AN EXAMINATION OF COMMUNICATION PREFERENCES FOR SERVICE MEMBERS SUFFERING FROM COMBAT STRESS-RELATED INJURIES: A FRAMEWORK FOR SERVING THOSE WHO SERVE US.

A Thesis

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Abstract

This grounded theory research study examines communication preferences among combat veterans suffering from combat stress-related injuries, including post-traumatic stress disorder (PTSD), major depression, general anxiety, and substance abuse. The study employed personal interviews of a purposive sample of such veterans and constant comparative analysis of the data to derive grounded theory. The author suggests a path to find the most effective communication strategies and channels to reach other veterans who are suffering from combat stress experienced in Iraq and Afghanistan. More than 2.4 million service members have deployed to these combat theaters, with up to 90 per cent experiencing the kind of trauma that can result in PTSD. The respondents sought credible sources of information about their injuries. These combat veterans report that credibility has two primary factors – shared combat experience or medical knowledge of their conditions expressed without judgment. Family members also serve as critical pathways of information about the veteran’s behavior and how it affects others.
Thesis dedication and acknowledgements

This research is dedicated to the men and women of the United States Armed Forces and their families, who for nearly ten years have borne the terrible burden of war in the distant world of FOBs, COPs, IEDS, cordite, terror, and death – and have also borne the battle to return to that much dreamed-of normal life back home.

I wish to thank my wife, Dr. Terri Kelley Wray, for her incredible patience and support through this journey – and for sharing the heavy burden of my own military service. Her guidance and counsel made the thesis process bearable even when it was not understood. She watched me alternately thrive and struggle in her world of academe, always willing to help, but waiting for me to ask. Above all else, I thank her for the love and laughter that fills our home.

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The United States has been at war in Afghanistan since 2002 and was at war in Iraq from 2003 until the final withdrawal of combat troops in 2011. According to the Department of Defense Manpower Data Center, more than 2.4 million service men and women from all military services have been deployed to fight those wars. Of the troops deployed, research has shown that 90 per cent have been exposed to the types of trauma and stress that can result in combat stress injuries, such as PTSD, major depression, general anxiety, and substance abuse (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). While these effects of combat stress are found in the general population from other causes, the military regards them as injuries because they are the direct result of combat experience and involve physical changes to the brain (Hoge, Castro, & Eaton, 2006).

Since the first combat deployments in 2002, 17 per cent of deployed service members have been diagnosed with some form of combat stress injuries (Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Hoge, Auchterlonie, & Milliken, 2006). This proportion represents more than 400,000 service members. Researchers found that somewhat less than half of all those affected seek treatment for these injuries (Hoge, et al., 2004).

Each of the Services and the Department of Defense, as a whole, expend considerable effort studying these disorders, making resources available to those who suffer, and encouraging service members to get the help they need to deal with these diseases. There are several
approaches that might help the services address communication strategies to reach a greater proportion of troops affected by combat stress.

One of these approaches is diffusion of innovation theory, which describes the “process in which an innovation is communicated through certain channels over time among the members of a social system (Rogers, 2003, p. 5).” This theory first addressed the spread of hybrid seed use in farming, but it has subsequently been adopted by many fields and embraced by the communication discipline.

THE PROBLEM/GOAL

Stigma stands as the greatest barrier to care for service members afflicted with combat stress injuries (Hoge, et al., 2004; Britt, Greene-Shortridge, & Castro, 2007). Communication channels and strategies employed by the military services and other groups must address the issue of stigma to be more effective at reaching the service members who suffer and persuading them to seek the help and support they need to recover.

Importance of the Study

For many of the men and women who have borne the brunt of nearly ten years of war, some making multiple combat deployments – and to the families they left at home to carry on – combat stress has profoundly affected their lives. The military, supported by the Department of Veterans Affairs, has an acknowledged responsibility to help restore these men and women to health and social function. They expend resources urging affected service members to seek help, but they have not, as yet, explored what specific forms and channels of communication are preferred by the affected members.
This study aims to close that gap in the research and provide a better understanding to the audience to enable services and veterans organizations to communicate more effectively with this population and help more seriously affected veterans find a path to managing their symptoms and eventual recovery.

Statement of the Problem

What has been lacking is an effort to determine which communication channels and strategies used by the services are most effective at reaching combat veterans and others affected by these diseases. The following literature review will show what current research has found concerning these injuries and will suggest avenues to explore when trying to reach out to those who suffer from combat stress injuries.

DEFINITIONS OF TERMS USED

The following terms are utilized in this thesis:

**Brigade combat team** (BCT) is the basic deployable unit of maneuver in the U.S. Army, usually numbering between three to five thousand men.

**Combat stress** is the mental, emotional or physical tension, strain, or distress resulting from exposure to combat and combat-related conditions.

**Combat/operational stress injuries** are subtle physical changes in the brain. They occur when stress is too intense or lasts too long. These injuries affect the brain’s ability to handle and adapt to stress, sights, sounds, movements, and memories. These are true physical injuries (Hoge, Castro, & Eaton, 2006).
**Individual augmentee** (IA) is a service member who supports or “augments” another Navy, Marine Corps or Army command for a combat deployment. These individuals usually return to their original commands following deployment. Their assignments vary in length from a few months to a year or more. The Army defines an IA as “Deploying with a unit or component that is not your own.” Source is the website for The Real Warriors Campaign is an initiative launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

**Post-Traumatic Stress Disorder** (PTSD) is an anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD. Source is Military Pathways DoD sponsored website (militarymentalhealth.org).

**ORGANIZATION OF REMAINING CHAPTERS**

This study is organized into five chapters. Chapter Two is the review of literature concerning diffusion of innovation and dissemination theories plus the nature and occurrence of combat stress injuries. This literature serves as the foundation from which the study is built.

Chapter Three describes the scope of the study and the methodology employed in this qualitative study. It includes the rationale for these choices. Chapter Four discusses the results of the study, themes that emerged from the data, and the implications of those findings. Chapter
Five discusses the limitations of the study, plus conclusions drawn from the research. This chapter also suggests areas for additional research.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

For nearly ten years, the United States military has been engaged in wars in Iraq and Afghanistan. According to Defense Department figures, to date more than 2.4 million troops from all services have deployed to fight those wars. Among those service members, more than 90 per cent have been exposed to the kinds of trauma that can cause combat stress-related ailments such as post-traumatic stress disorder (PTSD), major depression, substance abuse and anxiety disorder (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004).

There has been considerable research on the nature of combat stress disorders, the range of symptoms for these injuries, the likelihood of a service member developing them, and how to identify, diagnose and treat patients. There is a tremendous volume of material available in the general public and from the military about combat stress. There have been high-profile cases of tragic and violent actions taken by service members and later blamed on psychological damage caused by combat stress. Services have stepped up internal efforts to train leaders to spot signs of combat stress, but gaps remain. The following chapter will review communication and related psychology literature pertinent to the topic of study – namely the communication preferences of combat veterans suffering from combat stress-related illnesses or injuries.

Philosophical assumptions: Origins of duty

Military service is steeped in traditions and expressions of “duty” – duty to one’s country, to one’s unit, and to one’s fellow soldiers, sailors, airmen and Marines. The great philosopher
Immanuel Kant defines duty as “the necessity to act out of the reverence for the moral law (p.15)”. Kant’s categorical imperative states that one is to “act only in accordance with that maxim through which you can at the same time will that it become a universal law” (Kant, 1993, p. 14).

Military service, even in today’s all-volunteer force, places duty at the center of daily activity and conscience. Military culture espouses that, just as the individual soldier has a duty to perform his or her mission under almost any circumstances, the service also has a profound duty to the service member. That sense of duty is manifest in symbolic and practical ways. The Army and Marine Corps (the two predominant ground-combat organizations in the United States) both declare that they will not leave a fallen comrade behind on the field of battle. There are many examples of troops risking their lives to recover wounded or dead comrades. Even dead soldiers will be brought home and treated with dignity. This sense of duty and obligation to fellow soldiers carries over to those injured in battle. Combat-wounded veterans are afforded life-long free medical care associated with wounds suffered in battle. Indeed, Vice President Joe Biden has stated, “And the only sacred obligation our nation has is to care for those who we send to war, and care for them when they come home.” (Remarks at Al Fawr Palace in Baghdad, December 1, 2011, retrieved from the White House web page).

Certainly among that national obligation is the need to care for service members who suffer from injuries or illnesses resulting from exposure to combat stress, such as PTSD, general anxiety, substance abuse, and major depression. Hoge, et al., (2007) found that more than 17 percent of soldiers deployed to Iraq or Afghanistan during the recent conflicts experience PTSD and related injuries. The Army, for instance, actively reaches out to soldiers and their families via all
forms of internal and external media to provide information on symptoms of combat stress and resources (both service-related and confidential) to deal with it (G. Wright, personal communication, November 23, 2010). Even so, less than half of those service members affected seek treatment to deal with these injuries (Hoge, et al., 2004).

*Theoretical basis*

*Dissertation theory and diffusion of innovation theory*

Dissemination theory and diffusion of innovation theory offer insights into the military’s approach to communicating with its various publics about combat stress. According to Rogers (2003), dissemination often refers to diffusion efforts that are planned and managed. He finds that diffusion (understood as the spread or adoption of ideas) can be an outcome of efforts to disseminate information, although in his research, he refers to both planned and unplanned spread of innovation as diffusion. Diffusion of innovation theory describes four factors that influence the way in which innovations or ideas spread. They are: 1) the nature of the innovation, itself, 2) communication channels, 3) time, and 4) the social system.

Often discussed together, these theories describe how information is broadcast or shared and how new ideas are adopted and spread throughout communities or organizations, and are frequently sighted in the fields of public health and medicine. Dearing (2008) describes it this way:

> Increasingly, we are also interested in using what we know about diffusion processes to accelerate the pace of adoptions, enhance the quality of innovation implementation, sustain the use of worthy innovations, and, as ultimate outcomes, demonstrate innovation at individual client and client system levels (Rabin, Brownson, Kerner & Glasgow, 2006). These latter objectives, especially when they concern the translation of evidence-
based public health practices and programs, constitute dissemination interventions (p. 99).

What researchers and policy makers are trying to do, Dearing summarizes, is use “what we know about how and why innovations diffuse to design and conduct dissemination interventions (2008, p. 99). Indeed, Colon-Ramos, et al., (2009), describe studying especially networked individuals as a means of identifying a better way to disseminate health care information.

The Literature

Early dissemination theory looked at the broadcast of information to determine the rate at which it was absorbed by the intended audience with little attention paid to how that information was used (NCDDR report, 1996). Subsequent efforts to understand and apply principles of diffusion in the late 1960s introduced Ryan and Gross’ emphasis on individuals as change agents and the consideration of communication obstacles within the disciplines of sociology, medicine, education and later communication (Dearing, 2008).

The basic premise of diffusion of innovations theory is that innovations perceived as advantageous by early adopters who share their experiences with others will see a sharp increase in the rate of adoption (Rogers, 2003; Backer & Rogers, 1998). Diffusion, itself, is the process by which innovations are communicated over time through given channels to other members of a social system or network, making it predominantly a social process (Rogers, 2003).

Conceptual framework

Limits to dissemination
Military service and Department of Defense efforts to disseminate information on PTSD and related combat stress injuries are evident in any cursory examination of national media over the past 10 years. These efforts are even more abundant when examining military internal communication channels, such as service web sites, online forums, service magazines and base newspapers. The Army excels at repurposing and combining information products across media, such as their Army Knowledge Online (AKO) web site and social media sites (Annenburg and Ketchum Study, 2009). But there is still significant resistance among combat veterans to self-report emotional or psychological difficulties. Britt, Greene-Shortridge, and Castro (2007) found that the nature of PTSD makes it far less likely for individuals suffering from it to seek professional help.

The seminal work on the prevalence and nature of combat stress-related injuries and their impacts on service members from the U. S. most recent conflicts in Afghanistan and Iraq has been led by Dr. Charles W. Hoge, MD, of the Walter Reed Army Institute of Research. Hoge, et al., (2004) studied more than 6,000 soldiers and Marines following combat duty in either theater of war. Problems resulting from exposure to combat stress included major depression, generalized anxiety, PTSD, and substance abuse, with high rates of comorbidity among these. Significantly, less than half of affected service members reported they were likely to seek help, most reporting they were deterred from seeking help by the stigma of having a mental illness. The powerful effects of stigma were explored by Goffman (1963), which he described as “undesired differentness from what we had anticipated (p. 5)”. Stigma may apply to physical deformities, perceived character flaws or weaknesses, such as mental illness, alcoholism or imprisonment, and the tribal stigma of race, religion, or national origin. The second form of
stigma is at work in the case of soldiers and veterans with combat stress injuries. In the culture of warriors, especially, none may shirk their duties unless physically unable to perform – usually due to a gaping wound or obvious affliction. Being unable to perform one’s duties due to emotional or psychological trauma is devastating to the service member.

Friedman (2006) observed that people with PTSD frequently avoid seeking help due to fear of the stigma associated with mental problems and fear it may impede their careers. This reluctance to seek help is exacerbated by their symptoms of avoidance and isolation. Corrigan and Watson (2002) reviewed studies of stigma and mental illness to determine how the stigma associated with mental illness affects those suffering from it. They find that the stigma of affliction often leads to degraded self-esteem and becomes a significant barrier to seeking and benefiting from professional help. They did not look expressly at combat veterans, but their work is comparable to a meta-analysis by other researchers (Britt, Greene-Shortridge, & Castro, 2007) who found that social and self-stigma were deterrents to seeking help for mental health problems among the military, especially male service members. In the military, in fact, PTSD and other maladies caused by combat stress are known as “invisible injuries.” They cite studies that indicate those suffering from PTSD are most likely to see mental illness as highly stigmatized, suggesting that those who need help the most are ironically the most critical of people who seek help from mental health professionals (Britt, Greene-Shortridge, & Castro, 2007).

Additionally, other researchers reviewed twenty years of mass media content studies to analyze the representation of mentally ill persons and media’s effects on how they are perceived by others. The media content examined included news media reporting, movies, and television programming. They
found that media depictions are generally inaccurate and exaggerated and lead to stereotyping and 
enforce social stigma, (Klin & Lemish, 2008).

Possible avenues to overcome barriers

The foregoing recognition that there are special challenges and barriers to effective 
communication with this audience is critical to reaching them and encouraging them to seek help. A 
closer look at applications of diffusion theory may help frame efforts to reach affected service members 
and subsequently share successful interventions with other commands and mental health practitioners. 
There is often great disparity between how researchers and practitioners describe best practices, making 
it more challenging to share the results with those who would use them (Dearing, 2004). Once best 
practices are identified, diffusion theory can help suggest the best means to spread those practices 
among interested users, be they mental health professionals, military leaders, or family support groups.

Greden, et al., (2010) found that pairing National Guard soldiers who were in treatment 
for PTSD, with trusted fellow veterans who had been successfully treated for the combat stress 
significantly improved the new veterans’ willingness to engage in treatment (adherence) and 
successful outcomes for that treatment. Stephens and Long (2010) found similar results when 
they studied police officers in New Zealand who had been involved in traumatic events on the 
job (much like combat experiences). They found that social support was an important factor in 
mitigating the long-term effects of post-traumatic stress.

Canadian clinicians studied the combined effects of treatment and peer support in 
Canadian combat veterans. Heber, Grenier, Richardson, and Darte (2006) found that veterans 
with operational stress injuries (OSI) – their term for combat stress – were more likely to 
overcome stigma and to benefit from clinical therapies if they were paired with another combat
veteran who had already been treated for OSI. They believe that fellow veterans could be even more effective at encouraging early treatment through education and outreach to troops and throughout their chain of command. Credible peer experience and acceptance (demonstrated by the peer veteran volunteers) helped overcome the power of stigma. Given that pairing successfully treated veterans with individuals currently being treated has shown promising results, there may be reason to pursue greater involvement of treated veterans in outreach, as well as treatment.

Rogers (2003) introduces related variables, homophily and heterophily. In discussing interpersonal channels of communication, he defines homophily as “the degree to which two or more individuals who interact are similar in certain attributes, such as beliefs, education, socioeconomic status, and the like” (p.19). It is far more likely to achieve successful communication when homophily is present. Heterophily is the degree to which individuals are different from one another. Rogers warns that one of the greatest challenges in instances of diffusion is that change agents are almost always different than most others in the social network.

Similarly, among military service members today it is common to hear distinctions between combat veterans and those who have never been deployed to a combat theater. This includes doctors and mental health professionals, as well. Combat vets have a shared experience that others do not. Combat vets with PTSD or the like may feel that distinction even more strongly (Greden, et al., 2010). The standard uniform worn by deployed soldiers, the Army Combat Uniform (ACU), makes this combat service distinction evident – all service members wear the organizational patch of their current unit on the left shoulder. Members who have served in combat wear the organizational patch from their unit at the time they served in combat. Members who have not served in combat wear no patch on their right
shoulders. Soldiers size each other up by looking first at the right shoulder of new arrivals to their platoon to determine if they have “been there, done that” and have combat experience.

Another consideration explored by scholars for dealing with combat stress is social support. Boscarino (1996) explored the relationship between combat exposure and social support among Vietnam veterans. He found that combat veterans were more likely to have PTSD than non-combat veterans. But he also found that veterans with higher levels of current social support experienced better overall mental health. Furthermore, veterans who had lower levels of social support in the past were found to be more likely to have PTSD, generalized anxiety, substance abuse and depression.

Diffusion theory research suggests some ways in which sharing of information and the spread of ideas may be influenced within groups. Singhal (2010) advocates an approach to diffusion theory that encourages innovations from within, rather than those coming from external change agents. His “positive deviance” approach highlights behaviors and contributions of network members. Van Swol and Seinfeld (2006) studied the potential of minority and majority group members to affect group discussion of information. The authors distinguish between common information (known to all in the group) and unique information (known only to one or to a minority of members) and propose a strategy to use common information to enhance credibility by minority group members.

The role of individual efforts to influence behavior and share information is examined by White, Vanc, and Stafford (2006). They explore leaders’ roles of providing influence within their organizations and the role of organization members as public relations advocates outside the organization and try to identify preferred media for internal communication.
Rationale

This study sought to identify the communication channels and methods preferred by combat veterans. Future researchers, communication planners, and military leaders might be able to use this information to develop dissemination strategies likely to result in a greater number of affected service members and combat veterans self-identifying earlier and being more willing to seek help. Psychological literature is full of evidence that standard treatment modalities for combat stress can be very effective and almost always result in improvements (Blake, Cook & Keane, 1992; Hoge, Auchterloine, & Milliken, 2006), but these modalities cannot be effective until they are sought out by the men and women who are experiencing debilitating post-traumatic stress.

Research questions suggested by the literature

The foregoing review of the literature suggests that there may well be an important role for combat veterans who have already successfully dealt with the trauma and stigma of combat stress to communicate with veterans still suffering and untreated. Diffusion theory incorporates the importance of individual effort in sharing information and spreading innovation (Van Swol & Seinfeld, 2006; White, Vanc, & Stafford, 2006; Rogers 2003). Peer support and participation has also been seen as an effective enhancement to treatment modalities (Heber, Grenier, Richardson, & Darte, 2006; Greden, et al., 2010; Stephens & Long, 2010).

To address the study’s objectives and explore the communication preferences of combat veterans suffering from combat stress-related injuries, the study employed grounded theory research and extended individual interviews. The study used a purposive sample of Iraq and
Afghanistan theater veterans from a variety of Army and Navy units, mission specialties and ranks. A plurality of the respondents came from traditional Army combat units, called brigades. Troops assigned to these wars come from all sorts of units and specialties (i.e. combat, support, logistics, and aviation), and from all four military services and the Coast Guard. The single largest proportion of forces deployed to both wars comes from the Army’s traditional combat brigades (Contingency Tracking System of the Defense Manpower Data Center, 2011). Ninety percent of all forces deployed to both theaters encountered the kind of stressors and conditions that can trigger PTSD and other combat stress reactions (Hoge, et al., 2004).

The next chapter describes the scope of the study and the methods employed in this qualitative grounded theory study.
Chapter 3

Scope and Methodology

Scope

The study undertaken was qualitative in nature and employed grounded theory. Qualitative research may rely on direct observation of social phenomenon in a natural setting. Grounded theory research employs inductive reasoning and cyclical analysis of data and observations to develop theories that address the research objectives (Babie, 1989). According to Denzin and Lincoln (1994):

The word qualitative implies an emphasis on processes and meanings that are not rigorously examined, or measured (if measured, at all), in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning. In contrast, quantitative studies emphasize measurement and analysis of causal relationships between variables, not processes. Inquiry is purported to be within a value free framework (p. 4).

Glaser and Strauss (1967) define grounded theory as “the discovery of theory from data systematically obtained from social research” (p. 2). It involves continuous examination of field data, analysis, research, and other sources to create theory during the research process, rather than beginning with a theory that will be supported or disproven by what is observed.

This study employed intensive interviews of a purposive sample of combat veterans diagnosed with combat stress-related injuries. Thick description of the respondents’ answers and affect during the interviews will help bring readers into the setting and enable shared constructions of meaning (Erlandson, Harris, Skipper, & Allen, 1993).
Trustworthiness is critical to this kind of research. There are four components to trustworthiness – these are credibility, transferability, dependability, and confirmability. Credibility refers to the degree of confidence that the study has discovered some truth for the participants; Erlandson, et al., (1993), state that credibility is “the compatibility of the constructed realities that exist in the minds of the inquiry’s respondents with those that are attributed to them” (p. 30). Transferability refers to the degree to which findings from a study can be applied to another context. Dependability refers to reliability of the study – can results be replicated from like subjects in a similar context? Confirmability means the findings reflect the comments of the respondents and can be traced back to the data (Erlandson, et al., 1993).

Another critical component of naturalistic research is to ensure the confidentiality of the respondents. Care was taken to preserve the anonymity of all respondents. They were provided with a confidentiality agreement in advance of their interviews.

Methodology

The study was designed to address the primary research objectives listed below. Intensive interviews of combat veterans diagnosed with PTSD and similar combat stress-related injuries addressed how they came to recognize that they had a problem and what sources of information did they view as credible? Interviews began with “ice breaking” questions to ease the respondents concerns over what may be emotionally charged subjects and to give them practice answering questions (Erlandson, et al., 1993).

Research objectives include the following:
RO1: Examine the role that one-on-one dialogue plays in communicating with combat vets.

RO2: Examine how credibility, homophily, and affinity of the source affect communication outcomes.

RO3: Examine who combat veterans view as credible sources on PTSD and other combat-stress related injuries.

RO4: Examine where the subjects turn for information when they suspected they might need help.

RO5: Examine how the subjects became aware they needed help.

Sample and Population

The study employed a purposive sample of nine combat veterans who have left the service (seven Army and two Navy veterans). The group will be described in greater detail in the next chapter. A purposive sample provided a great deal of information about a few combat veterans. According to Patton (1980), “the logic and power of purposive sampling lies in selecting information rich cases for in-depth study” (p. 169). Much more may be learned about in-depth discussions with a few combat veterans than by gathering brief answers to standardized questions administered to a large number of combat veterans. A random sampling is not preferred here because the intent of the research is not to generalize the findings to a broader population but to discover greater depth of knowledge of patterns and themes in the context being studied (Erlandson, et al., 1993).

Respondents were initially sought from among Army veterans who served in front line combat units, known as brigade combat teams or BCTs. This selection was intended to ensure
greater uniformity of experience among the respondents. Service members from different kinds of units (such as logistics or security details) and services (Navy, Air Force, and Marines) could have experienced vastly different conditions and duties within the combat theaters of Iraq and Afghanistan. Personnel in BCTs make up the single largest category of soldiers (26 percent) deployed to Iraq and Afghanistan according to Department of Defense reports. Respondents were self-identified from among online communities of combat veterans, personal referrals from Army personnel, and veterans support groups. A slow initial response from the intended subgroup of soldiers led to the inclusion of military personnel from a broader range of units and the inclusion of two sailors who served on the ground in Iraq and Afghanistan (with joint service organizations) in the group of respondents. Iraq and Afghanistan are witness to a form of asymmetric warfare, absent the traditional front lines and exclusive combat zones of WWI and WWII. Anyone stationed anywhere in these countries can be exposed to rocket attacks, sniper fire, and the threat of car or road-side bombs, known in the military as improvised explosive devices (IED). The experiences of the respondents clearly represent that nearly any service member deployed to Iraq or Afghanistan can be exposed to combat stress.

Measurement Procedures and Instrument

The research instrument (Appendix A) was a series of open-ended questions derived from the research objectives. The questions include ice-breaker questions designed to put the respondents at ease and give them practice talking about their experience during and following their combat deployments. The instrument was developed in consultation with researchers who have performed similar field research. The questions were pilot tested with a combat veteran to ensure their credibility and ability to encourage dialogue between the respondent and researcher.
Data Collection

The primary data collection was through one-on-one extended interviews with combat veterans, with the majority conducted over the phone due to the location of the respondents. The purpose of the study was made clear to the respondents prior to beginning the interview. Care was taken to explain that their identity and personal information would be protected in the study (Confidentiality Agreement is Appendix B). Data from the interviews is only presented in aggregate. Respondents are identified by an alpha-numeric designation assigned by their sequence of interview and service affiliation (i.e., the first Army veteran interviewed is AV1; the third veteran interviewed was from the Navy and is designated NV3).

Interviews were semi-structured, with topics and basic questions developed and used in all interviews. These were not rigorously scripted and allowed for follow-on questions and spontaneous sharing of information. Telephone interviews became necessary due to the geographic distribution of the respondents. Interviews were conducted in a private setting to facilitate open sharing of information. Interviews were recorded with permission from the respondents (audio only) and the researcher took field notes. Field notes were reviewed and expanded immediately following interviews to capture as much rich detail as possible. Recordings were saved and transcribed to enable confirmability.

Erlandson, et al., (1993), suggest that it is preferable for researchers to gather data in a variety of ways from a variety of sources because respondents are unlikely to be able to identify and describe constructed realities to the researcher’s satisfaction, because “the respondent, like the fish who would have a hard time describing water, is unlikely to be aware that the common language would evoke any constructions other than those he or she is using” (p. 81). Questions
are asked to elicit responses, certainly, but respondents were encouraged to share in a less structured way in hopes that their hidden assumptions might be revealed. The interviews identified sources of information used by the respondents. These sources were examined, as well, to provide for triangulation of data.

**Data Analysis**

Data analysis begins immediately for the naturalistic researcher. Erlandson, et al., (1993) cites Marshall and Rossman (1989) as they describe data analysis in naturalistic research:

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative, and fascinating process. It does not proceed in a linear fashion; it is not neat. Qualitative data analysis is a search for general statements about relationship among categories of data; it builds grounded theory (p.112).

Data analysis is an interactive process that occurs at the research site and away from the site, in between interviews or observations. While traditional research separates data collection and analysis, naturalistic research sees them as inseparable (Erlandson, et al., 1993). Data collection will lead to refinements in the interview instrument (new questions), which will, in turn provide additional data. According to Erlandson, et al., (1993), “The interactive refining process never really ceases until the final report is written. Even in the final member check interpretations are challenged and modified if the weight of data supports modification (p. 114).”

Data collection and analysis continue in parallel throughout the study, leading to constant revision and enhancement of emerging themes and grounded theory.

In this study, data was analyzed using the Glaser and Strauss (1967) constant comparative method. This is a grounded theory process that generates theoretical properties for categories of
data. These provide understanding for the data and how it relates to and interacts with other categories. Initial analysis began by pouring over the interview data to identify recurring themes.

Themes and categories that emerged were member checked with respondents to ensure the interpretation was accurate and reliable. Andenoro (2005) suggests that similarities in member responses will emerge and these will lead to identification of categories. There is no predetermined limit for the number or type of categories to emerge, which comes from the data itself.

The research and findings are presented in the next chapter, providing an understanding of how the study group of combat veterans obtained information about their combat stress-related injuries, where that information came from, and what sources they considered most credible. The themes emerging from the data are identified in bold type. These themes provide the foundation for the grounded theory developed from all the data reviewed.
Chapter 4

The Study Analysis and Results

Introduction

The review of the literature has established that there is a wealth of information and research about the nature and effects of combat stress. Research in dissemination theory and diffusion of innovations theory provides promising leads into the realm of how information about combat stress might spread among audiences, but there is a notable absence of research about what communication methods and messengers might be most effective at reaching the service members who are already suffering from the effects of exposure to combat stress. This chapter pursues that very area of inquiry. The research is presented as a narrative. Erlandson, et al., (1993) suggest that the narrative is an alternative to the case study method as a means of writing up qualitative research. The narrative is written from only one perspective and is less complex than the case study. According to Eisner (1991), the narrative helps the researcher describe, interpret, and appraise what he or she has observed and is reporting on.

The Respondents

The nine respondents ranged from 25 to 51 years of age. Most were male from front-line combat brigades or support battalions serving side-by-side with front-line troops. Two were female. Two were Navy enlisted personnel that served as Individual Augmentees (IAs) with joint service units. Their military ranks spanned from specialist (E-4) to lieutenant colonel (O-5) and their length of service in the military ranged from 4 to 21 years. One served in Combat Support Hospital (CSH, pronounced “CASH”) units working feverishly to save wounded
soldiers in both Iraq and Afghanistan, as well as the primary US military evacuation hospital (in Landstuhl, Germany) for wounded troops from both wars.

One interviewee performed forensic analysis at the chaotic scenes of scores of improvised explosive device (IED) attacks across Iraq, sifting through body parts and bits of burned clothing from victims to learn as much as possible about the weapon of choice of the Iraqi insurgency. One female was raped by fellow soldiers while deployed. One soldier worked closely with two officers murdered in their tent by another soldier in an early case of fratricide, having often visited them in that same tent. One soldier served as a prison guard in the largest detention facility in southern Iraq. Another respondent, in the course of his duties, watched the unedited video of the decapitation of American contractor Nicholas Berg. Despite having been blown out of his bed by a huge truck bomb used to assassinate an Iraqi leader early in the war (leading to permanent nerve damage), his most disturbing memory from the war is that haunting and grisly video.

All of the respondents were exposed to enemy fire. Many saw comrades killed or maimed. One had a 2,000 pound bomb mistakenly dropped on his position by a US warplane – fortunately for his platoon, the bomb did not detonate. Despite being reasonably well-adjusted now, nightmares of fireballs falling on him from the sky persist nearly ten years later – he calls them his “weekly reminders” of his time at war. One had a British soldier die in her arms following an attack on a convoy. When she got back to her base, she had to change out of her blood-soaked uniform.

The nine respondents experienced a total of 17 combat tours among them, with three serving one each; four serving two combat tours; and two serving three combat tours. Upon
returning home, three attempted suicide and at least one more considered it. Three have been assigned or sought service dogs as part of their recovery from TBI and PTSD. Many remain on medication for sleep disturbances, depression, and anxiety. Five have also been diagnosed with a traumatic brain injury (TBI). Three have been medically retired due to their injuries. The respondents come from Texas, Louisiana, Ohio, Washington (state), New Mexico, West Virginia, Wisconsin, and Colorado. None thinks they will ever be the same as before their combat experience, but they all hope for improvement.

<table>
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<tr>
<th>One combat tour</th>
<th>Two combat tours</th>
<th>Three combat tours</th>
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<tr>
<td>3</td>
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Number of combat tours experienced by study respondents.

Data Analysis

During the initial analysis of data, common themes began to emerge among the respondents. These themes were aligned under the research objectives and re-examined and refreshed with each subsequent interview. Themes and the data that supported them were verified by member checking throughout the process.

Research Objective 1

Examine the role that one-on-one dialogue plays in communicating with combat vets about combat stress.

The first theme that emerged from the interviews is that almost no one talked about combat stress within their units, except occasionally among friends or peers. This code of
silence is consistent with psychological research that highlights the stigma of mental illness (as some regard these invisible injuries) as a significant barrier to care (Hoge, et al., 2004; Britt, Greene-Shortridge, & Castro, 2007).

When asked if respondents ever discussed their experiences or symptoms of combat stress with other members of their units (when they were still on active duty), the answers were resounding. According to NV3, he was reluctant to discuss his symptoms with anyone for fear of the stigma associated with it:

No one ever talked about it. I honestly couldn’t say, even looking back. There’s only one person that I ran into that had it (PTSD). And the only reason I knew was because when I was getting ready to check out I had to go over to mental health. And this person happened to be there and we got to talkin’. And found out they were getting medically retired for it. I was like, you know what? My second enlistment’s almost done. I don’t even want to try and mess with that (NV3).

Despite serving as a medical professional with clinical knowledge of the symptoms of combat stress and despite serving in a leadership role where she looked out for signs of stress in her subordinates and peers, AV5 said, “Oh, no. (laughing). We didn’t talk about that! I don’t know why. Probably ‘cause we were medical, you know, we’re all invincible. Didn’t you know that? (more laughing).”

For NV9, no one spoke about PTSD during his deployment. The first mention of it he recalls was during his post-deployment health screening in Kuwait. NV9 minimized his experiences and denied any symptoms for fear it could delay his return home. When told nothing revealed in the screening would hurt his career, he recounted, “yeah, right! I didn’t believe a word she said.”
Despite the lack of discussion about their combat stress during deployments and while still in the active service, all of the vets currently seek out or have in the past sought other vets with which to discuss their shared experiences. Some have been almost evangelical in their eagerness to share their experience. AV1 even wrote a book about his experiences – something, he believes, that aided his healing. Following release of his book, it seemed all he did was talk about it; now he is reluctant to do so (he thinks it has run its course with him). Others are talking about it now in Community of Veterans online established by the Iraq and Afghanistan Veterans Association (IAVA), a non-profit organization founded by veterans to support combat veterans.

Respondents in this study have been observed sharing with others (and one another) in a forum for service members with PTSD hosted by the IAVA. Two of the respondents, in particular, are quick to reply to anyone expressing frustration or dismay with the progress (or lack of progress) of their individual recovery, offering encouragement or sharing that they have had similar experience, and to share their own struggles and little triumphs. It is a community of mutual support and shared pain. AV5 recently answered another vet struggling, “Hey C. - It's such a slow process, 1st learn to live back in the world, then get well enough to actually live well, what is their follow-up plan.”

Research Objective 2

Examine how credibility, homophily, and affinity of the source affect communication outcomes concerning combat stress.

This objective differs from the previous objective in that it seeks to get at the qualities of someone with whom the respondents are willing to speak about combat stress. A recurrent theme
for combat veterans suffering from combat stress injuries is that they **want someone to talk to who understands** what they have been through or what they are currently experiencing (**code of knowledge**). The two principal factors of credibility most often cited by the respondents are combat experience (representing homophily and affinity) and medical knowledge. They have little patience for questioning from military service members who have not served in combat or civilians who have no understanding of the nature of their injuries. After a tour in a CSH in Afghanistan, one respondent said, “I went to the VA (Veterans Affairs) just to try and see. I didn’t think there was anything seriously wrong with me. I just wanted, you know – it was like I felt like I just needed to talk to somebody a little bit to, you know, get calmed down (AV5).” Eventually, she readjusted to life at home and felt better, but a deployment with a surgical team in Iraq led to significant trauma and her eventual diagnosis of PTSD.

One respondent served in Baghdad with the command responsible for training and equipping the Iraqi military and national police. His base in the International Zone was rocketed daily and he narrowly missed being blown to bits by a blast that killed another soldier on the path he had just left. He was a Navy petty officer (non-commissioned officer) deployed from his ship as an individual augmentee (IA). “When I went back to my command, there was only like five or six people who had went IA. None of those (non-deployed) people understood. They were complaining about not having candy in the candy machine. I said, “You gotta be fuckin’ kidding me. You’re complaining about this?” . . . I want to be around people who understand me (NV9).”

Respondents most often found non-military medical professionals to be credible sources of information about combat stress, as there was no perceived desire to push them back into
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combat. Chaplains were often good sources, as well. But when the respondents sought help because of worsening symptoms, they almost all experienced a sense of relief when an intake physician, psychologist or psychiatrist validated their experiences and explained the cause of the symptoms.

Following an unsuccessful suicide attempt, AV 2 became an in-patient at the VA Healthcare Center in Seattle. “They told me what PTSD is and what it is not and I will tell you that is the best program I ever went to. They built up my confidence because before I had tried to commit suicide, was unsuccessful (AV2).”

AV8 now talks to her grandfather, a combat veteran from the Korean War.

He wouldn’t tell me anything before I went to Iraq. My first duty station was Korea and I would ask him what Korea was like when you were over there and all he would say was, “It stunk when I got off the plane and it stunk when I got on the plane to leave.” But now, after I got back, he’s told me how he got his Purple Hearts (medal awarded when a service member is wounded in combat); how his unit, how some of the guys from his unit hid up in the hills – in the caves in the hills when they got ambushed on Outpost Reno. And those guys are still over in Korea in the hills (AV8).

She summarizes, “’Cuz I mean there’s nobody that can really understand except for people who’s been there. So – and honestly that’s a lot of people’s mentality about it, too, for veterans. You can’t really try to explain to someone what it’s like (to be in combat, AV8).”

AV7’s realization that he had persistent combat stress injuries came about in large measure because another combat veteran with PTSD recognized the symptoms and called him on it at work.

I’d say in December 2006 the nightmares started. And then I was helping a Virginia National Guard Unit getting ready to deploy. Something that fell and made a loud bang – and I’d say that was my first flashback. It might have something to do with all the medication I was on (after back surgery). I was on
Valium, Percocet, morphine, Flexoril, and . . . something else. After the unit from Virginia deployed . . . we moved to Charlestown, WV and started working at Fort Dietrich, MD. . . When I started working up there, the NCOIC (non-commissioned officer in charge) goes, “How long have you been having nightmares?” I said, “How’d you know I’ve been having nightmares?” He said, “I can see it in your face.”. . . He told my doctor I needed to have a psyche eval and a referral for a shrink and a counselor (AV7).

These veterans witnessed or experienced death or serious injury to others. Their combat stress injuries helped create a condition of isolation from family and friends and they feared that military doctors would push them out of the service or back into combat. As their conditions grew worse, they wanted to know what was wrong, but they were extremely wary of whom they would confide in. For all of them, shared combat experience established instant credibility.

Research Objective 3

Examine who combat veterans view as credible sources on PTSD and other combat-stress related injuries.

Most of the respondents expressed wariness or distrust of military medicine (code of distrust). They feared that information shared with Army (or Navy) doctors would be shared with their command and impact their careers. They suspected that medical personnel had an agenda or were perhaps were being directed to rush people back to the fight.

Unique among the respondents, AV1 believes that he was well-trained by the Army to identify and deal with combat stress . . . he just never thought it would be applicable to him.

Actually, I got pretty good training on this when I was at Infantry School. I never thought I would be associated with it or have to understand it. But I remember it. I remember it to this day. I remember at Army Infantry Officers Basic Course at Fort Benning (Georgia). Ah, I remember we spent an afternoon talking about it. We watched videos on it and they had films of these dudes from World War II who were like completely fucked up. I probably would have remembered it
anyway. You know, the military gets kind of a bad rap for lack of preparation in this area. But I felt like I knew exactly what I was dealing with. I had a good upbringing in the Army. I felt mentally prepared for it. That is also what I think kinda screwed me up. Because I thought I was going to be impervious to this. I thought it could not affect me because I knew about it. I could see it coming and I was mentally prepared for it. And that was not true (laughs). That was a miscalculation. (AV1).

Several respondents sought information online when they began experiencing worse symptoms. During their out-processing from the military, all were briefed by representatives of the VA about documenting health concerns or injuries that had occurred while in military service. Several recall looking at VA web sites for information about combat stress, PTSD and related topics. Others just looked at sites of non-profit organizations offering support for veterans or simply relied on their search engine. Not one looked at military-sponsored or official Defense Department web sites on the subject. They wanted information they believed would be objective and accurate, and vaguely distursed the military sites.

In addition to web-based information, some vets sought information from military chaplains. AV5, who was active in the practice of her faith until returning from her second tour, often sought out information and perspectives from the chaplains. Chaplains serve a unique role in the military in that they conduct worship services and also serve as counselors. They are charged with observing and supporting the mental and emotional well-being of the units they serve.

When asked whom he found credible, NV9 answered quickly, “The docs at the VA. They didn’t seem to have an agenda. They were just trying to help (NV9).”

Similarly, AV8 responded, “My psychiatrist (at the VA) and my grandfather (the Korean War veteran). I don’t want to have nothin’ to do with Army medicine!”
Research Objective 4

Examine where the subjects turn for information when they suspected they might need help.

It is worth noting that fewer than half of the respondents were diagnosed with combat stress injuries while still on active duty. Nearly all of the respondents sought information and assistance from the VA (code of the veteran) – some even talked to VA representatives while still on active duty. The military services all have members screened by the VA prior to separating to document any injuries or problems that began while the members were on active duty.

“I heard the VA helps, you know. I just didn’t know much,” said AV2. “I mean, I knew about vet centers, I just didn’t know much about ‘em. I just thought that well, you know, I’ve heard about the VA helping others before so now why not try it for myself (AV2).”

When he realized he was having problems he could not solve by himself, AV1 headed to the VA.

I didn’t have any issues with doing it either. I think we talked about it on the phone. It’s a lot easier when you’re no longer on active duty. I was already out. I wasn’t around any of my peers, so I think there was nothing to be ashamed of or embarrassed of. Because I had had the training, I was able to . . . self evaluate (AV1).

For AV8, recurring nightmares and sleeplessness finally drove her to seek help from the VA. She did not know what to expect, just that something had to change.

I’d been having flashbacks. I’d kind of repressed the whole rape thing – I mean, I knew I’d been raped, but I just kind of pushed it aside and ignored it. Eventually I was having flashbacks to different things and I eventually I would get about two
hours of sleep a night. Because the nightmares would come between one and two in the morning . . . so I would just stay up until four or five in the morning to avoid the nightmares – and have to get up at 7 to get my daughter ready for school. After a while it led me to . . . three different VA hospitals – as an outpatient for mental health -- and one of their small outpatient clinic to finally find a mental health professional who didn’t judge, didn’t make me feel uncomfortable in any way for me to actually talk about everything that happened (AV8).

Combat veterans make use of Internet search engines and online communities of interest to learn about combat stress and PTSD, in particular.

After I got back from deployment and got diagnosed with it – because I had heard about PTSD during our debriefing . . . But that debriefing just went in one ear and out the other. But after a year, when it didn’t go away, they changed it from adjustment to PTSD and I just picked up every pamphlet I could find at the VA. Then, I just typed post-traumatic stress disorder into my search engine . . . and followed where it led me (AV9).

Several non-profit organizations have emerged that are dedicated to supporting veterans in general and veterans with PTSD and other combat stress injuries. IAVA, an organization that reports a membership of more than 200,000 member veterans and supporters, operates an online community of interest for veterans of the wars in Iraq and Afghanistan -- they call it the Community of Veterans (COV). The COV provides an opportunity for veterans to seek out others with whom they identify in some way. This can be by units they served with, regions they served in, and where they live now; or shared outside interests such as motorcycles, running, or mountain climbing.

Research Objective 5

Examine how the subjects became aware they needed help.
The respondents’ paths to discovering their combat stress injuries were as different as they are. But often, friends or family were involved (code of relationships) in some way.

For the first veteran interviewed (AV1), his realization came while he was living at home awaiting the start of graduate school.

I don’t remember what my personality was like, up to a certain point. But I’ll never forget the night I decided that I should just go turn myself in to a therapist or something. My mom, in my old bedroom, moved my pillow or something. And I completely blew my fucking top about my stuff – I want to know where my stuff is, you know. And looking back, in retrospect, it’s all about accountability and tying down your weapon. Knowing where your gear is is a life and death situation. And she had moved my pillow or something and I completely lost it. I’m like ranting and raving, “Don’t move my stuff! Don’t touch my stuff! I’ll take care of my own stuff. Quit movin’ my stuff!” And my parents were exasperated and at one point she goes, “Are you listening to yourself? You’re talking about a pillow.” And I said, “Yeah. You’re right. I’m talking about a pillow.” I should probably go take care of this before it becomes a problem (AV1).

For AV2, the realization came months after he had left the Army.

When I could really tell I had PTSD was when I got out and was doing a lot of job-hopping and also had a lot of problems with relationships. I mean, a lot of failed relationships and basically job hopping is really what caused the problem for me. And basically I realized I was suicidal – I was like, “What’s the point of living if I can’t hold a job (AV2)?

NV3’s wife was aware before he was.

I was definitely different. My wife could tell it before I could. I was havin’ problems dealin’ with anyone in the shop I was in. Little things kept freakin’ me out. I kept getting what I thought was stress headaches, and it took the military four years to finally diagnose that I have nerve damage, and not stress headaches. . . . I had this funny feeling, and so I’d been hearing people talk about PTSD and stuff, and I looked on line, and I actually found a test, a 20 questions test. It was actually designed to be taken to a military provider. So, you know, print this out, answer the questions and then take it to your command doctor . . . answered yes to 18 out of the 20 questions (NV3).
Similarly, AV4 was encouraged to seek help because of the support and insistence of his wife.

Well, when I came back this last time I was, to put it in nice terms, I was a very angry person and my wife said that I really need to go see somebody and when we got our reintegration (brief) back onto the post they touched lightly on it. They asked us a few questions and stuff and they said, “Well, yeah, you should probably go see somebody over at Adult Behavioral Health.” But it was mostly my – through my wife coaching me such that I actually went and sought help (AV4).

Crippling and overwhelming anxiety led AV5 to recognize she had a problem that she and her family were unable to solve.

And when I got back for Iraq (second combat tour) I was dead inside. I didn’t realize it at first, you know. And my family was so happy to see me. And, you know, I just didn’t feel anything, you know. And I just thought well, maybe this will kind of just blow over like it did with the Afghanistan (deployment). . . . But, you know, then like about – oh, about five or six months after that – I don’t know what happened. Just blew up inside of me and I was like a wreck, you know. . . . couldn’t go out of my house . . . I was like jumping out of my skin (AV5).

In the case of AV6, the Army recognized he was having problems while he was still deployed to Iraq. His supervisor and commander were ill-prepared to deal with his condition.

I was actually, ah, brought out of country. Because I started doing things -- experiencing a breakdown and I was actually evacuated out. So I spent time in a hospital in Germany and then the US and then basically came back home to begin some sort of treatment. There really wasn’t much in place at the time (AV6).

The final respondent was diagnosed while still in the Navy. He had deployed from a ship to serve with a joint organization in Baghdad. When he returned to the Norfolk, Virginia, the ship was out to sea. He was experiencing sleeplessness, flashbacks, hyper vigilance, and anxiety. “I was in the parking lot and they were testing the tornado warning at the naval station. I heard it and I hit the deck – I just hit the deck. I was happy nobody was around (NV9).” Later,
after his ship had returned from sea, he was preparing to check back in. As he left his car, he suddenly became nauseated.

I first day I checked in with my command, I was getting ready to walk in from my car and all of a sudden I just felt this sudden burst of vomit and I started throwing up. I don’t know why. I had a week of it and I finally went to the doctor. First I talked to one of the corpsman – one of the guys I trusted. And, you know, I was really scared shitless to talk to someone about this because I was afraid of stigma. I was afraid of what it would do to my career. How could somebody in the Navy have PTSD, you know. I didn’t want to get labeled. I wondered what would happen to me. I thought they’d lock me up and throw away the key . . . I thought I’d get labeled. So I met with the doctor and told her what I was experiencing. So she put me on Ambien, which was a godsend to me (NV9).

Results of the Study and Discussion

The study reveals several possible implications for applying dissemination and diffusion theories and, most importantly, some possible insights into the communication preferences of veterans with combat stress injuries. Rogers (2003) identifies four factors that determine how ideas or innovations spread as 1) the innovation, 2) communication channels, 3) time, and 4) the social system. These categories are helpful in reviewing the interview data.

In the context of this study, the innovation or idea can be understood as a service member’s recognition of his or her need for help with symptoms of combat stress and the willingness to seek that help. Rogers (2003) defines innovation very broadly. It can be “an idea, a practice, or object that is perceived as new by an individual or other unit of adoption (p. 12)”.

There are five characteristics of innovations which, according to Rogers (2003) help explain relative rates of adoption of innovations. These are 1) the relative advantage of the innovation, 2) the compatibility of the innovation with social experience, existing values, and adopters needs, 3) the complexity of the innovation or how easily it may be understood by
adopters, 4) trialability of the innovation or the degree to which it can be experimented with without wholesale commitment, and 5) observability or the degree to which results of the innovation are observable to others. According to Rogers (2003), “The first two of these attributes, relative advantage and compatibility, are particularly important in explaining an innovation’s rate of adoption (p. 17)”

The relative advantage of the innovation of personal acceptance or recognition that one is suffering from a combat stress injury is that none of the respondents could begin recovering until they first understood what was wrong with them. All respondents expressed frustration, shame, and confusion at the symptoms they experienced and a profound sense of relief when they were diagnosed with a known condition that was treatable. The challenge in this case is the idea’s compatibility with the social norms and experience of military service members. Current norms include the strong stigma many experienced while dealing with invisible injuries and the reticence of service members to openly share their experience with combat stress while still in their units.

Communication channels, according to Rogers (2003) are “the means by which messages get from one individual to another” (p. 18). Based on the data, initially the most effective communication channels were personal conversations with other veterans (AV7, AV8, NV9) and one-on-one discussions with non-military mental health professionals or doctors (AV2, NV3, AV4, AV5, and AV6). Interestingly, all of the respondents would eventually prefer talking with others who had shared similar experiences – many seek out such affiliations via online communities or through membership in other veterans groups, such as the American Legion or the Veterans of Foreign Wars. Family observations or expressions of concern also proved to be
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effective channels (AV1, NV3, AV4, AV5, and AV7). Seeking or accepting messages from fellow veterans is consistent with Rogers’ contention that people are more apt to listen to someone they perceive to be like themselves. According to Rogers (2003):

> An obvious principle of human communication is that the transfer of ideas occurs most frequently between two individuals who are similar, or homophilous. Homophily is the degree to which two or more individuals who interact with are similar in certain attributes, such as beliefs, education, socioeconomic status, and the like (p. 19).

The third element in diffusion process is time. This variable accounts for the rate at which the innovation is adopted in the system, the time it takes for the individual to go from awareness of the idea or innovation to full adoption, and relative earliness or lateness that the individual adopted the innovation compared to other members of the system (Rogers, 2003). The study did not account for this factor, although several of the respondents became aware of their combat stress injuries very early in the war when it was still relatively uncommon (AV1, AV2, AV6, and AV8). The study respondents would not provide an adequate sample to assess this factor.

The final element of diffusion is the social system. Rogers (2003) defines the social system as “a set of interrelated units that are engaged in joint problem solving to accomplish a common goal (p. 37).” Each system has a structure and social norms that serve to impede or facilitate diffusion. The social structure in military service could facilitate information exchange and innovation adoption as it requires rigorous compliance to certain behaviors and demonstration of common attitudes. Previously noted norms among service members, (unwillingness to discuss combat stress with others, distrust of military medicine, stigma of
invisible wounds) however, make it difficult for members to admit to experiencing symptoms of combat stress.

But diffusion theory appears to have a limitation in dealing with PTSD and similar combat stress injuries. Victims of combat stress injuries have built in resistance to seeking treatment (Britt, Greene-Shortbridge & Castro, 2007), analogous to the denial experienced by alcoholics. Stigma is such a strong counter to reason and evidence of abnormal thinking that many service members never come forward and seek help for debilitating symptoms. Each of the respondents described considerable emotional upheaval and disruption and several were barely functional socially before they sought help for their problems. It may be reasonable to conclude that the population of combat veterans suffering from combat stress would be similarly resistant to information dissemination programs in use by the services.

It is evident from the study that three things mitigated stigma and other barriers to care when conditions got bad enough to demand some kind of action. First, was credible medical authority that appeared non-judgmental; second, was peer veterans who had experienced combat stress and its effects first hand; and third, was family intervention. These channels seemed to have the greatest impact on the respondents.

The final chapter brings together the literature, the analysis of the interviews and additional data to derive theory to explain communication preferences for combat veterans suffering from combat stress injuries. The chapter will discuss the limitations of this study and make recommendations for additional areas and populations to study.
Summary and Conclusions

Limitations of the Study

Every effort was made to conduct a credible and dependable study to answer the questions posed for this research, but there were limitations to the study. Of note, the brief amount of time available to gather data and an initial slow response rate necessitated abandoning the intended study group of brigade combat team veterans and widening the pool to accept combat veterans from other kinds of units and even other services. It also necessitated shifting to telephone interviews due to the wide geographic distribution of willing respondents. While this may more accurately reflect the composition of modern warriors, it introduced a greater range of experiences and settings while deployed. It is impossible to know if this variable had an impact on the findings of the study, but that will be addressed later in this chapter.

Telephone interviews were effective, but in person interviews would have afforded even richer data including nonverbal cues and further indications of each respondent’s affect while answering questions. Each narrative is compelling by itself, but in person interviews would have provided additional information about the veteran and his or her context during the interview, ensuring greater identification of transferability by future researchers.

The analysis and categorization of data was performed by only one researcher. It would have been preferable to have several researchers do the analysis and establish the categories together to achieve greater reliability and consistency. Member checking was limited, as well. Care was taken during interviews to clarify meanings and to report back information for
verification, but additional member checking during follow up interviews might have enhanced data interpretation.

Finally, the study could have achieved a greater degree of triangulation by examining more of the online sources and information sought out by the respondents during their personal quests for help. Additionally, two of the respondents mentioned tracts or pamphlets provided by the VA that they found helpful. It would have been helpful to examine this kind of material, as well.

Future Research

The immediate priority for future research should be to conduct similar qualitative studies with active duty service members (from each of the services, in turn to help identify service-specific differences or requirements for communication). This would require a cooperative research agreement with the services and completing their institutional review board process, but it would be well worth the effort. Purposive samples within different types of units and job specialties could provide further indications of potential differences – or commonalities – among communication preferences. Respondents should be sought from those with recent combat exposure and more recent diagnosis. This might provide fresher recollections of their communication experience prior to and during diagnosis.

It is also possible that service members further removed from combat have a more developed capacity to reflect on their experience and provide greater insights than those for whom that particular stressor is more recent. To that end, cohorts of respondents could be sought
from among each successive year in each theater of war, or from particular periods during the
conduct of the wars to enable comparison of the results over time.

Today’s conflicts are being fought by a mix of active duty personnel and mobilized reservists. Reservists often complete their tours of duty and then return to their former civilian lives with widely varying access to military medical and support services and little or no contact with the men and women with whom they went to war. Respondents should be sought among reservists to determine how their communication preferences and needs are different from their active duty counterparts.

Another common feature to emerge in these recent wars is the Individual Augmentee. These service members deploy and serve apart from their normal organizations and when they leave the combat zone, they return to a unit that they did not go to war with – or move on to another new command of complete strangers. In either case, they are removed from their comrades and suddenly surrounded by people who have not shared the same experience. For this reason, there should be a study of respondents drawn from service members with combat stress injuries who have completed an IA deployment to determine if their communication needs and preferences are different.

Combined research, employing qualitative and quantitative methods should be done to take full advantage of their relative merits and to evaluate derived theories and communication strategies emerging from this and related research.
Conclusions

There is much left to be learned, and Kant’s emphatic call for duty demands that interested parties such as the Department of Defense, the military services, veterans groups, and the Veterans Administration should cooperate to examine these questions and make every effort to help more affected service members find assistance and support dealing with combat stress injuries. The men and women studied for this research, as with all current service members, volunteered to serve and defend their country under all circumstances. Their experiences in war resulted in debilitating emotional and psychological injuries, many of which continue to burden them years later. Surely the country and services that deployed them to war have the duty to help them heal once they have returned home.

It might not require all of the future research described above, but there exists an unmistakable obligation to do much more than has been done to date to understand how to reach these men and women with invisible injuries. It is unlikely that all of those affected by combat stress will ever be willing to seek or accept help, but until services and service support organizations understand how to overcome the barriers of stigma and isolation that come hand in hand with combat stress injuries, they will not reach these people. They have a duty to find a way to serve those who have served us.

The study reveals three significant findings. First, veterans seek and respond to credible sources of information when struggling with the effects of combat stress injuries. They want to know what is wrong with them, but they are afraid others will find out – fear and the effect of stigma is a serious barrier to seeking care that is difficult to overcome. Second, that credibility has two primary sources for these veterans, the first being shared experience (a critical
component of homophily for veterans) and the second being medical knowledge describing the symptoms they have been experiencing without judgment.

Finally, family members have intimate knowledge of the service member prior to their combat experience. That base-line knowledge and their proximity to the veteran during difficult times may enable them to help the service member identify that something is terribly wrong. Several respondents urged that the services make every effort to engage and inform spouses and family members about the signs and symptoms of combat stress injuries and provide them with access to resources and information that may help them and their veteran. This could be especially important for reservists who return home far from the support and camaraderie of their battle buddies.

It appears that direct personal communication with a credible source may be effective at overcoming the shame and stigma experienced by these service members. Perhaps the military could enable earlier detection and increased treatment of combat stress injuries if they use these credible sources to communicate more broadly and via multiple channels, sharing their own experience (in the case of combat veterans who have overcome PTSD) and specific clinical information and symptoms (in the case of medical experts). This implication for military policy and communication practice presents the most promise to affect the lives of service members presently suffering in silence. Communications strategies using this insight should be developed and implemented at once to begin reaching out to the half of all Iraq and Afghanistan veterans with combat stress injuries who are not presently being treated.

Subsequent research should be conducted to help develop more effective campaigns and communications to reach men and women suffering from combat stress injuries and bring them
to the treatments and resources that will help ease their suffering. This supports the sacred honor of a nation to care for the men and women it sends to war. The effects of combat stress are documented as far back as ancient Greece, and there is ample evidence in recent history from this century and the last. It is shameful that the military and society have what AV6 referred to as “recurring amnesia” about the prevalence and magnitude of combat stress injuries in each new war our nation undertakes . . . and the need to be prepared with sufficient resources to meet the needs of returning warriors suffering from invisible injuries.
References


Hoge, C. W., Auchterloine, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from
deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295(9), 1023-1032.


APPENDIX A

Interview Instrument

Day/Date: __________ Time: ______ Location: ________________

Introduction of Study and Researcher

Me – military background, deployed to Iraq, interested in how we communicate

Study – looking at how we communicate about combat stress, interested in your experiences.

Confidentiality – agreement covers it; No one will know who you are except me. You will only be referred to by “Respondent ID Number”.

Study contents – I am solely responsible for what goes in the study and is written up. No other planned publication, just thesis for degree, but want to share results with Army and other services in hopes it can help them adjust their communication efforts.

D1) Respondent ID: ______________ D2) Age: _____ D3) Gender: _____

D4) Entered Service: ________ D5) Left Service: ________

D6) Rank/grade: ____________ D7) No. of combat tours ______

D8) Location(s): _______________________________________________________

D9) Units: ___________________________
D10) Where’s home for you? (Where living now? Originally from? What do you consider home?)

A1) Where did you do your combat tour? Did you do more than one? Who were you with then?

A2) What were your thoughts about the mission before you deployed?

A3) How did you feel?

A4) Describe the first time you were in contact with the enemy.

A5) Describe your worst experience.

A6) Describe what it felt like when you got back from deployment.

Study questions

1) How did you feel about the deployment before you left?

2) What had you heard before you left about combat stress?

3) What events led to your diagnosis? (How are you doing now?)

4) Who talked to you about PTSD/combat stress? 4A) Whom did you believe?

5) What kinds of things did people say to you?

6) What did you hear that made sense to you? 6A) Where did you hear it? (Web sites, command information, base newspaper, TV, documentary, family members, other sources?)

7) Did anyone from your unit talk to you about combat stress? 7A) What did they say?

8) Anyone share their own experience with combat stress/PTSD? Tell me about that.
9) Did you hear anything about PTSD/combat stress that angered or frustrated you? 9A) Who said it and what was said?

10) If you went looking for information about PTSD (and other illnesses), where did you look?

11) What did you find? 11A) How did it help?

12) Do you ever talk to others about your experiences? Tell me about it.

13) What haven’t I covered that you think is important to tell me?
APPENDIX B

Confidentiality Agreement

Principal Investigator:  David Wray  Phone: 703-969-6716
Faculty Supervisor:    Dr. Tony Andenoro  Phone: 509-313-6480

Department of Communication and Leadership Studies
Gonzaga University
502 East Boone Ave Spokane, Washington 99258-2616

Project Title: AN EXAMINATION OF COMMUNICATION PREFERENCES FOR SERVICE MEMBERS SUFFERING FROM COMBAT STRESS-RELATED ILLNESSES: A FRAMEWORK FOR SERVING THOSE WHO SERVE US.

Expected Duration: This interview should take 45 - 60 minutes to complete.

Purpose and Background: You are invited to participate in a study of communication preferences among combat veterans with combat stress-related illnesses. I am conducting this research because of my interest in this area, and as part of my thesis, which is a requirement for a Masters Degree from Gonzaga University. You were selected as a possible participant in this study because you are a combat veteran who has been diagnosed with one of several combat stress-related illnesses.

Procedures: If you decide to participate, I (David Wray) will ask you a series of demographic and open-ended questions about your experience. With your permission, I will record the interview for accuracy. Your responses and your identity will be kept completely confidential. My notes and the recordings will remain in my custody.

Risks/Discomforts: There are no measurable potential risks or discomfort involved in this survey other than anxiety caused by the questions. You can stop the interview at any time.

Benefits: There may be no direct benefit to you from participating in this study. However, the information that I provide may help the military services leaders and communication professionals better understand how to reach out to others who may be suffering from combat stress and need help.
Confidentiality: Any information obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. My findings will be summarized and shared (without any identifying information about you) with my academic advisor and my thesis, when complete, may be shared with the Department of Defense and the military services. In its final form, my thesis will not contain any information about your identity.

Consent: If you decide to participate, you are free to discontinue participation at any time.

Questions: If you have questions, please ask me. If you have any additional questions later, I will be happy to answer them. My email is dwray@zagmail@gonzaga.edu.

You will be offered a copy of this form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form should you choose to discontinue participation in this study.

__________________________________________________________________
Signature Date

__________________________________________________________________
Signature of Investigator Date