shooting at us?”

The driver shouted back, “Yeah, man! I can’t believe it!” and I was overcome with elation at being alive.

After several miles the convoy commander called for us to halt and hold an after action debriefing (AAR). We discovered, thankfully, no one in our convoy was wounded, and that no one in our convoy had even fired a single return shot. During the AAR the convoy commander singled me out and questioned me about my motive for not shooting. He asked if I had acquired a target, if my sight picture was good, and why I failed to return fire. He was angry with me, and I felt as though I had let him and everyone in the convoy down. A new feeling crept into my heart; shame. I had been terrified in the moment; but now I felt like a coward for not squeezing the trigger. I had no idea how this experience would haunt me months later in the peace and quiet of my own home.

### **Coming Home**

When I stepped off the battlefield I had hoped to leave the disturbing images of war and the growing internal monster of fear and rage behind me. Like many warriors

before me, I yearned to find a small corner of the world to live out my life in peace. Having spent a year in near constant turmoil, I was interested in returning to the solace of my family and enjoying a fairytale ending to my wartime narrative. Yet it was only a matter of weeks before the nightmares began:

*The explosion is so powerful I am knocked into back of the driver's seat. My ears are still ringing from the blast when I see the muzzle flash to my left. I hear screaming and shooting through a muffled haze as an insurgent, his head wrapped in the typical checkered keffiyah, rushes toward me firing his AK-47.*

*In an instant I am locked in mortal combat with my assailant. He is on top of me; the gun replaced by his bayonet slashing toward my throat. I block the thrust with my left arm, grab the rag on his head and roll with all my might. Using the centrifugal force of the roll, I desperately smash his face with my right fist. I feel bones crack as I connect and I hear a woman scream in pain and confusion.*

*Our struggle continues. I have him trapped beneath me now and am punching furiously and blindly with both arms. Again it registers that I hear a woman screaming.*

I awake with clenched fists straddling my wife in bed. She is screaming and shielding her head from further blows. The first punch bruised her ribs as I battled the phantom of my recurring nightmare. It takes a few moments for me to realize I am not in Iraq anymore; I am in bed with my wife. Her screaming quickly turned to sobbing as I became fully aware of the situation. I scrambled to the corner of the room, curling into the fetal position at the horror of what I had just done. Fixed in my sight is the image of her eyes projecting sheer terror of the

man who shares her bed. The look encompassed more than fear, her eyes were filled with loss and despair. She looked at me as though she didn't know me or what I am capable of. And she was right; I am not the man she married any more.

Among the symptoms of posttraumatic stress disorder (PTSD) are nightmares and flashbacks (Feczer & Bjorklund, 2009). I was 35 when I returned home from a year at war in Iraq, it was only a few months later when symptoms of PTSD became more than words on a page to me, they became my lived experience. They wove their way into every aspect of my life, disrupted family relationships, and friendships, overturned my belief system, stretched my mental and emotional paradigms past the point of breaking, and shook me to the very core. Although my life today resembles normalcy, many burdens left by my war experience remain; unseen, beneath the surface.

I am no longer the gentle husband who once protected her from all things. I am consumed by anger, fear, and anxiety. At times I feel dead inside, incapable of the gentle feelings of connection to loved ones I once cherished. I am constantly agitated, irritable, and unpredictable. At the slightest provocation I am consumed by a rage that envelops everything around me and destroys all it touches. I have become cold and calculating, unfeeling, and capable of extreme violence without remorse. Yearning no longer for a gentle touch or kind word; I hunger for revenge, justice, retribution, blood. I am a mere shell of my former self.

Part of me understands these things have no place outside of war and that I am no longer in the war, but the war rages on within me. I want the old me back, but he is dead and will never return. My wife's cries cause me to sob and wonder what kind of monster I have become. I have become something to hate and revile, and I wish *this* me were dead so I would stop hurting

those I loved—those I still love. I want to show my family I love them, in the ways they want to be shown, but I am unable to control the monster within me.

**Coping poorly.** After this incident we tried to hide that something was wrong. We tried to carry on a façade that all was well at home. My wife didn't talk about my angry outbursts to anyone, and I tried to pretend they never happened. I went to work; she stayed home with the kids. We went to church, and the kids went to school. Everything looked normal from the outside. My wife later commented it was "like walking on eggshells" when I was around, never knowing what would set me off. I sought advice from my chain of command. My first sergeant told me "PTSD isn't even a real illness! It's a souvenir you picked up in Iraq that you didn't have to claim at customs. Now, get over it!" I tried to shake it off, and get over what others, outside the chain of command, began to see as symptoms.

I had left Iraq months previously, but it was clear Iraq had not left me. Plagued by intrusive thoughts, nightmares, flashbacks, and paranoia; and fueled by the fear my own family felt toward me, I sought help from the VA hospital through counseling and medication. I wasn't thinking of recovery, I just wanted to stop the symptoms. I wanted the old me back. My primary concern was to numb the emotional pain and prevent myself from acting out against my family. If I could sedate the monster, it couldn't hurt me or my family, I reasoned. The drugs numbed the pain, and I began thinking "*If one works so good, two or three must work even better.*" Life became a jumble of one drugged stupor after another. I spiraled into a pattern of abuse and justification. "*It's not like I'm doing illegal drugs, the VA gave them to me, they make me better,*" I thought as I swallowed a handful of pills. My life became one painful moment followed by another, and I began looking for a more permanent solution.

I had hardened during the war and become accustomed to violence, and that hardness followed me home. During the war violence made sense, was a means to an end; it was acceptable. Unfortunately, those attitudes followed me home, and I became violent toward my family. At home, violence is not acceptable, and I believed only a monster would perpetrate it on his own family. I was filled with guilt, violent memories, and persistent reminders of combat. I wanted it all to stop. I was supposed to protect my family, not hurt them. If I hurt them, I believed I did not deserve to live. I looked for opportunities to end my life, as many other veterans in my position had done (Guerra & Calhoun, 2011; Jakupcak et al., 2009), believing my family would then be safe from the monster within me; they would be better off without me. My therapist became concerned and admitted me to the acute psychiatric care unit at the hospital. I was there for a week as the doctors adjusted my medication and I attended group and individual therapy to learn how to cope with symptoms. This stay in the hospital served its purpose in making me slightly more stable through medication, but it did not provide any lasting relief from my symptoms.

**Coping better: Why I fly fish.** While I was in the hospital, my wife contacted a high school friend of hers. He was a veteran of the first Gulf War who used a wheelchair for two years until he began fly fishing as a means of rehabilitating himself. He invited me to Idaho for a professionally guided fishing retreat with other disabled veterans.

I made excuses not to join him; “I’ve never fly fished before,” “It looks complicated,” “I don’t have any gear.”

He insisted it would be worth my time, and I finally relented. I distrusted most strangers, but he was a veteran, and a disabled veteran at that, and that meant he was familiar with the struggles in my life. At dinner the first evening, some of the guides gave us a fly-tying



demonstration. It looked extremely complicated, and they used words I was unfamiliar with, but it was amazing how they could make thread, foam, feathers and fibers look so much like a real insect. I was intrigued.

We were dressed for cold weather as we ate breakfast and then drove to the river. We loaded two veterans in each boat. Our guide gave us simple directions and rigged our lines, then rowed into the middle of the current. As we began to drift lazily down the river, the guide explained the basics of casting, mending the line, and what to watch and feel for when a fish struck. It wasn't long before the fish started hitting the flies. I felt exhilarated as my strike indicator was sucked under the surface and I felt the fish on the hook dart away. I lifted the rod in the air and struggled against the fish. Instantly there was only the fish and me. It tugged on the line as my heart raced, and my mouth formed an involuntary smile as I reeled and tugged back. As quickly as it began, our battle was over, and my line arced over my head as the fish freed itself.

I stood there in the middle of nature, surrounded by thousands of gallons of water, mountains, trees, and birds, with snowflakes sticking to my nose and eyelashes. Gone were the horrible images of the dead and dying. Absent was the strangulation of anxiety in my chest. I was completely in the moment, surrounded by a gentle breeze and the boat rocking beneath my feet. The harder I concentrated on the fly, the less aware I was of ancillary distractions, the less aware I was of my negative emotions and anxiety. For the first time in years I felt something other than anger, rage, and fear...I felt peace. Years of constantly being on alert had taken its toll on my soul. But, in that moment on the water with a fly rod in my hand and nature embracing me, I felt peace, and it felt good. Peace was persistent throughout the day, and I experienced my first real respite in years.

Shortly after my introduction to fly fishing, my therapist suggested finding new pursuits in life that could revive a zest for life. I practiced casting my fly-rod in the front yard, read fly fishing blogs and magazines, and talked regularly with my veteran friend in Idaho. Eventually my therapist suggested I go back to school to pursue a new career and made a referral to vocation rehabilitation services at the VA. The counselor at that office suggested a career in therapeutic recreation. This led to my volunteering in the PTSD clinic at the VA where my friend and I created a weekly fly-tying class that he would teach and I would assist because I had never tied a fly before. We got equipment and supplies donated by local and national suppliers, spread the word to other veterans, and scheduled everything with the staff at the VA.

The day before our first class, my friend fell sick and called to tell me I would have to teach in his stead. I panicked. I had never tied a fly in my life; how was I supposed to teach it? At his direction I watched several videos on the internet, printed instructions for a woolly bugger, practiced at home a couple of times, then walked into class hoping the others would think I knew what I was doing. The formula worked, and I taught the weekly class until I returned to school.

It was difficult to drop everything to go fishing whenever my symptoms occurred, but I felt the same relief when I tied flies as I did when I was fishing. I leaned heavily on this activity to escape my negative emotions. During classes I began talking to other veterans about how tying flies and fishing helped me cope with PTSD. While the activity did not eradicate symptoms from my life, it did help mitigate and manage negative emotions that in turn gave me hope of recovery.

Over time, the frequency of waking in the middle of the night in full combat mode decreased. One morning, my wife remarked “You must have been dreaming about tying flies last night.”

She had awakened suddenly to observe me talking in my sleep and moving my hands through the air in the motions she had seen me use while tying. She said that if I was going to toss and turn at night, she’d rather wake to see me dream about fly fishing as opposed to being punched in the ribs.

### **Episode 2: Flashbacks**

I was picking up medical supplies from the air-conditioned hospital and had barely removed my helmet when every siren on base screeched at full volume; announcing yet another attack. I remember thinking “*You’ve got to be kidding me! Not again!*” Immediately, every person on base stopped what they were doing and evacuated all buildings, tents, and vehicles, to seek cover in the nearest concrete bunker. The outside heat assaulted me like I was entering a blast furnace. Adding to the misery, I was crammed like a sardine into the inadequate space of an overcrowded bomb shelter hoping to avoid incoming shrapnel. It was close to 120 degrees outside. In fact, the thermometer hadn’t read less than 100 in weeks. With that kind of heat, it was impossible to feel clean, so most people didn’t bother trying. The smell was putrid.

My senses were immediately barraged by the nauseating stench of stale cigarette smoke and unwashed soldiers mingled with the stink of burning garbage, human waste, and the iron tinged smell of dried blood. “*Just another day in paradise,*” I thought as I settled in to await the all clear.

Among those sharing my bunker was an Iraqi family. The mother knelt behind her husband, who was sitting cross-legged with a child draped across his lap. This miserable child was wrapped, from the waist up, with day-old gauze caked with dried blood, plasma, and dirt. Many families cooked with kerosene stoves, and children were often burned when the stove or cooking pot was knocked over. Less frequently, yet culturally accepted, some parents poured scalding water on misbehaving children. I wondered about the cause of this boy's suffering. He whimpered as he lay open-mouthed in the oppressive heat as flies landed on his bandages and face. The whimpers were interrupted occasionally by a choked sob or desperate gasp for air.

My training as a medic commanded me to give aid and comfort to the wounded, but I forgot to grab my aid bag as we rushed out of the hospital, and I was without means of relieving the boy's pain. I was powerless to improve his situation. A wave of self-contempt and guilt washed over me and choked my conscience at my perceived failure to act. I closed my eyes and silently pleaded with God to make the boy stop crying. Not because I wanted him to feel better, but because every whimper accused me of failure. I no longer cared about his suffering; I no longer cared about compassion; I simply wanted him to stop crying. His crying made me feel uncomfortable, and I didn't want to be uncomfortable any more. I stopped seeing him as a patient, or even an actual person. He was just a source of noise now, and I wanted him to be quiet. Not because it meant his suffering would end; rather so I didn't have to listen to it any more.

This type of crying and whining became synonymous with horrific wounds and seemingly endless suffering that I observed firsthand. These images crowded my conscious thought and invaded my dreams and made it difficult to sleep. I became cold

and calloused toward whining and complaining and even harsh in my reaction to people who were genuinely hurt. This caused me to wonder at times if I had become some sort of monster.

### **Back Home**

Once home, I began experiencing increased anxiety, difficulty connecting with others, trouble falling and staying asleep, and conflict at work and home. It strained my family relationships as I struggled to understand and define where I fit in (Feczer & Bjorklund, 2009). Amid these struggles, I arrived home from work tired, agitated, and hungry. My son asked for permission to play at a friend's house just as we were sitting down for dinner. Irritated that he would ask so close to dinner, I told him no.

Whining, he asked, "Why not?"

Feeling as though he were challenging my authority, I raised my voice and retorted, "Because, I'm the dad, and I say so. That's why not!"

"You never let me do anything I want to do!" he immediately shot back.

Something snapped inside me, and I was transported across time and space. I no longer saw my son, but a vision filled with flies and the face of the crying boy from the bunker.

Hearing the whining Iraqi boy and wanting only the noise and accusations to stop, I turned my fury on my son and bellowed "You want something to cry about? I'll give you something to cry about."

I no longer cared about my son's complaint. I wasn't really seeing or hearing his protests. I heard only the pathetic whining of the burned boy crying for relief, and I wanted that out of my head, even if it meant beating it out. I was interested only in silence.

His frantic screaming could not penetrate the disorienting rage that engulfed me as I dragged my son into another room. He kept crying. I shouted for him to shut up as I pulled him onto my lap. He continued to cry. I repeated the command as I exhausted my arm spanking him. He was shrieking now.

“Shut up!” I yelled with spittle falling from my lips. I roared in exasperation, and I heaved him to the floor.

The more he cried, the more enraged I felt at my inability to stop the crying. I pounced on top of him and repeatedly slammed my fist into the floor inches from his head as I screamed “Shut up! Shut up! Shut up!”

He finally did.

Only then did the fog clear enough for me to recognize the terror in my son’s eyes as he cowered on the floor beneath me. Slowly, a realization of where I was and what I had done washed over me as I tumbled away from my boy and began sobbing uncontrollably from the unspeakable grief that gripped my heart. The monster of rage growing inside me finally broke its bonds and took control of me. I could no longer contain the monster inside; it was controlling me, and finally I realized I needed professional help. Although I had been admitted to the hospital for acute psychiatric care multiple times, it was obvious I needed additional help. I was admitted to a long-term residential program for veterans with PTSD and received parenting classes, group therapy, and leisure education as additional tools for coping with PTSD.

### **Leisure Ritual to Heal Relationships**

The providers during my prolonged treatment helped me to see I had been the perpetrator of domestic violence, which is all too common among OIF/OEF veterans (Goff, Crow, Reisbig, & Hamilton, 2007). I self-reported the spanking incident with my son to child protective

services. I wanted to ensure the safety of my family. Later, I was introduced to the concept of using leisure rituals to establish meaningful leisure experiences between family members in order to improve communication and relationships (Doherty, 1997). Shortly thereafter, I began tucking my children in bed each night in hopes of alleviating the guilt I felt for my bad behavior, like yelling and spanking. I would tuck each child in and tell them “I love you,” and wait for them to say it back. I would hug them and kiss them on the cheek or forehead and for a moment it all would be right in the world. Each night was generally the same with the oldest and youngest children, but the ritual took on additional significance for my middle son and me as, every night, I told him sincerely how sorry I was that I lost control that night long ago and spanked him. I begged forgiveness from him until, months later; he finally told me “Dad, I forgive you. You don’t have to bring it up again.”

With him the ritual was different. He doesn’t like to use a top sheet, only blankets; and those blankets go on in a certain order. If I didn’t follow the order he claimed he would have bad dreams. First, his plaid comforter, then his fuzzy blanket with the soaring eagle, followed by the U.S. Army fleece blanket he made himself in sewing class. Next, the fleece blanket with cars on it his mother and I made him for Christmas, and finally a camouflage fleece blanket.

Once he is sufficiently tucked in, we exchange a hug and an “I love you.” This nightly ritual offers the opportunity for him to bring up concerns while affording me the chance to stay connected emotionally, as well as expressing mutual love and respect. One amazing aspect of this ritual is how long it has survived. He is in his late teens now, and regardless of how late he goes to bed, he will find me and ask the same question; “Dad, will you come tuck me in?” At a time when most adolescents experience conflict and distress, my son and I experience a daily oasis from the tumult through this intimate leisure ritual. As Doherty claims, this simple act

provides a special connection between us and strengthens our family ties (1999, p. 43).

Juxtapose this experience with the spanking incident described earlier; and we see even the deepest of emotional scars can be ameliorated through purposeful recreation rituals.

### **Episode 3: Rocket Attack on the PX**

I was stationed on one of the largest American bases north of Baghdad for most of my time in Iraq. Many concrete buildings from an existing air base survived the intense bombing from the beginning of the war and were repurposed to serve the needs of more than 24,000 troops. The base was home to a fighter squadron, combat support hospital, and flight wing of medevac helicopters. It also boasted a movie theater, post exchange (PX), Olympic sized pool, and even a Burger King and Subway for rest and relaxation purposes.

We were attacked almost daily by mortars, rockets, and small arms fire. The base was large enough that the attacks never threatened the entire population. Insurgents would typically hit targets of opportunity in sporadic shooting or launch explosives at people or equipment surrounding the edge of the based. The attacks were frequent, and occurred randomly around the perimeter of the base. As a result, any time we left the protection of a building we were required to wear what we affectionately called “battle rattle.” This consisted of our weapon, Individual Body Armor (IBA), and Kevlar helmet. The IBAs were fitted with front and back ceramic bullet-proof plates, weighed 45 pounds, and increased the feel of the outside temperature by 10 to 15 degrees. Pouches were clipped to the IBA for carrying extra ammunition or medical gear.

At the end of a long day, our company held a formation at which I was promoted alongside five other soldiers. Following the ceremony, my buddy and I walked to the



alterations shop housed in the PX compound at the center of the base to have my new rank sewed onto all my uniforms. Our conversation was light and upbeat as we approached the PX. In front of the PX building was a large telecommunication tent and a bus stop that shuttled personnel around the base. As I walked into the alterations shop I heard a loud BOOM. I remember thinking it was caused by the person behind me slamming the door shut, and I turned to comment accusingly. Through the glass doors I saw a black cloud of smoke and dust rising above the roof of the front wing of the building. Thinking there might be wounded, I started toward the door, trying to leave the shop and run around to the front of the building to do my job as a medic. My buddy grabbed the handle on the back of my IBA and pulled me back, saying we had to stay inside where it was safe. I hesitated a moment as people around us began shouting in confusion. I yelled back that there were probably casualties just around the corner and I needed to get to them. A commissioned officer near us ordered me to stay inside. I felt anxious that I was now ordered to stay put and could not give aid to the wounded.

Suddenly, I felt the ground tremble again, almost knocking me down. The lights in the building flickered out when the sound of the second explosion reached us. I turned to see smoke and dust billowing from the building a few meters from us. Fear and anger filled every part of me as I imagined wounded soldiers while someone was preventing me from doing my job. The doors across the courtyard burst open as someone screamed for a medic. There was no holding me back this time, and I bolted toward the beckoning soldiers. I entered a hallway crammed with soldiers seeking cover. It was hard to breathe, and when I was finally able to, my nose was assaulted by the usual smell of cigarettes and sweat, smoke and dust, and the metallic smell of blood—lots of it!

The entryway doors were shattered inward with shards of glass everywhere. I pushed my way through the tangle of soldiers in an effort to get to the injured. Time seemed to slow down as I remember seeing several soldiers from my company in the hallway. I felt their stares, and when I met their eyes, they seemed to be accusing me of not getting there sooner. I finally pushed past the last soldier in time to watch a pair of boots being dragged through an enormous pool of blood. Two medics loaded the wounded soldier on a stretcher as he muttered something about choosing the wrong day to buy shaving cream. I followed the gruesome party out the entrance and took in the scene of carnage. It was chaos with soldiers kneeling, giving aid to others who lay or sat bleeding on the ground. Several stretchers were being carried to waiting vehicles that served as make-shift ambulances. One soldier cradled his head from a shrapnel wound, screaming about how much it burned. Another soldier lay on the ground with his foot blown off. Another was hit with shrapnel in his thigh and severed his femoral artery. A group of civilian personnel who had been standing at the bus stop a few feet from where the first mortar landed now lay scattered around a crater. Some of the wounded screamed in agony and fear as others stared blankly forward or stumbled around in a daze.

Blood was spattered everywhere, more than I'd ever seen in my life. In the middle of the entryway to the PX was an immense pool. The center was deep maroon, and the outer edges were smeared thin and bright red. Footprints broke the surface of the pool leading toward the exit, the oppressive heat baking them into dark red cakes on the floor. *"There's too much blood for that guy to make it"* flashed through my mind.

I locked eyes with another soldier as he shook his head. His gaze begged me for answers, and I felt as though he was asking me why it had taken so long for me to arrive.

I felt awful; my stomach rose to my throat and continued to turn over and over for some time. I turned back to survey the scene as a janitor came with a mop and bucket. Every swab seemed to make the mess grow larger as he smeared blood all over the lobby. The scene filled me with fury. I remember thinking “*What the hell are you doing, trying to make it like this never happened? That guy hasn’t even been gone 5 minutes! Give him a little respect!*”

In all, 17 people were wounded that day, and two died, including the one I watched being carried away. I still feel regret for not getting there sooner. It’s possible, that, had I arrived on the scene earlier, carrying bandages and IV fluid, I could have treated him, perhaps saved his life. In retrospect, however, I realized that if I had broken free after the first explosion, I would have been running around the corner at the exact moment the second rocket landed and could have been injured myself, or worse. My buddy likely saved my life when he grabbed my IBA, but I continue to live with the guilt that 19 other people weren’t so lucky. Perhaps I should be grateful, but gratitude seems disingenuous when I’m plagued by their images in my mind.

#### **Fourth of July Fireworks**

After my initial treatment at the VA and the doctor’s readjustment of my medications, I actually thought I was getting better—until the Fourth of July rolled around. I knew I would be anxious and nervous when the neighbors set off their traditional store-bought fireworks in the street, so I planned to preemptively take some medication to calm my nerves and do my best to make an appearance at the neighborhood gathering, acting as though the pyrotechnics didn’t bother me.

I was standing in my bedroom when I heard the first explosion in our neighborhood. The fireworks included a series of 20 rapidly firing rockets that shoot 50 feet in the air then explode in succession. It sounds very similar to small arms fire from a distance. I promptly dove for cover and crawled halfway under my bed. Then a series of 20 explosions rattled my bedroom windows, and I began to relive that day at the PX. The images of dead and dying civilians and soldiers crowded my conscious. The sights and smells were refreshed in my memory, and the image of one soldier dying as I was unable to save him kept repeating in my mind. I am not sure how long I spent half concealed by my bed, on the floor of my bedroom. I went looking for anything to help me numb the pain and confusion. I found my anxiety medication and swallowed several until the edges of my vision smeared.

The neighbors gathered in the street to share desserts and fireworks, and I desperately wanted to fit in. I wanted to feel normal and not be bothered by the noise or lights; I did not want to let my wife and children down again by me not participating in a neighborhood event. So I let the meds do their job and then joined the party outside. In my drugged state, I believed I was acting normal, but really I spent time flitting from person to person, conversation to conversation, more mumbling than talking, then I retreated to the rear of the gathering and paced back and forth, jumping at every pop and snap until I couldn't take it anymore. I excused myself to go back inside, images from Iraq swimming in my mind until I eventually passed out, letting my family down and embarrassing them. They were clearly less satisfied, as was I, with our life after the war (Friedman, 2006).

Emotional numbing is commonly aided by the use of alcohol and medication (Price & Stevens, 2011). The drive behind this symptom seems to be the desire to avoid reminders of trauma, leading to a loss of interest in pursuits previously enjoyed (Feeny et al., 2005). For me,

it manifested itself as a desire to escape feeling all emotions and horrors I could not stop from playing in my mind. I began participating less actively in family-related leisure activities, even avoiding healthy individual leisure pursuits (Evans et al., 2003). The memories of mangled bodies and life-threatening situations would override my ability to deal with “real time” emotions. It wasn’t that I couldn’t feel appropriate emotions for my loved ones, it was that I was overwhelmed by past emotions that would not resolve until I was too exhausted to feel anything else (and I didn’t *want* to feel anything else). I saw how my behavior affected my family. They were embarrassed by me, made excuses for my behavior, then cried themselves to sleep in the privacy of our home. They learned quickly that they could no longer depend on me to do basic things like get out of bed, shower, work, or stay awake for any extracurricular activity. I avoided feeling anxious, angry, or feeling anything at all. Escaping emotion became more important to me than being a good husband, father, neighbor, or friend. This explains my family’s diminished satisfaction as I distanced myself from them physically and emotionally (Friedman, 2006). To cope I began taking my prescribed anxiety medication sooner than the label advised and in greater quantities in an effort to drown out the flashbacks, nightmares, and the pain and disappointment I saw in the faces of my wife and children. In retrospect, it is obvious why many veterans with PTSD struggle with substance abuse (Tanielian & Jaycox, 2008).

### **Recreational Outreach**

While I was admitted to the long-term residential treatment program for PTSD, we were assigned to schedule recreation time and activities designed to make us stretch our comfort zones and to reintegrate us back into civilian society. As we were planning our weekend activities around the beginning of July, one of my fellow patients remarked how difficult Independence Day celebrations were with fireworks, crowds, and confusion. Our treatment team urged us to

overcome our irrational fears and attend public celebrations anyway. This fellow patient remarked, privately, that he would like to see a bunch of veterans get together to celebrate the fourth of July away from the crowds out in nature.

His comments resonated with me as I returned to school and became an advocate for recreation. As I considered his comments and the personal benefit I received by being in nature and participating in leisure, a desire to share these benefits grew inside me. My first efforts were with my family, and after we noticed leisure participation improving our lives, we wanted to share it with other families like ours. This is indicative of the process Erikson (1981) called generativity, wherein people who go through difficulty eventually arrive at a point where they want to give back or help others. From conversations with practitioners in the field of rehabilitation, and my own observations, this appears to be a common pattern experienced during the healing process. As patients experience the healing process, they frequently express a desire to help others who are experiencing similar difficulties. When I first began using recreation to address my PTSD symptoms, I was in no condition to even consider other people. As I experienced the amelioration of symptoms, however, I was able to see outside my own difficulties and began to notice the similar challenges other veterans and their families were experiencing. This opened up opportunities for me to reach out to other veterans.

Over the past year and a half my family and I launched, and now run, a nonprofit organization to share the healing benefits of family recreation with other disabled veterans and their families. My veteran friend's comment served as the impetus for the creation of such a program, and it finally came to fruition in July of 2012. We organized, planned, and raised the necessary funds to host 12 veterans and their families for a four-day First Annual Firework-Free Fourth of July Celebration for Disabled Veterans and their families.

Recreation activities for families were programmed around meals, lodging, and were specifically considered to improve family relationships through teaching communication skills, leisure education, and participation in activities to improve quality of life. Activities began with ice-breaker games for families to get to know each other and feel welcomed and part of a larger community. Families were lodged in their own camping cabins with linens and restrooms. We taught outdoor games that could be participated in at or near home, were inexpensive, and required relatively few resources. Additional activities for younger children were led by my teenage children. The families participated in a half-day train ride on a restored steam engine and rail cars through the mountains, canyons, and valleys of Utah. Actors dressed in period clothing and performed a train robbery for riders while veterans and family members took pictures, and conversed with peers about various topics both related and un-related to military service.

The evening of Independence Day we hosted the public to a family style barbeque, picnic and out-door games, and a benefit concert performed by local artists, including a band of disabled veterans. The crowning event was a campfire program with patriotic speakers and songs, and, finally, a flag retiring ceremony with a 30 by 60 foot garrison flag. Every family member and veteran was involved and included in the process of retiring the flag. It was a moving and meaningful ceremony, and the veterans stayed up discussing it for hours after.

A second full day of boating, adaptive waterskiing, swimming, and hiking was cancelled due to rain. Families adapted, however, to spend time at the campground recreation facility and played indoor games and recuperated from the previous long day of activities. At the end of the retreat, families gathered to discuss what had gone well and what had not. Each family received a gift package including games they could play at home and were asked to remember to play

together at least once per week. I did not feel as though I had missed anything from the traditional Independence Day celebrations of fireworks and festivals. I felt a quiet appreciation for the sacrifices other veterans and I had made, as well as a deeper connection to my family and other veterans and families who were dealing with difficulties similar to our own. I felt engaged with my own family, and I knew that I was not withdrawing from activities, which had previously caused friction in my own family.

### **Discussion**

The leisure stress and coping literature speak of stress as the presence of worry and anxiety and pressures both internal and external, but they explain that it is fleeting or temporary and can be coped with or endured until a return to a state where it is absent (Iwasaki & Schneider, 2003). My experience with combat-related posttraumatic stress disorder has been more than a temporary or transitional presence of worry and anxiety. It became my “new normal” (Demers, 2009), my homeostasis after the war. I experienced a complete reversal, where peace and calm became transitory and temporary experiences that interrupted a negative state of emotional being.

My world had become a cacophony of nightmares, flashbacks, depression, anxiety, and thoughts of suicide (Rourke et al., 2006), and while I utilized every remedy offered by the VA health care system, I found little relief. The experience of having PTSD and not being able to get over it challenged everything I believed secularly, as well as spiritually. It shattered all my paradigms and caused me to build new ones. While leisure has not been a panacea for every ailment, it has made an enormous difference in where I am today. Once my friend got me to the river, something changed. There, knee-deep in the gurgling water and surrounded by nature’s grandeur, the symptoms plaguing me began to dissolve, and, for the first time in years, for those



few hours, I finally felt at peace. That peace gave birth to the possibility of recovery and hope for a better future. This is the power of leisure.

The desire to redeem myself in my family's eyes served as the impetus for me to break free from my symptoms. Prior to going fly fishing, I had no hope that things could improve. I believed I was losing my family and that I deserved to because of the monstrous things I had subjected them to. I identified myself with other veterans with combat-related PTSD and succumbed to upholding a negative self-concept related to society's expectations of veterans with combat-related PTSD. I surrendered to the disorder, embraced it, and got lost in it. Unfortunately, its effects were not limited to only me. PTSD is not experienced in a vacuum. The memories of combat experiences expand from the veteran's mind outward, infringing on the lives of those closest to the affected veteran (Demers, 2009). The effects of PTSD are pervasive as they affect physiologically and psychologically how a veteran reacts to every social situation, including family interactions (Lester et al., 2010). My family paid a high price for my disorder, as we were driven to the brink of divorce (Zoroya, 2005; Shea et al., 2010).

### **Who I am Now**

The man I was before the war still hasn't returned. I can still be short tempered and cranky, freeway traffic and crowds still cause me anxiety, and unexpected loud noises still make me jump and my skin crawl. However, I recognize a hope for recovery that I did not feel when I was hospitalized. I have experienced respite and relief from my symptoms through leisure participation, and that is enough for me to keep trying to get better, as opposed to surrendering to the symptoms. I truly went through a healing process and moved from being the patient to earning a certification in therapeutic recreation, becoming the practitioner. I often ask if I will

ever be “all the way better,” then realize how grateful I am to be much better than a few years ago.

One therapist at the VA told me I was using PTSD as a crutch and that I never wanted to get better, while other therapists tell me that a complete recovery is unattainable, that I will have this condition the remainder of my life. Perhaps I am not as recovered as I will be, but I’m much better than I used to be, and that’s a good start.

I am not entirely consumed by symptoms of PTSD anymore. I have found a measure of peace from the turmoil and a means of coping when the demons of war catch me unawares. My recovery is tenuous and cannot be considered a permanent cure, but I would consider it a quasi-recovery (Axlesen, 2009), as I am a very different person now from the one who was hospitalized three times for suicidal ideations. I recognize my struggle with combat-related PTSD may be a lifelong battle with associated ups and downs; that this period of improvement may be transitory, and by deeming it a “quasi-recovery” I admit the necessity of constant attention and vigilance in order to maintain its benefits.

What helped me reach this point of quasi-recovery is a pertinent question, considering I still have relapses and admit the grip of this disability is not easy to break. The answer lies within my leisure involvement and specifically, for me, my fly-fishing, fly-tying, and family leisure rituals. Using my own experiences as evidence, I offer an insider’s viewpoint of PTSD and propose that fly-fishing and family-centered leisure can play a positive role in the health of people with combat-related PTSD.

### **Conclusions**

To say my involvement in fly fishing, as well as other leisure pursuits, changed my life would be a gross understatement—fly fishing saved my life. Prior to that first fish, I had given

up on life. I was living from one day to the next, believing broken relationships were all I could expect and feeling that I had nothing to look forward to. I defined myself by my illness. PTSD was me.

After an initial dabbling in leisure pursuits, I embarked on a journey to learn all I could about the therapeutic benefits of leisure solely to help heal myself. Leisure became part of my everyday life and now helps define who I am. Leisure taught me the skills I needed to repair damaged relationships with my wife and children; it improved our sense of cohesion and our quality of life. In fact, we were on the verge of divorce when we found the benefits of family recreation. In addition to making the claim that leisure saved my life, I claim it also saved my family. We are together still because leisure provided a foundation upon which we could rebuild.

Combat-related PTSD is a condition that sufferers can live with for life (Bowling & Sherman, 2008; Benedict, 2009; Price & Stevens, 2011). As I often ask “when will I get better,” I am reminded by professionals in the field that there are veterans from World War II still living with the effects of PTSD. I have not been able to fully break free of its bonds, but I do have tools that allow me planned breathers (Patry et al., 2007).

This is how I see it now...

The old saying goes “the lucky ones in war are the ones who die.”

Their struggle is over.

I left Iraq years ago, yet it remains with me even still.

My struggle continues.

I struggle to hold it together for the sake of my family.

I still have flashbacks.

I still have nightmares.

I wage mortal combat daily against depression and suicidal thoughts.

At times I wish I could just shrug and make it all go away.

When that happens, now...

I head to the nearest river for comfort.

I see the wind as it whispers through the aspens.

I hear the cleansing gurgle of water rushing over rocks.

I feel the embrace of the water pressing waders to flesh.

Someone told me the voice of God is the sound of many waters,

In the thick of nature, among the pines, great oaks, and aspens.

Below the eagle, osprey, and sparrow I believe He speaks to me.

I cast my fly upstream and watch it weep past me on the flow.

I focus on my tiny fly.

Right then, there is only me and my fly.

Everything else disappears.

Right then, God utters one word to my soul.

Peace.

Perhaps I have replaced an addiction to medication with an addiction to leisure, and I have only highlighted the positive implications of leisure participation (Glasser, 1976). It may be true, but my new addiction to leisure is far healthier for me physically, emotionally, and socially. I proffer that my addiction to leisure and sharing its benefits with other veterans leads to a more positive and healthy lifestyle. The healing I have experienced was born out of leisure

participation. It has truly been a therapeutic recreation, and it has grown into a firm belief that leisure can legitimately be used to help veterans with combat-related PTSD.

It is obvious further research is required to better understand this subject. Future research might extend this personal account by considering the theoretical underpinnings necessary to bring about the change I experienced, thus providing more opportunity to make programmatic recommendations. I call on my colleagues now to take up this banner and study my peers and me longitudinally to determine how leisure can provide lasting beneficial change in the lives of veterans and their families. I call for an organic exploration into what veterans believe they need to get better, as opposed to providers externally deciding what services should be offered. Researchers should consider gathering ethnographies from more veterans and their families and asking what they feel they need most. This grassroots research may lead to more effective treatment models and programming.

I conclude by asking if I will ever be the man I was before the war? No. But am I the same man described in the stories above? No. Will I have PTSD the rest of my life? Probably. But, I'm okay with that. Because I can fish for relief or tie flies for a break. I can even tie flies in my sleep.

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Appendix A: Prospectus

### **Author Bias**

Dear committee member:

Thank you for agreeing to serve on the committee for my thesis project. I look forward to the insight and guidance you will provide. I have chosen to employ a qualitative research method called autoethnography to discuss the topic of combat-related posttraumatic stress disorder (PTSD) and the role leisure played in ameliorating the negative conditions associated with it in my life. As this is not a traditional method used in leisure research, you should be aware of some noticeable differences in order to help you feel more comfortable with this project.

The proposal will still follow a three-chapter outline similar to the department handbook. You will notice four primary differences in the proposal: 1) the introduction chapter is slightly longer; 2) the literature review may seem superficial and shorter than normal—in the final article there is a second, more comprehensive review of literature following a narrative section; 3) the sample size is only one subject (researcher as research subject); and 4) the majority of the project is written in first person and introduces an intentional author's bias. The purpose of an autoethnography is twofold: 1) to give an academic voice to the experience of an individual with a disabling condition while exposing the nature of disability from the inside and 2) to encourage understanding between the author and reader while spurring questions for future research on the subject.

My bias is manifested as an underlying belief that leisure is a powerful modality for treating PTSD resulting from my lived experience. I expect that the autoethnographic process may provide some insight as to why leisure is powerful as my experiences are viewed through existing research on the subject. The nature of autoethnography is more a process of understanding perspective than explaining statistical findings.

## **Chapter 1: Introduction**

Eleven years following the terrorist attacks in New York, Washington, D.C., and Pennsylvania, there are still American soldiers fighting and dying on foreign soil in the “War on Terror.” More than two million women and men have left their families and lives behind to serve their country. Hundreds of thousands have come home with an acquired disability. I am one of those. This is my experience with posttraumatic stress disorder (PTSD) and the role leisure has played in my quasi-recovery.

There is a wealth of literature concerning both PTSD and leisure stress; however, there is a dearth of literature concerning PTSD from the perspective of the patient, and very few connections between leisure and coping with war-related traumatic stress. This paper will address an individual perspective of PTSD while simultaneously describing how leisure became a coping mechanism for my symptoms of war-related trauma.

### **Posttraumatic Stress Disorder**

Posttraumatic stress disorder (PTSD) is an anxiety disorder associated with exposure to trauma (Feczer & Bjorklund, 2009), and it is not experienced in a vacuum. The memories of combat experiences expand from the veteran’s mind outward, like ripples on a pond at the drop of a stone, infringing on the lives of those closest to the affected veteran (Demers, 2009). The effects of PTSD are pervasive: they affect physiologically and psychologically how a veteran reacts to every social situation, including family interaction (Lester et al., 2010).

This study seeks to deepen understanding of how PTSD affected my life as well as my family relationships. My experiences with PTSD seem to be similar to other veterans.’ Additionally, this study will illustrate the connection between recreation in my life and my PTSD symptoms, and, to a lesser degree, the impact it had on my family relationships.



## **Leisure, Stress, and Coping**

The majority of literature on leisure, stress, and coping deals primarily with the stress most people experience on a daily basis, or even in relation to short durations of overly trying situations which cause an increase in stress (Arai, Griffin, Miatello, & Greig, 2008; Iwasaki, Mackay, Mactavish, Ristock, & Bartlett, 2006; Iwasaki & Schneider, 2003). Iwasaki et al. (2006) only superficially mention that some leisure, stress, and coping studies could also be applied to more chronic types of stress such as war-related trauma. The study of PTSD is timely, given the recent influx of war veterans into society from the decade-long wars in Iraq and Afghanistan. Researchers, government officials, and treatment professionals are looking for effective and affordable solutions for PTSD. The existing leisure, stress, and coping literature provides a possible framework for finding answers to pressing questions. This study seeks to relate existing research on both PTSD and leisure directly to my personal war-related trauma and show how leisure became a method of coping with my disability.

## **Autoethnography**

Despite the breadth of research into PTSD and leisure, most studies examine the symptoms and causes of PTSD with a focus on pathology as opposed to the experience of living with these symptoms. The use of traditional quantitative research methods result in the understatement of individual experiences of a person with PTSD. Autoethnography is the act of telling a personal story about a certain phenomenon (Axlesen, 2009). As a research method, it is analytical through drawing out life lessons and insights as well as understanding between reader and researcher (Austin, 2005).

Researchers who have used forms of autoethnography to explore PTSD and leisure include Feczer and Bjorklund (2009) and Axlesen (2009). Feczer reflected on her own

experience as a nurse in Iraq and her development of PTSD symptoms. Axlesen showed how she used the leisure activity of triathlon training to recover from anorexia-nervosa.

Autoethnography highlights the emotional struggles and paradoxical situations experienced by people who live with, and often suffer from, disabling situations (Axlesen, 2009).

### **Problem Statement**

The problem of the study is to deepen our understanding of Posttraumatic Stress Disorder (PTSD) by exploring the relationship between leisure and its effects on symptoms of PTSD from a first-person perspective and provide a basis for future research concerning leisure as a coping mechanism for combat-related PTSD. The rigorous autoethnographic process will facilitate, as Chang (2008) delineates, self-reflection, self-examination, and self-understanding for both author and reader. Autoethnography not only increases understanding of a segment of the population (Reed-Danahay, 1997), it also facilitates introspection for the reader (Ellis, 2004). This study additionally explores the role recreation may play in mitigating symptoms.

### **Purpose Statement**

The purpose of this study is to identify the role leisure plays in alleviating symptoms of PTSD such as depression, anxiety, social isolation, impulsive behavior, and uncontrolled anger. Greater understanding of the role leisure plays in reducing PTSD symptoms will allow leisure professionals to provide innovative treatment for disabled veterans. While other veterans have written autoethnographies (Feczer & Bjorklund, 2009), none have specifically examined leisure's role in recovery from PTSD. The need for establishing such a line of research is critical for alleviating combat-related stress and its negative outcomes for veterans and their families.

### **Significance of the Study**

In the grand scheme of academic research, I represent only one individual. However, my experience of going to war, enduring combat-related trauma, and my subsequent acquaintance with Posttraumatic Stress Disorder is similar to nearly half a million other veterans (Wounded Warrior Project, 2012). As I relate my experience through the autoethnographic method, the reader may come to a greater cultural understanding of mental health-related issues; recreation practitioners may discover techniques for reducing symptoms and improving quality of life for other veterans and patients; families of disabled veterans may gain crucial information for building unity and cohesion; and as a research subject I will be able to assign additional meaning to my experience. My experience includes a great deal of suffering, not merely for myself, but for those who are closest and most meaningful in my life. If this study has the potential to ameliorate grief for other families, it will be significant enough to merit the effort.

Scholars, healthcare professionals, government agencies, and veterans are searching for innovative solutions as PTSD disrupts an increasing number of families. Often, physical injury accompanies PTSD, such as traumatic brain injury (TBI), amputation, or penetration wounds caused by munitions or explosives. While not visually discernible, PTSD can be equally disrupting in the life of an affected veteran (Huebner, Mancini, Bowen, & Orthner, 2009; MacDermid-Wadsworth, 2010). TBI and PTSD are often referred to as the unseen wounds of war and are associated with more outwardly observable disruptions such as hyper arousal, increased anxiety, depression, and anti-social behavior, as well as increased likelihood of divorce, abuse, and suicide (Alici et al., 2010; Demers, 2009; Manos, 2010).

The family is a societal system (Whitchurch & Constantine, 1993), which is defined by interrelated elements which exhibit coherent behavior (Constantine, 1986). PTSD negatively impacts family cohesion (Olsen & DeFrain, 2000). As one piece of a family system breaks down, the entire system is affected and becomes dysfunctional. This can lead to a greater societal impact since families form the fabric of the societal system (Whitchurch & Constantine, 1993).

Treatment models for PTSD that I have participated in as a patient seem to focus on treating only a single element of the system by removing the veteran from the family for the duration of treatment in an effort to reduce symptoms and build coping skills for the veteran only. The Veterans Administration healthcare system was overwhelmed by the numbers of veterans returning home and reporting symptoms of PTSD, and they have been playing catch up ever since. Only recently have government programs begun providing family service in a holistic way (Huebner et al., 2009). The PTSD phenomenon is not fully understood by government officials; however, they recognize there is a problem and have increased funding to find effective family-based programming (Sherman, Fischer, Sorrocco, & McFarlane, 2010). By and large, veterans are still removed from the family environment, placed in a situation similar to the military, and receive treatment with peers. Once the veteran makes improvements, they go home to an often broken family system in the hopes that everything will work out. This, however, does not address the underlying issues the family faces as a result of their relationship to the affected member. It is as though the treatment providers are taking a cog out of a broken watch, having it remotely precision-tuned, then placing it back in the watch and wondering why it won't tell time.

The healing effects of leisure in my personal life have facilitated a quasi-recovery from PTSD and provided a vehicle to heal broken family relationships. I make the claim that recreation saved my life, by giving me the tools to manage symptoms of PTSD and deal with thoughts of suicide. As I have become a student of recreation and its therapeutic benefits, I have applied its principles to my PTSD symptoms. This study will provide a timely and intimate examination of leisure's role in the life of one veteran with PTSD and my family.

### **Delimitations**

The scope of the study will be delimited to the following:

1. The sample represents one combat veteran who is a husband and father, living in Utah.
2. The length of time examined in the study ranges from the beginning of my struggle with PTSD in 2004 to the present as I currently deal with symptoms.
3. The data of the study will be gathered through an autoethnographic approach.
4. The data will be collected and analyzed between November 2012 and February 2013.

### **Limitations**

This study will be limited by the following factors:

1. The study sample includes a single combat veteran with PTSD living in a small town in Utah, from the age perspective of 35 to 43. Therefore, findings and conclusions of the study may not generalize to the larger population, of any age, with or without PTSD.
2. Personal bias associated with recalling personal events and the inherent human tendency to want to paint oneself in the most flattering light must affect the way this

- study is presented. However, I have committed to exposing the vulnerable self (Ellis, 1999) by revealing unflattering details of my wartime experience as I relate even experiences that may show me in a negative light.
3. This study is retrospective in nature and subject to the lens of hindsight. There is a possibility of critical elements being forgotten, as memories are not as accurate as recording events as they happen, and therefore some details of the experience may be lost.
  4. An autoethnographic study is also developmental, because new meaning is ascribed to past events through the analysis process and the connection of current ontology with past events.
  5. The use of autoethnography is not a conventional research approach within the leisure discipline. Fleming and Fullagar (2007) admit autoethnography is an emerging methodological approach within leisure research while it is simultaneously employed across myriad social science–related disciplines (Axlesen, 2009; Feczer & Bjorklund, 2009; and Neville-Jan, 2005).

### **Definitions of Terms**

The following terms are defined to clarify their use in the study.

1. *Family leisure*. Family participation in free-time activities as a whole, either structured or unstructured; such activities represent special meaning to family members individually or collectively.
2. *Posttraumatic stress disorder (PTSD)*. An anxiety disorder characterized by “a triad of symptoms following exposure to trauma, including persistent re-experiencing of the traumatic stressor(s) through flashbacks, nightmares, and/or intrusive thoughts,”

- with external symptoms including persistence of avoidance/social isolation, emotional numbing, and heightened arousal concerning surroundings (Feczer & Bjorklund, 2009, p. 278).
3. *Autoethnography*. An autobiographical cultural analysis and interpretation with narrative details from the author's life experience (Chang, 2008) which uses ethnographic methods to discover the interplay and introspection of self with culture (Ellis and Bochner, 2000).
  4. *Verisimilitude*. The autographical equivalent to validity, best understood as the approximation or approaching of truth in a way that rings true to the reader. Verisimilitude is approached when a reader accepts what is written because they recognize something similar in their own life or in the life of someone they have observed. It evokes the feeling that something is lifelike or believable (Ellis, 1999).
  5. *Transferability*. A qualitative term resembling the construct of generalizability in quantitative methods. Due to the small sample size in autoethnography, it is virtually impossible to make general claims of applicability to a larger population; however, the findings of autoethnography are often applicable in the lives of the readers. Transferability is achievable when the reader recognizes similar experiences in their own life as well as situations familiar in the lives of people close to them. To the extent that data is applicable, it is referred to as transferable and therefore useful in interpreting culture and self (Corbin & Strauss, 2008)
  6. *Trustworthiness*. A re-conceptualization of the construct validation using multiple data sources, methods, and theoretical schemes to triangulate and evaluate the truthfulness of the writing (Creswell, 2007).

7. *Credibility*. The reader's confidence in the data presented is established by following the rigorous methods of analysis in autoethnography (Corbin and Strauss, 2008).
8. *Dependability*. A method is said to be dependable if it can be repeated to achieve the same results (Erlandson, Harris, Skipper, & Allen, 1993).

## **Chapter 2: Review of Literature**

Many soldiers return from war with physical wounds, yet even more return without any visible reminder of combat while carrying the unseen baggage associated with war-trauma indelibly etched into their psyche. (Alici et al., 2010; Demers, 2009; Manos, 2010; Zoroya, 2005). Radical improvements in body armor technology and battlefield medicine prevent many fatalities (Jaycox & Tanielian, 2008), but therefore increase the number of individuals and families who must now learn to live with the lingering effects of war (Benedict, 2009). The signature wounds of the wars in Iraq and Afghanistan have proven to be traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). These wounds represent the highest incidence numerically as well as an elevated public awareness concerning them Tanielian & Jaycox, 2008). Both TBI and PTSD disrupt family life and can produce potentially devastating conditions within family functioning.

Much research has been dedicated to understanding the effects of disability on the veteran as an individual (Nunnink et al., 2010; Stefco, 2009; Feczer & Bjorklund, 2009). We are all connected to one another and no woman or man truly experiences life, or war, in a vacuum. In this manner, the families of veterans are affected, which in turn creates a ripple effect beyond the family and throughout society by virtue of the family's interactions within society.

### **Challenges Facing Veterans and Their Families**



Since October 2001, approximately two million women and men have deployed either to the Iraq War or the Afghanistan War, and an additional three million Americans have had a parent or spouse deploy (Tanielian & Jaycox, 2008; Price & Stevens, 2011). The Research and Development (RAND) Center for Military Health Policy Research found that 18.5% of returning service members (approximately 300,000 veterans) from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) meet the criteria for PTSD (Price & Stevens, 2011) and only slightly more than half of those have sought and received “minimally adequate treatment” (Tanielian & Jaycox, 2008, p. 108). According to the Office of Army Demographics, 45% of National Guard, 46% of Reservists, and 59% of Active Duty personnel are married, implying that combat stressors may potentially impact roughly half of all military families.

The global war on terror has introduced many unique challenges into the lives of veterans and their families. Among those challenges are the increased likelihood that soldiers will deploy to a war zone, extended separation from family for training and assignments, short reprieves between multiple deployments, and waning public support. While the vast majority of service members who deploy do not experience injury or disability (Price & Stevens, 2011), those who are exposed to trauma are increasingly likely to develop signs and symptoms of PTSD in a compounding way with successive deployments (Stefco, 2009).

**Reintegration.** Once the deployment is over and the family is reunited, soldiers face the challenge of reintegration. While the service member is gone, families pick up the slack left by their vacancy, each member taking over a different aspect of the service member’s household role, such as taking out the trash or paying the bills (Yano et al., 2010). The spouse often takes over the financial responsibilities and becomes both mother and father, while the children take the garbage out and do other odd chores around the house. Once home, the veteran and family

must redefine their roles in the family “in many instances, a traumatized soldier is greeted by a traumatized family, and neither one is ‘recognizing’ the other” (Hutchinson & Banks-Williams, 2006, p. 67). In addition to reporting increased anxiety, difficulty connecting with others, trouble falling and staying asleep, and remorse over the absence of military structure and camaraderie; the returning soldier often struggles to understand and define where he or she fits in (Feczer & Bjorklund, 2009).

As service members return from deployment, many struggle to reintegrate into society. This struggle is frequently manifested first within the family as service members often report feeling as though the family doesn’t need them or has replaced them (Benedict, 2009; Bowling & Sherman, 2008; Alici et al., 2010; MacDermid-Wadsworth, 2010; Demers, 2009).

**Divorce.** Multiple deployments also seem to especially strain intimate relationships. Between 2001 and 2004, divorce rates among Army officers tripled, and rates among Army enlisted service members increased by 50%. Rates of divorce for enlisted personnel, returning from combat in Iraq and Afghanistan, increased from 28% in 2000 to an astounding 53% in 2003 (Zoroya, 2005). Shea, Vujanovic, Mansfield, Sevin, and Liu (2010) connected combat-related PTSD to functional impairment in family relationships, which is a contributing factor to the rise in divorce among veterans of OIF/OEF. Divorce has been well documented as a negative influence on parent-child relationships and certainly does not affect the veteran only (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011). Divorce causes chaos in the life of veterans and their families and can lead to other challenges such as substance abuse, depression, or suicide (Koenen et al., 2003).

**Suicide.** Kang and Bullman (2009) explored whether there was an epidemic of suicides among current and former members of the U.S. military. Between 2003 and 2009 there was a

trend of increasing suicides among OIF/OEF veterans to 20.2 per 100,000 (Kang & Bullman, 2009, p. c759). It is unclear why there was an increase in suicides of veterans from the most recent conflicts in comparison to previous wars. In their Health Promotion Risk Reduction Suicide Prevention Report (2010), the Army stressed the need for additional services to facilitate reintegration into civilian life once veterans return from war. These programs are intended to reestablish healthy marital and family relationships and reduce the risk of suicide among returning veterans. Suicide is a considerable public health concern within the U.S. military as it often results in additional risk to family members (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Guerra and Calhoun (2011) indicate that “exposure to wartime stressors” is compellingly linked to an elevated risk of suicide; however, an increase in reported PTSD symptoms are blamed for the increase in suicidal ideation (p. 17). In the same study we learn that PTSD is often experienced simultaneously with other diagnoses such as major depressive disorder (MDD) or alcohol use disorder (AUD), which may explain an increase in suicidal ideation (Guerra & Calhoun, 2011, p. 13). Another troubling trend is that veterans with PTSD are four times more likely to succumb to suicidal ideation than veterans without the disorder (Jakupcak et al., 2009).

**Substance abuse.** When veterans face disruptions in life many turn to drugs or alcohol as a means of escape (Nunnink et al., 2010). Families including a member struggling with substance abuse have demonstrated how addiction can permeate every domain of family life (Malkin, Phillips, & Chumbler, 1991). The comorbidity of substance abuse and PTSD among OIF/OEF veterans is the subject of much discussion (Brown, Recupero, & Stout, 1995; Nunnink et al., 2010; Guerra & Calhoun, 2011). Since 2008, military sources report a reduction in tobacco use and illicit drug use while prescription drug misuse and alcohol abuse are on the rise

among OIF/OEF veterans (Bray et al., 2010). Trauma related to wartime stressors can lead to substance abuse which in turn has a negative impact on relationship satisfaction in the form of sleep problems, disassociation, and severe sexual difficulties (Goff, Crow, Reisbig, & Hamilton, 2007).

**Dealing with disability.** In previous wars, soldiers who experienced mental or physical trauma often did not survive long enough to deal with the long-term ramifications of their wounds (Benedict, 2009). With the improvements in battlefield medicine more veterans survive while acquiring a disability. Acquired disability can come in the form of amputation, paralyzation, and reduced mobility due to shrapnel or enemy bullets. There are, however, disabling conditions which are not readily recognizable on visual inspection. Traumatic brain injury (TBI) is more prevalent in OIF/OEF veterans due to improvements in body armor (Jaycox & Tanielian, 2008) and has become one of the most frequently diagnosed disabilities since the onset of these wars. Veterans with TBI often experience a comorbidity of psychiatric disorders like PTSD (Rogers & Read, 2007). OIF/OEF veterans report symptoms of PTSD so frequently it has come to be called the signature wound of the wars in Iraq and Afghanistan (Alici et al., 2010; Manos, 2010; Zoroya, 2005). Any time veterans acquire a disability; it represents a disruption in their life pattern and may present unique challenges to their families. This paper will primarily focus on the effects of PTSD.

## **PTSD**

PTSD is an anxiety disorder characterized by a triad of symptoms resulting from exposure to trauma (Feczner & Bjorklund, 2009). This triad of symptoms includes persistent re-experiencing of trauma, avoidance or reminders of trauma and/or emotional numbing, and a high level of general anxiety and psychological arousal (Rourke, Hobbie, Schwartz, & Kazak, 2006).

Estimates of OIF/OEF veterans reporting symptoms of PTSD are between 20 and 40% (Bowling & Sherman, 2008; Benedict, 2009; Price & Stevens, 2011). Additional psychological symptoms are connected to combat and may be experienced simultaneously with PTSD. These symptoms include anti-social behavior and/or social isolation (Alici et al., 2010), depression (Demers, 2009), and hypersensitivity to crowds or loud noises (Evans, Cowlshaw, Forbes, Parslow, & Lewis, 2010). As veterans with PTSD struggle to control their symptoms, their frustration often spills out and can lead to domestic violence (Manos, 2010).

Domestic violence among OIF/OEF veterans is often attributable to substance or alcohol abuse (Goff et al., 2007). Each of the aforementioned symptoms can be associated with lower levels of family satisfaction and functioning (Evans, McHugh, Hopwood, & Watt, 2003; Friedman, 2006). Veterans with PTSD are less emotionally expressive, less cohesive, more violent, and more inclined to divorce than their counterparts without PTSD (Carroll, Rueger, Foy, & Donahoe, 1985; Solomon, Mikulincer, Fried, & Wosner, 1987). As PTSD disrupts the life of the service member, it ripples outward to negatively impact those close to the veteran (Demers, 2009). Typically, the family is first in line when dealing with a veteran with PTSD and experiences the brunt of negative emotions and symptoms. Lester et al. (2010) call this the “wear and tear effect” of combat deployment (p. 317).

PTSD therefore extends beyond the veterans to disrupt the lives of their families, and in turn ripples further outward to affect their associations until the effects of PTSD are felt throughout society. Parental behavior also affects outcomes in children’s lives. Substance abuse, divorce, and suicide rates among children of veterans with PTSD can be attributable to the parent’s disability and behavior (Rosenheck & Nathan, 1985; Demers, 2009; MacDermid-Wadsworth, 2010).

Because PTSD is commonly associated with a tendency toward emotional numbing and avoiding reminders of the trauma, veterans with PTSD often report a loss of interest in pursuits they previously enjoyed (Feeny, Zoellner, Fitzgibbons, & Foa, 2005). This loss of interest is expressed outwardly as veterans participate less actively in family-related leisure activities, even avoiding healthy individual leisure pursuits. This may explain lower levels of family life satisfaction (Evans et al., 2003; Friedman, 2006) as veterans with PTSD distance themselves from family members physically and emotionally.

The continual exposure to stress-inducing situations can cause an emotional overload for veterans with PTSD. Seeking an escape from the near-constant negative emotional state, veterans may participate in negative leisure activities such as alcohol or drug abuse (Jakupcak et al., 2009; Nunnink et al., 2010), unprotected sex (Cameron et al., 2011), thrill-seeking, which can be dangerous or self-injurious (Strom et al., 2012), and in extreme cases even criminal behavior (Aprilakis, 2005). Any of these activities can lead to illness, injury, and possibly death and may negatively impact veterans' families (Agaibi & Wilson, 2005).

Positive leisure activities can reduce risk to the veterans and their families. Introducing leisure as a means of coping with stress provides what Patry, Blanchard, and Mask (2007) describe as "planned breathers," giving veterans enough of a break from negative emotions to allow them to regroup and move forward through challenging circumstances.

### **Leisure, Stress, and Coping**

Leisure has long been recognized as a potent force for both its individual benefits and potential for improving family cohesion, adaptability, and communication (Freeman & Zabriskie, 2003; Shaw & Dawson, 2001). The rejuvenative, diversionary, and therapeutic benefits of leisure have been alluded to for some time (Caldwell, 2005; Hutchinson, Loy,

Kleiber, & Dattilo, 2003). In addition to these advantages, leisure is effectively used as a coping mechanism for myriad ailments. Kleiber, Hutchinson, and Williams (2002) assert leisure can be used to transcend negative life experiences which include stress. Hutchinson, Bland, and Kleiber (2008) contend that leisure can be an important resource for coping with chronic stress (p. 10), although they don't make the connection to war-related stress or PTSD. Leisure has been shown to be effective in mitigating symptoms of stress (Hood & Carruthers, 2002; Juniper, 2005; Iwasaki et al., 2006) and can be a powerful coping tool for veterans adjusting to an acquired disability.

The majority of literature on leisure, stress, and coping, however, does not directly mention war trauma or combat-related stress, although some applications have been suggested (Arai et al., 2008). Living with any disability is likely to have an impact on personal, social, and economic aspects of life (Iwasaki et al., 2006). Iwasaki et al. (2006) do not mention PTSD specifically; however, it is a disabling condition and further research should be done in order to understand the benefits of leisure for combat-related veterans specifically.

Wartime trauma leaves a lasting impression on individuals and negatively influences thinking, feeling, and behavior which can be mediated through leisure (Arai et al., 2008). Stress related to trauma is emotionally overwhelming and beyond the normal human experience, and war-related trauma is experienced by far fewer people than any other traumatic event. As such, it only is parenthetically mentioned in the discussion of using leisure and recreation for healing from trauma (Arai et al., 2008, p. 38). Recovery from trauma is not a clearly defined destination; rather, it is a "long journey an individual embarks on in search of a deeper understanding of self" (Arai et al., 2008, p. 38). Trauma can also impact leisure behavior as veterans fall into patterns of isolation and avoidance (p. 40). This is important in understanding the most effective ways

for treating veterans with PTSD as symptoms of the disorder can be alleviated by primary benefits of leisure participation such as empowerment, emotional support, and palliative coping (Iwasaki & Mannell, 2000).

Considering the PTSD symptoms of emotional avoidance and social isolation, Arai et al. (2008) suggest the potency of leisure and recreation involvement in healing from trauma by providing positive social support that improves issues of trust, intimacy, and boundaries (p. 40). This assertion is further supported by Iwasaki and Mannell (2000) as they describe how building leisure friendships improves personal relationships (p. 164). Leisure participation can also serve as a respite from the negative emotional states brought on by PTSD symptoms (Patry, Blanchard, & Mask, 2007). In this way leisure serves as a buffer between the individual and negative emotion, allowing them to regroup and move forward (Iwasaki & Mannell, 2000, p. 164).

While connections to combat-related PTSD can be drawn, there is no existing literature that draws these conclusions. More research is needed to illustrate the possible benefits for pertinent social issues related to wartime trauma.

## **Summary**

We are uniquely poised in history to study the effects of war on veterans and their families and to examine how leisure can ameliorate negative life stressors. These negative situations include greater likelihood of divorce, increased risk of suicide, higher levels of alcohol and substance abuse, and rising numbers of veterans dealing with disabilities, including PTSD. These conditions represent a timely need to provide viable solutions.

Existing literature affirms the potential for leisure to provide possible improvement for conditions associated with disability. Given the recent surge in veteran disability issues, far too few authors address the potential benefits of leisure on combat-related PTSD. What research



does allude to combat-related PTSD or leisure's potential use for treating veterans is presented from an outsider's perspective looking in.

There is a gaping hole in the literature representing an intimate understanding of PTSD from the perspective of the patient. Additionally, there is a glaring absence of literature addressing combat-related PTSD and the therapeutic benefits of leisure as a means of managing stress and coping. Very little is understood about what PTSD looks and feels like from the vantage of one experiencing it. While there is an increase of veterans returning from war with PTSD, there is a dearth of literature on combat-related trauma and references to it are weak at best.

This study presents an opportunity for us to better understand the nature of PTSD while strengthening the argument for leisure as a coping mechanism or treatment modality by making a direct connection to its use and a pertinent social issue like combat-related trauma. This study will examine PTSD from a personal, inside-looking-out perspective while simultaneously examining the palliative nature of leisure participation in the healing process. Rather than seeking to portray leisure as a magic bullet or cure-all for disability, this study recognizes that there may not be a total healing from the effects of wartime PTSD and will examine leisure in the light of ameliorating symptoms and improving quality of life in order to cope and move forward.

Therefore, the purpose of this study is to identify the role leisure plays in alleviating symptoms of PTSD such as depression, anxiety, social isolation, impulsive behavior, and uncontrolled anger. The rigorous autoethnographic process will facilitate, as Chang (2008) delineates, self-reflection, self-examination, and self-understanding for both author and reader. Autoethnography not only increases understanding of a segment of the population (Reed-

Danahay, 1997), it facilitates introspection for the reader (Ellis, 2004). This study additionally explores the role recreation may play in mitigating symptoms.

### **Chapter 3: Methodology**

The problem of the study is to deepen our understanding of Posttraumatic Stress Disorder (PTSD) by exploring the relationship between leisure and its effects on symptoms of PTSD from a first-person perspective and provide a basis for future research concerning leisure as a coping mechanism for combat-related PTSD. As a combat veteran who is diagnosed with PTSD, I will identify the role leisure played in ameliorating my chronic mental health symptoms.

Additionally, I will examine the role leisure played in stabilizing my family relationships. This chapter outlines the methods of the study, including (a) introduction to subject, (b) autoethnographic process, (c) data gathering and analysis, and (d) plan for establishing trustworthiness. While there will be a definite narrative to this research, it is important to note that the autoethnography is more than merely telling a story, it is a research process which compares the narrative to existing research literature, follows specific data gathering procedure, and uses analytical tools to identify patterns in the narrative which may offer a more intimate understanding of existing research.

#### **Subject**

I am Warren Price, a 43-year-old white male who is married and has four children. I was an Army medic in the Utah National Guard from 1995 to 2008. In December 2003, I volunteered to go to Iraq. At the time of my deployment, I was 34 years old, my wife was 30, and our four children were ages nine, seven, four, and one. As a member of the armed forces, I experienced firsthand the horrors of war, the inherent anxiety, the frequent firefights and attacks,

and the confrontation of my own mortality that are all common to soldiers who serve in combat. I returned home after 12 months and tried to return to normal life. Instead, I had trouble adjusting at home and felt as though I didn't fit in the family. I also had difficulty keeping a job.

Family members and other soldiers noticed changes in my behavior, such as illogical angry outbursts, being suspicious of others and generally paranoid, being easily startled by loud noises, and experiencing discomfort in crowds, as well as a newfound difficulty with authority figures. Following an incident at home, I was ordered by my company commander to seek treatment at the VA hospital in Salt Lake City, Utah. I was diagnosed with PTSD and began treatment, which included individual and group therapy coupled with significant doses of several anti-anxiety, anti-depression, and anti-psychotic medications. I fell into a pattern of abusing Xanax and Ambien, leading to greater difficulties at home and work, and eventually I was also hospitalized multiple times for suicidal ideations. I spent two years in a chemically induced haze of confusion, depression, anger, and personal darkness. Amongst a host of other therapies, I was eventually introduced to fly fishing as a means of coping with PTSD symptoms and embarked on a transformative journey to where I am today.

**Protection of subjects.** An exploratory meeting with Institution Review Board personnel indicated that due to the nature of autoethnographic study it would not be necessary to secure IRB approval for this project. After further consideration, Dr. Lundberg and I realized that, as I tell this story, there may be collateral fallout on members of my immediate family. The story contained in this thesis of my experience with PTSD did not happen in a vacuum. The anger, depression, and violence often spilled out to affect my wife and children. While this autoethnography is primarily my story and I am the only research subject, the story is not entirely mine. It also involves the lives and privacy of other people who could be considered

part of a vulnerable population. Therefore, we will submit an IRB application in order to protect family members from any unintentional exposure to risk. My wife and children will also be involved in the member checking process; they will be given the opportunity to review experiences they were directly involved with as either a participant or an observer. I will not conduct interviews to gain their perspective, only to have them check my perceptions for accuracy. Children who were not directly involved in an experience will not be exposed to it for the first time through the member checking process.

The publication of these events may have unintended consequences for members of my family. In an effort to minimize those consequences, family members who are discussed in the research will be afforded the opportunity to read transcripts and make corrections, additions, or deletions. Family members will have final approval for inclusion of the events that relate to them, if my relating the event will be troublesome for them, they will have the right to deny its publication. In the event part of the narrative is denied I will identify a replacement narrative subject. I will also ask family members for their perspective, interpretation of events, and any additional information I may have not included. This process will serve as a quasi-member checking for accuracy and trustworthiness. Rather than use pseudonyms for my family members, they will be referred to generically according to the role they play in the family (i.e., wife, son, daughter) as a means of affording some semblance of anonymity. I will also complete an IRB application following approval of this proposal.

### **Autoethnographic process**

Chang (2008) suggests autoethnography is becoming a powerful and useful tool for researchers in various fields dealing with human relations (p. 51). Among the benefits of this method of research are that it offers a mode that is friendly to both researcher and reader, it

enhances understanding of self and others, and it has the potential to change attitudes and encourage coalitions across cultures (Chang, 2008). Prior to beginning an autoethnography, Chang (2008) suggests the researcher answer the following four questions: Why do you want to do it; how will you focus your research; what are the initial steps; and how will you handle ethical concerns?

In answering the first question, I feel my personal experience with PTSD is unique among graduate students while being similar to the experience of other combat veterans and therefore may offer solutions not discussed by previous research. Throughout my involvement with the VA healthcare system, I have met numerous combat veterans struggling to recover from wartime exposure. An in-depth examination of the role leisure has played in my recovery may provide a basis for future research to benefit other combat veterans. I believe my story has the potential to help veterans who have experience PTSD by exposing my life to the academic scrutiny which will lead to future research on using leisure as a coping mechanism in dealing with PTSD. What drives my desire to do this project is the hope that my suffering may be assigned greater meaning by using it to reduce the suffering of others.

Chang's second question addresses the focus of my research. I first experienced therapeutic recreation as a patient and then embarked on a formal education in the subject. I first found relief from symptoms of PTSD through leisure pursuits and gained critical coping skills which have aided my path toward recovery. This path has helped me to narrow my broad interest in leisure in general to a specific curiosity concerning the role leisure can play in mitigating symptoms of PTSD. Closely related to the answer to the first question, I have been driven to find an explanation for why leisure has worked in my life. Through a greater understanding of the why and how to use recreation in treating combat veterans, my suffering

has been assigned new purpose and meaning as I realized my experience could serve to help others.

The third question concerning what initial steps must be taken can be answered by following the examples of other authors (Chang, 2008; Reed-Danahay, 1997; Ellis & Bochner, 2000). I will gather my journals from Iraq, identify three traumatic events that still trouble me today, and engage in analytical writing and emotional recall for each experience. I chose to concentrate on three incidents out of concerns that one or two were too few to find patterns and effectively compare incident to incident, and more than three could prove to make the project exceedingly lengthy. It is noteworthy to indicate I experienced more than thirty life and death situations while in Iraq where my life was directly threatened or where the life of someone under my care was directly threatened or ended. Each of these incidents could be considered traumatic and related to my eventual development of PTSD symptoms. However, it is not my intention to make this project an exhaustive evaluation of every incident, merely a sampling. Three is adequate for the purposed of effective coding as well as comparative analysis. Additionally, I will gather material from my medical records during my hospitalization for PTSD, transcribe writings that were part of prolonged exposure therapy, and explore how those incidents contributed to my PTSD symptoms. I will also identify three leisure-related experiences I have participated in since my diagnosis and evaluate how they have enabled me to cope with my symptoms.

Finally, I will handle ethical concerns by working with the IRB office to determine the appropriateness of my research methods and take every precaution to minimize the risk to my wife and children. I will also work closely with Dr. Lundberg to identify the appropriateness of topics within my research before it is printed. My committee and I want to ensure we reduce the

possibility of causing collateral harm to people in my life who experienced my PTSD first hand, but as observers. One incident that will be analyzed involves my wife and me as I was startled awake in the middle of a nightmare to find myself on top of her punching her. My children may not be aware that event ever happened, and they will not be exposed to it during the member checking process. Only family members involved in the incident as participant or observer will be involved in the member checking and triangulation process.

Ellis and Bochner (2000) describe the data-gathering process for autoethnography as a systematic sociological introspection process of first gazing at the data through a wide angle lens and examining the social and cultural aspects of the data or writing broadly about a formative experience (p. 739). This is followed by focusing inward to expose the “vulnerable self” (Ellis, 1999, p. 740) and writing in even greater detail about critical moments, thoughts, or epiphanies that occurred to give meaning to the experience. This allows the researcher to move backward, forward, inward, and outward (Ellis, 1999, p. 773) through the events which make up the data. Chang (2008) delineates the process into seven steps: a) conceptual preparation, b) personal memory collection, c) self-observation and self-reflection, d) collecting external data, e) managing data, f) analyzing data, and finally g) writing the autoethnography. The following sections explain each of these steps in greater detail below.

### **Data Collection Procedures**

**Conceptual preparation.** Chang (2008) explains that a researcher must explore topics with particular meaning for the researcher. PTSD has become a defining factor in my life since 2006. It has proved to disrupt even the most basic of functions, challenge my belief system, interrupt relationships, and finally strengthen my resolve. The conceptual preparation has already been completed as I decided on a thesis topic. Choosing this topic was not difficult; in

fact, I feel it chose me. As I returned to school and began studying recreation and social behaviors, I have consistently been enlightened with greater understanding of how PTSD affects not only me but other veterans and perhaps people who experience non-combat-related PTSD. This step was completed during the proposal phase of this project and is represented in the preceding chapters.

**Personal memory collection.** I kept a semi-consistent daily journal during my deployment to Iraq, missing very few days. These journals will be used as documentation of events which, upon reflection, could be seen as the source of my PTSD. During post-deployment psychiatric counseling at the VA, I was assigned to document certain traumatic events in greater detail in the form of incident reports and writing assignments from prolonged exposure therapy, all from memory. These writings are part of my medical record and will serve as documentation of collected memories. Each of these events will be subject to additional analysis during the research phase of my thesis, and I will also conduct reflective writing to examine the situations more closely. This autoethnography is not intended to be an exhaustive documentation of every traumatic experience from Iraq, as there would be too many to consider and evaluate in the time allotted for a thesis project. I have chosen three traumatic events to examine in an attempt to help the reader understand what was going on inside my mind and how they may have contributed to my PTSD. Further elaboration of the chosen incidents will occur between December 2012 and April 2013 as I read, review, then rewrite each incident in greater detail then import data into NVivo 9 for coding and analysis.

Specific attention will also be given to three leisure-related experiences from my post-war life. These experiences are significant in describing how I learned to manage PTSD symptoms through recreation participation. As my PTSD has negatively impacted my family



relationships, I will also discuss how recreation participation has helped me to repair some of the damage done to those relationships. During the data-collection phase of this project, I will analyze and write insights concerning these experiences, which will be entered into NVivo as methodology notes and memos, that have come from current literature and coursework which is pertinent to understanding my recovery journey. I will discuss these insights weekly with my committee chair.

**Self-observation and self-reflection.** The process of observing and reflecting on myself has been naturally occurring for the past eight years, and, in a greater sense, for the past two and a half. Following the memory collection process, I will formally engage in self-reflection by documenting observations specifically on written data. The most notable form of self-reflection will occur during the coding and comparative analysis processes as I compare incident to incident and assign meaning or patterns in the data to specific codes. The first step is to write the experience, then read and discuss it with colleagues or committee members. After a day or two, I will revisit the event by rewriting it in greater detail and with more depth, focusing on physiological detail, emotional reactions, and thoughts experienced both during the original event and during my reflections. These reflections and greater detail will be discussed with my committee chair once a week, and his notes and observations will be included as well. Dr. Lundberg will consider the appropriateness of the categories or codes I choose as well as check my work for consistency. If he finds a set of data need to be recoded I will follow up on his impressions, notes, and memos.

**Collecting external data.** Two primary sources for external data collection will include gathering medical documentation from the VA Hospital as well as sharing these sources and transcripts from memory collection and self-reflection with members of my family and allowing

them to comment on the data. This differs from memory collection by including the input of people who were not present when the traumatic events occurred. I will not record conversations with family members, Dr. Lundberg, or colleagues in my graduate program. Their participation will be limited to checking my memory work for accuracy by comparing their observations to my own. Dr. Lundberg will review the codes I establish and check my coding to evaluate the appropriateness of my data assignment, his evaluation will be considered during subsequent coding sessions. If any outside auditors have impressions that differ from mine, their insights will be recorded as notes and memos in NVivo 9 and coded to determine patterns in how others interpret my experience. Much of the external collection process has been completed as I gathered current medical records from the VA hospital, transcribed journals from handwritten to electronic format, and sketched out versions of incidents I considered important to evaluate.

#### Treatment of Data

**Managing data.** Each of the writing examples will be transcribed, entered into NVivo 9 software, and categorized chronologically. Data will undergo a constant comparison as researcher and committee chair check for frequently occurring themes, colleagues examine codes for consistency, family members review transcripts for accuracy, and I will conduct further analytical writing. Through this process of constant comparison and pattern analysis I hope to identify emerging core variables with potential for explaining other themes and patterns. At this point, Dr. Lundberg and I will enter selective coding and will focus on fully understanding the core variable. I will keep all hard copies of data in a locked cabinet in the graduate studies office for the duration of the study, and then will transfer custodial care of these document to Dr. Neil Lundberg for three years.

This process will occur on most week days as I delve deeper into each incident and record impressions and analyze data for similarities and patterns. The analysis process occurs throughout the duration of the project from beginning to end as I look for relativeness to existing research concerning PTSD and leisure, stress, and coping. The final steps of this process will be drawing conclusions from the data and discussing the implications of these conclusions on the current body of work on combat-related PTSD and leisure, stress, and coping.

**Analyzing data.** Data analysis will be conducted within NVivo 9, a qualitative software program. During analysis, I will engage in the process of axial and open coding and comparative analysis as described by Corbin & Strauss (2008), to identify (a) situational narratives, which are personal descriptions, (b) re-episodes, or reoccurring situations or themes, (c) metaphors, a term or phrase used to represent something else, (d) subjective definitions, which are personal perceptions of the researcher, and (e) argumentative-theoretical statements, which are explanation of concepts (Flick, 2008).

Coding is an analytical method for building theory and helping analysts consider alternative meanings of phenomenon (Corbin & Strauss, 2008). Axial coding is a process of relating concepts to each other (Corbin & Strauss, 2008, p. 195) and identifying categories that parts of the narrative will fall into. I will use a basic list of related codes provided by Corbin & Strauss (p. 192) as a base from which to form my own codes. Open coding is the process of breaking data down into established codes. I will go through the narrative data line by line and assign each sentence to an appropriate code. After I have coded the data Dr. Lundberg and I will meet weekly to discuss codes and review patterns in the data. Dr. Lundberg will review my coding and agree or disagree with each code, and I will rely on his input and insight to ensure data is properly coded. Data saturation will be achieved when the research committee comes to

consensus that all data have been properly assigned to appropriate codes. Once saturation has been achieved, I will engage in the process of comparative analysis, wherein themes and incidents will be tested against each other in order to identify emerging patterns representative across events. “Incidents that are found to be conceptually similar to previously coded incidents are given the same conceptual label and put under the same code” (Corbin & Strauss, 2008, p. 195). During each of these processes I will keep notes concerning impressions and interpretations of my recollections, in the form of methodological notes or memos, both from the wide social lens and the personal lens of emotional recall.

To meet rigorous academic standards every effort to verify data must be made. I will achieve this through a process of triangulation involving data checks with individuals who are intimately aware of the events being described. Triangulation for this project will include sharing narrative data with three groups of external auditors; veterans who were in treatment with me for PTSD, members of my immediate family (i.e. spouse and children) who were directly involved in the incident being reviewed as either a participant or observer; and members of my committee or colleagues who are familiar with my narrative. It is important to note that members of my family will not be exposed to an incident for the first time through member checking or the triangulation process. For example an incident involving only my wife and I will not be submitted to my children who may still be unaware the event ever occurred. I will work closely with graduate committee and family members to ensure a sense of accuracy in the data.

**Writing the autoethnography.** The final step in the autoethnographic process is constructing the written thesis for this project in a narrative format that blends my account with literature concerning autoethnography, PTSD, leisure, stress, and coping in a flowing and engaging manner. I will spend three days per week for four to six hours per day writing this

narrative. Much of the data already exists in the form of handwritten journals and medical records; however, this information will need to be transferred to an electronic format in order to be entered into NVivo 9. As I transfer this data into NVivo 9, I will write notes within the program during the data analysis process, and these notes will be included in the final product as data analysis and conclusions. While Chang suggests a semi-structured format for writing an autoethnography (Chang, 2008), the method is still organic and fluid in nature. This fluidity has been evident during the process of discovery and evolution as Dr. Lundberg and I have determined steps to follow while allowing for naturally occurring event to shape topics of interest. Beginning in January 2013, Dr. Lundberg and I will evaluate conclusions I draw from NVivo and my reflective writing and determine the format for presenting these findings.

### **Plan for Establishing Trustworthiness**

Qualitative research is often scrutinized more vigorously as a result of lack of familiarity with qualitative processes (Ellis, 1999; Ellis and Bochner, 2000; Chang, 2008). As a result of such scrutiny, it is important to establish trustworthiness in qualitative research (Erlandson et al., 1993). Although Lincoln and Guba's (1985) four criteria for establishing trustworthiness are not a part of the autoethnographic process as summarized in current procedural writing (Axelsen, 2009; Ellis, 1999; Ellis and Bochner 2000; Feczer & Bjorklund, 2009; Pearce, 2008), they are included here because they have become common and accepted in qualitative research. The four criteria are credibility, transferability, dependability, and confirmability. Following is a discussion on how this study seeks to establish trustworthiness in each of these four areas, thereby promoting trustworthiness throughout both data collection and analysis. Inherent weaknesses in this validity plan for establishing trustworthiness are also discussed.

**Credibility.** By successfully creating confidence in the data through verisimilitude (Ellis, 1999), the researcher establishes credibility (Erlandson et al., 1993, p. 29). A well-established method for increasing credibility is triangulation (Gibbs, 2007; Miles & Huberman, 1994), which will be utilized in data analysis. In data analysis, triangulation will appear in the form of constant comparison through consultations with thesis committee members, peer debriefing with individuals who are not invested in this study, and member checks for validity of results. For the purposes of this study, triangulation will occur by sharing self-reflective and analytical writing with three groups. The first will consist of events I experienced in Iraq without my family and will be shared with a veteran who was in treatment with me to evaluate verisimilitude in comparison of language consistent within the military community. The second type of events will include those where a family member is involved as either a co-participant or direct observer of the incident in question. These incidents will be shared only with members of my family depending on whether they were directly involved with the incident they will be member checking. Finally, both types of incidents will be reviewed by my committee chair to determine appropriateness in coding, wording, and clarity of ideas expressed. Peer debriefing will occur weekly as I share excerpts of the narrative through email for their monitoring and follow up phone conversation to discuss interpretations and patterns in the data. This method of triangulation will enable the researcher to step outside of the study, enabling him to make societal and cultural interpretations. Additionally, credibility will be enhanced by thick descriptions of study events, serving to reposition the reader and researcher as coparticipants in a dialogue (Ellis, 2000). An audit trail consisting of saved notes, memos, and queries. A reflective journal will also strengthen credibility of this study as external auditors will be able to review the analysis process and clearly see how results were achieved.

**Transferability.** Erlandson et al. (1993) defined transferability as the “extent to which [study] findings can be applied in other contexts” (p. 29). Ellis (1999) emphasized that transferability is achieved when the readers recognize the findings either in their own life or in the life of someone they are acquainted with who had “been through a similar experience” (p. 677). Application to other contexts is the responsibility of consumers of this research, though the researcher will seek to enhance transferability through thick description and honest exposure of less-than-flattering aspects of the lived PTSD experience. Rich description “connects readers to writers and provides continuity in their lives” (Ellis, 1999, p. 676). A reflexive journal provides an ongoing analytical writing process concerning the data, contains the researcher’s thoughts and impressions throughout the process of data collection and analysis denoting interpretation of events, and reveals the fluid nature of understanding lived experience.

**Dependability.** When a research study provides “evidence that if it were replicated with the same or similar respondents (subjects) in the same (or a similar) context, its findings would be repeated” (Erlandson et al., 1993, p. 33), it is said to have dependability. There is a glaring paucity in researchers possessing the necessary criteria to conduct such a study; however, in an effort to establish dependability, the researcher will maintain an audit trail through transcribed notes and memos, a reflexive journal, and saved queries for potential use by other researchers as a template for conducting similar studies in the future. The audit trail will consist of hard-copy journals, saved email transcripts between committee members and me, and electronically saved writings. This information will be saved on removable hard drives as well as in NVivo 9, where the formulation of emerging patterns and themes will also be documented. This file will be reviewed with Dr. Lundberg, my spouse, and my children as auditors throughout the process of data collection and analysis, thereby enhancing dependability through triangulation of auditors.

While this study does not include the experiences of other veterans, dependability is the concept that my experience makes logical sense. Those involved in triangulation will be able to compare what they are reading in my narrative with their knowledge of other veterans in their respective lives and that the narrative is similar.

**Confirmability.** Finally, in light of the difficult nature of eliminating and minimizing researcher bias in an autoethnography (Ellis, 2000), a level of confirmability will be achieved by creating an audit trail containing saved notes, memos, queries, a reflexive journal, and well-documented emerging patterns and themes, leaving a trail future researchers may follow. Confirmability is similar to dependability in that both hold the teller of the narrative accountable. However, confirmability is more concerned with the actual occurrence of the event, that it is not fictionalized; rather it is backed by historical documentation and can be verified through outside sources. The researcher will work closely with auditors consisting of his thesis committee and independent individuals who have lived with a veteran with PTSD in order to establish confirmability of this study. As auditors review the researcher's data collection and analysis, researcher self-understanding and understanding of others (Ellis, 1999, p. 673) will be achieved. Additionally, the researcher will seek to increase confirmability by conducting audit reviews with peers and family members.

**Researcher bias.** A major concern in any form of research is researcher bias; however, within the autoethnographic narrative it is considered a prerequisite perspective. The data is the life experience of one person and cannot be entirely separated objectively. Christopher and Hickinbottom (2008) insinuate it is naïve to believe personal experience can truly be looked at objectively. This autoethnographic exploration of PTSD symptoms and leisure activity offers a unique perspective of the diagnosis from the inside, allowing the reader, as Slife (2008) suggests,



to assign meaning to what is being observed (p. 704). Through reading my experience, others may gain what Ellis and Bochner (2000) describe as a deeper understanding of self, and “with understanding yourself comes understanding others” (p. 738). Slife (2008) explains that what is real or true cannot be examined without taking context into account and advocates for relationist ontology toward research. The autoethnographic method allows for an understanding of the richness of human experience, (Slife, 2008, p. 702) as opposed to separating feeling and emotion from strictly observable data.

**Potential weaknesses.** While this validity plan seeks to establish trustworthiness, there are inherent weaknesses in both data collection and analysis. Only the primary investigator will be collecting data on his personal experiences and interpretations of events, meaning only the primary investigator will be transcribing data and will necessarily be close to the data which might make it difficult to examine the wider implications. A modified form of member checking will be employed in this study. As the researcher is the only subject, he will include family and committee members in the review process, allowing them to add recollections or delete inaccuracies in the transcripts, as family members have shared in the lived experience of the PTSD of the researcher and may provide the “wide angle lens” Ellis (1999, p. 673) speaks of in providing some external perspective. Additionally, the researcher’s personal experiences as an individual living with PTSD may serve to weaken the study by activating PTSD symptoms, though this will be minimized as the researcher conducts confirmability and continues contact with mental health professionals. These weaknesses will also be minimized as the researcher reviews transcribed notes and memos with Dr. Lundberg weekly, enabling him to address concerns in upcoming transcriptions of data and analysis within NVivo 9.

**Conclusion**

The project will be completed when all four of Chang's (2008) questions have been satisfactorily answered and each of the seven autoethnographic research steps are finished. Each coding and analysis process must be completed and evaluated at least twice by external auditors and the author. The project will not be considered complete until the research committee is in full agreement that sufficient efforts have been made to detail accurately the incidents, analysis, and conclusions. Finally, the study will be complete when it has been organized in an acceptable format for submission for publication to an academic journal in the leisure discipline.

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