Serving Canadian Armed Force (CAF) Members, Veterans, and their Families With Experiences of Trauma

By

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Abstract

Canadian Armed Forces (CAF) members make the courage decision to protect Canada at all costs. Their decision entails risking the detriment of their physical and mental well-being. CAF members and veterans often face unique and traumatic experiences. The current CAF modernization strategy has prioritized mental health care, implementing more holistic style approaches as it recognizes the growing need for continuous improvement to both the services delivered to users and their quality of life. The current medical model of care has been critiqued for perpetuating oppression and stigmatization of its users and does not allow for the full consideration of socio-economic factors. The following Advanced Practicum report explores the effects of various external factors using principles of trauma-informed care and a Mad Studies in response to stressors such as childhood experience or gender on current experiences.

Keywords

Canadian Armed Forces (CAF), Military, Social Work Officer, Social Work, Trauma-Informed Care (TIC), Mad Studies, Gender, Adverse Childhood Experiences (ACE).

Abstrait

Chaque membre des Forces armées canadiennes (FAC) prend la décision courageuse de protéger le Canada à tout prix. Leur décision comporte des risques pour leur bien-être physique et mental. Les membres actifs et les anciens combattants des FAC sont souvent confrontés à des expériences traumatiques uniques. La stratégie de modernisation actuelle des FAC accorde une priorité aux soins en santé mentale. Cette dernière met en œuvre une approche holistique qui reconnait l'importance de la qualité de vie des utilisateurs ainsi que de l'excellence des services qui leur sont offerts, et ce, dans une perspective d'amélioration continue. Les critiques du modèle d'intervention clinique actuel suggèrent que le cadre d'intervention soutient la répression et la stigmatisation des utilisateurs et ne considère pas l'effet de déterminants socio-économiques.

Le rapport de stage qui suit explore l'impact de divers facteurs externes en utilisant les principes des soins traumatiques (*Trauma-Informed Care*) et de la perspective des études sur la folie (*Mad Studies*) en réponse à des facteurs de stress tels que l'expérience de l'enfance ou le sexe.

Mots-Clés

Forces Armées Canadiennes (FAC), Militaire, Officier(ère) en Travail Social, Tavailleur(use) Social(e), Soins Tenant Compte des Traumatismes, Études sur la Folie, Sexe, Éxperiences Négatives de l'Enfance

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I dedicate my work to my late grandmother, Hope McCormick,

Your love and selflessness guided me toward helping others in your honour.

We will always have *Hope.*

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Chapter 1

1 Introduction to Mental Health in the Military and Their Families

The Canadian Armed Forces (CAF) is primarily made of two groups of service members (1) Full-time regular force and (RegF) and reservist (ResF) who mainly serve on a part-time basis with the opportunity for full-time service. RegF Health and Mental Health are often provided through a CAF health system. In contrast, ResF often access services through civilian providers and provincial health plans in their geographical area instead of on-base and federally covered services (Thompson et al., 2014). Beyond current service members of both groups, we have veterans; veterans are "any former member of the Canadian Armed Forces who successfully underwent basic training and is honourably discharged" (Veterans Affairs Canada, 2022). Veterans can access services through Veterans Affairs Canada (VAC). Many veterans do not see themselves as veterans and feel unworthy of the title 'veteran' or completely transition back to civilian life, making opportunity and access to services inconsistent and precarious (Rowan-Legg, 2017; Thompson et al., 2014). Regardless of the stream of service and who is providing the service, it was not until 2006 that the CAF and VAC moved away from focusing on the chronic health maintenance of its members to the promotion of a more holistic perspective centered on ability, well-being, and independence (Thompson et al., 2014).

Despite efforts, the current context of military social work has been criticized for its emphasis on biology and psychology and for lacking the importance of social factors (Blackburn, 2015). A medical model frames many socially constructed ideas as something inherently wrong with the individual and lean towards diagnosis and stigmatization prior to exploring the environment and experiences. The predominance the medical model in military mental health services restricts the

service provider from exploring connections that include family, socio-cultural factors, and structural considerations (Blackburn, 2015). In this way, the individual internalizes the struggles associated with living with issues relating to mental health. Some argue that the medical model perpetrates oppression as it does not guide us to consider social determinants of health in practice. It can promote segregation and discrimination against those living with mental disorders or exhibiting symptomology related to mental health issues or trauma (Bunbury, 2019). The medical model is rational and efficient for on-base service delivery and provides services and assessment to ensure members' combat readiness and reintegration in a regimented way structured in power and hierarchies. However, the model leaves little accommodation for trauma symptomology and life stressors in civilian life, nor does it account for the intersectionality of adverse childhood experiences (ACE) and gender (Blackburn, 2015; Bunbury, 2019). This placement allowed me to explore the epistemic dominance of medical models in services and how the implementation of trauma-informed care through a mad-studies framework may be a relevant approach for the population in question while keeping in mind the gendered experience of mental health.

To fulfill Laurentian University's Master of Social Work requirements, I have chosen the advanced practicum option. The Advance Placement hours and experience were completed at Connected Counselling Services of Pembrooke, Ontario, As a clinical social worker. During this opportunity, I was introduced to off-base models of care, barriers to services for military personnel, and discussions with an on-base mental health team lead from a Canadian Force Base. My placement focused on empowering those supporting people living with those who have experienced trauma in the military context and seek to integrate aspects of trauma-informed care

as appropriate into such services. The goal is to help loved ones better understand the experience of those experiencing trauma in the military; to empower them to understand what trauma is at the foundational level. A trauma-informed approach aims to provide the context to understand the needs of those traumatized better and attempt to create a framework for those supporting loved ones during difficult times. Due to the pervasiveness of the medical model amongst mainstream health care and military services, a mad studies theoretical framework will be applied to highlight the conflicting priorities. I worked with other social workers, psychotherapists, and community members during my placement. Based on the discussions, I created and facilitated a trauma-informed skill-building group for the spouses of Military members and Veterans, “Supporting Through Adversity & Trauma.” The group provided a unique experience to implement a mad-studies and trauma-informed care approach to trauma therapy without direct intervention while empowering others to make a difference in their homes and communities. The encompassing experience has allowed me to create this final report which will be divided into the following chapters.

Chapter one of this advanced practicum report will create a shared understanding of the current mental health care service and approach to services in the Canadian Armed Forces, including the service member, their spouses/partners, and children. The chapter will outline the practicum guiding questions, the mad-studies theoretical framework and encompassing considerations. It will locate me within the context of the chosen placement and the military.

Chapter two is a review of the academic literature that examines the current understanding of mental health among military populations. The literature review comprises two subjections,

including exploring the applicability of trauma-informed care to military populations and the intergenerational effects of ACEs.

Chapter three is an overview of the advanced practicum experience and environment. Throughout the chapter, a discussion of supervision delivery, service delivery, and other requirements of the placement setting will be explored. This chapter will discuss learning goals, opportunities, supervision model and shadowing. This will continue into the overall reflections from the experiential learning opportunity at Connected Counselling Services that was created through research, service delivery, supervision and my first experience developing and facilitating a group. The description of the learning experience will rely on the experience itself, trauma-informed care approach, a mad studies framework, and practice to exhibit the interplay of the previous in the practical realities of a social work placement contrasted by the dichotomy of military health services. An overview of a personal interview and informal discussion with a current Social Work Officer in the CAF will conclude the chapter.

Finally, chapter four will incorporate key portions of the above chapters to review the learning experience outcomes and their implications for social work, including reflection and considerations for future practice. There will be a conclusion of the report and practicum experience to close the chapter and report.

1.1 Reflection on Social Location

The International Federation of Social Workers (2018) states that social workers are positioned with conflicting priorities in their work. The worker must often function within systems that

share different values (IFSW, 2018). As a 2nd Lieutenant and emerging Social Work Officer within the Canadian Armed Forces (CAF), I have been increasingly interested in the dichotomy between social work ethics and military command. This tension motivated me to seek the development of critical consciousness on a personal and professional level. Critical consciousness in social work calls for awareness and commitment to understanding the interplay of power differentials and how consequently, they may create an oppressive experience for the clients (Sakamoto & Pitner, 2005). Using my developing ability to engage in critical consciousness as an ongoing process will lead me to understand how my position and title interplay with power in helping relationships. I must remember that military and social work governing agencies embody significantly different meanings of ethics and justice (Olson, 2018). Despite notable differences in practical and functional principles, the systemic structure also places social work services under the direction of health services within the CAF, meaning there is an epistemic dominance of the medical model within service delivery (Blackburn, 2015). When looking at the social work profession and my career in the Canadian Armed Forces, I cannot wholly answer who I am. What I can do is reflect on the isolation of being a social work student in the military. I experience tension between wanting to fulfill the assignment requirements but not having gone through basic training and being scared to say or do the wrong thing. I can also locate myself within the context of this placement and report. When I began my advanced practicum, I had set out to discover what it meant to be a social work officer and what it meant to work with military populations. What I discovered is that I will only know what it means to be a social work officer once I have completed basic training and when I have completed my on-the-job training. After working with the families and spouses of military members, one thing is certain; I cannot even begin to imagine what it might be like to experience

what they are going through. This is ironic because the reality is I will be in their shoes one day: it is a question of when, not if. However, the biggest realization was one I had to often check and examine throughout the placement. I felt like an imposter waiting to be discovered, standing on both the inside and outside of a military experience. Despite being honest about who I am; A Master of Social Work Student, a registered social worker and social work officer in training; I still felt like the military families felt like I was one of them, that I could somehow understand.

As a social work officer training for the Canadian armed forces, exploring this topic may serve as a framework for my work with future military populations. To best serve this population, I must understand parts of the unique experience and complex traumas that may members may be met with. As a social work officer, I do not experience the frontlines as many other members do and immediately outrank members who have been in service for far longer than myself. This power and privilege are due to my education and recent structural emphasis on the importance of interdisciplinary practice for mental health support and operational readiness within the CAF (Blackburn, 2015; Thompson et al., 2014). However, in social work, we often discuss the hierarchy of power, which causes friction in how this will play out in the field due to the emphasis on rank within the military.

Furthermore, as a woman, I am part of the gender minority representing only fifteen percent of the Canadian military population (Canadian Forces Morale and Welfare Services, 2018). I feel that I must work harder to prove myself within the male-dominant industry of the forces. In conjunction with my role and research, the interplay of my gender and the inherent power of my role create dynamics that I will have to live with to understand better how they apply to the real

world. However, some of the experiences that I may be difficult, I trust in my ability to navigate and be resilient in the face of adversity and barriers should they arise. I believe that the Canadian Armed Forces, the Department of National Defence, and the Canadian Government will uphold their commitment to providing workplaces free from sexual assault, harassment, and discrimination (Deschamps, 2015; Government of Canada, 2014). Since 2015 external reviews of problematic behaviours and attitudes have been described by Deschamps' (2015) key findings as an "underlying sexualized culture that is hostile to women and LGBTQ members, and conducive to more serious incidents of sexual harassment and assault" (para. 2). With this coming to light, and in my future social work role within this system, I look forward to seeing the changes within the system and attitudes, and behaviours may shift from a female perspective within a male-dominated system.

1.2 Theoretical Framework

When considering military populations and settings, it is difficult to ignore the impact of medical models and power structures, as social workers and mental health services reside under the overhead of medical and general health services (Blackburn, 2015). The literature has yet to conclude an encompassing standpoint on social justice perspectives and theories. The research is limited and treads lightly around justice-based discourse, assuming due to conflicting interests or alternative definitions of the fields. To move forward in the placement while occupying the role of social work officer in training within the Canadian Armed Forces, I adopted a Mad Studies framework to examine the tension between the medical model, mental health, and pulling on the interconnectedness of trauma and gendered experiences.

1.2.1 Mad Studies

Macdonald et al. (2018)., uses the work of many psycho-political influences to encompass the essence and the idea of mad studies. A Mad Studies framework, according to Macdonald et al. (2018), “Unites scholars from the mad pride and the anti-psychiatry movements to represent service user/survivors’ perceptions and their lived experiences of mental distress” (p. 101) and continues to challenge the dominance of current practices in mental health services. Macdonald et al. (2018) explain that with this perspective, there must be careful attention to not undermining the realness of mental distress or diagnosis through the rejection of pathology, explaining that the pathology could be seen as the presenting dysfunction and that the cause is not biological but due to socio-cultural experiences.

The current context of military social work has been criticized for its emphasis on biology and psychology (Blackburn, 2015). Medical models frame many socially constructed ideas as something inherently wrong with the individual; medical models lean towards diagnosis and stigmatization prior to exploring the environment and experiences (Macdonald et al., 2018). When working within a heavily pathologizing model, such as within the military context, it would be difficult not to relate to mad studies to conceptualize mental health (Macdonald et al., 2018).The use of mad studies to conceptualize mental health is important distinction in the military as the consider the pervasiveness of social constructs within such an organized, governmental, regimented instruction designed to create mental and medically fit soldiers (Foucault, 2009; MacDonald et al., 2018). It is also important to acknowledge from this standpoint that agility, abled-bodied and mental sharpness of members is the standard of the military population (Foucault, 2009). Differing from civilian life and clinical settings is the

intensity of constructionism in the institution of military life, which is why mad studies is so important in order to differentiate the social or environmental reasonings rather than the pathological trajectory (Faulkner, 2017; Macdonald et al., 2018). The outlook may provide insight into challenging existing structures of pathologizing oppressions and the impact on individuals, with the use of the lived experiences of trauma and gender. This framework prioritizes the experiential understanding of lived experiences of the service user rather than the traditional status achieved through professional knowledge, such as psychiatry or the DSM-5 (Faulkner, 2017; Macdonald et al., 2018).

In mad studies and anti-psychiatry, the goal is not to undermine the individual and their mental health experience; however, it emphasizes that mental illness is constructed due to social conditions (Macdonald et al., 2018). In a domain where individuals are conditioned to focus on the communal, undergo life changes, experience natural disasters, isolation from civilian life, visit war-ridden countries, and witness death, danger, and the severity of war, it is human that these social factors impact the individual (Ali et al., 2020; McGuinness & Waldrop, 2015). Expecting that mental distress can be diagnosed as an individual's biochemical defect under the constructs of military life and be treated with medication in the same way you would expect physical injury or disease is unjust (Gottschall et al., 2021). Applying mad studies perspectives to the human condition within the military and environment would consider the social influence impacting individual functioning, such as early experiences related to trauma as well as the impact of gendered experiences.

1.2.2 Considerations Within the Theoretical Framework

If military mental health services would accord emphasis on socio-political and economic factors, it is my hope that we would see consideration of early childhood experiences, ACEs, as well as the consideration of experiences of trauma that gender may influence.

Adverse Childhood Experiences (ACEs). Research has shown evidence associating the presentation of adult psychopathology with ACEs being prominent in military populations (Gottschall et al., 2021). This factor for creating individualized frameworks is imperative for instilling feelings of empowerment, safety, resilience, and capacity (Herzog et al., 2020; Landes et al., 2013; Xie, 2013). Services regarding trauma in the military population emphasize the difficulties related to a military career (Ali et al., 2020; McGuinness & Waldrop, 2015). The literature explains that current services are doing little to address ACEs, pre-military traumas, and non-military-related traumas (Ali et al., 2020; Blackburn, 2015; McGuinness & Waldrop, 2015). Although emerging research is attempting to bridge this gap, the current context, however, remains problematic as it mitigates discussion surrounding structural inequalities, abuse and marginalization of adverse early life experiences that construct the base for stress tolerance, perceived trauma, and the ability to regulate emotions and the use of executive functioning (Ali et al., 2020; Gottschall et al., 2021; Levenson, 2017; Sanders, 2019; Voith et al., 2020).

Gendered Experience of Traumas. To further strengthen the framework of mad studies in relation to trauma, the lens of gender must be explored as well. Genders report similarly with overall exposure to ACEs. However, there are differences to be addressed, as they impact the overall well-being and symptomology presentation amongst genders in adulthood. When

compounding ACEs with the military populations, specifically recruits/officer cadets, according to Gottschall et al. (2021), women prior to basic military training are "more likely to report witnessing domestic violence, experience sexual abuse, and living with someone with mental health problems or alcohol misuse" (p. 659); they were also more likely to screen positive for depression and adjustment mood disorders. Both men and women within the military population who experienced ACEs became more vulnerable to positive outcomes on probable mental health condition screenings, congruent with civilian data (Gottschall et al., 2021). However, where the gender analyses differ from civilian data is with men. Gottschall et al. (2021) research suggests that men who experienced childhood sexual abuse were more susceptible to depression compared to women in the military; and were almost twice as likely as women to develop post-traumatic stress disorders (Gottschall et al., 2021). That said, the term depression itself is difficult for men to conceptualize and accept, having negative impacts on their masculinity, attributing mood disturbances as a female experience (Hoy, 2012). Understanding that the experience of trauma and its potential outcomes is gendered, it is also important to consider the gendered help-seeking behaviours to guide practices and policies (Gottschall et al., 2021; Hoy, 2012). The Canadian military is comprised of men and women. However, men account for 85% of the forces, knowing that the military is a field that is vulnerable to being witnesses and victims of trauma; understanding their desire to seek help is equally as important as understanding how to help them.

Trauma-Informed Care. Providing the client with the opportunity to understand their individualized frameworks bridges the connections between presenting concerns and childhood experiences and provides the opportunity to mitigate stigma and pathology seen in the medical

model and social structure that can be reframed to understand that it emerged as a survival response or learned behaviour. (Hoy, 2012; Levenson, 2017). Levenson (2020) looks at TIC to "incorporate knowledge about the neurobiological and psychological impacts of early adversity" (p. 288). It is crucial when working with military populations to be aware of the pervasiveness of trauma and its implications due to the autonomic stress response and frequencies of seeking services in crisis; therefore, diminishing the risk of re-traumatization and triggers may allow the actual therapy and sessions to be more meaningful (Voith et al., 2020)

At the foundational level, the medical model asks, "What is wrong with you?" TIC asks, "What happened to you?" whereas mad studies and anti-psychiatry perspectives ask, "what systems or social conditions allowed this to happen to you?" (Voith et al. 2020, p. 172). Social conditions worth exploring may include gender inequalities and the influence of patriarchal notions of gender roles. Language regarding oppression and identities relating to culture, history and gender have been reframed as "intersectionality," and regardless of the inherent social wealth of men, their needs cannot be overlooked (Hoy, 2012; Voith et al., 2020).

The above framework, combining aspects of the critical perspectives associated with mad studies with TIC and the consideration of ACEs and gendered unveils identities related to power dynamics by contextualizing oppressions and experiences and externalizing trauma's unequal exposure and distribution (Baines, 2011; Voith et al., 2020). Furthermore, it provides both the client and worker the opportunity to externalize the experience through understanding social structures and their gendered impacts on adult life rather than being confined through diagnostic

and pathologizing definitions (Baines, 2011; Faulkner, 2017; Hoy, 2012; Macdonald et al., 2018; Voith et al., 2020).

Chapter 2

2 Literature Review

Chapter two will be the literature review portion of the advanced practicum report. This chapter will offer a deeper understanding of the military mental health experience and needs. Understanding the mental health needs of military populations is multidimensional and is comprised of many literature gaps. This literature review will draw on literature themes for the incorporation of TIC principles and their potential application in military mental health service delivery while exploring the consideration of intergenerational ACEs. Background information regarding the composition, demographics, and enrollment process specific to medical fitness and mental health screening will be provided for context, followed by themes in the literature regarding the implementation of trauma-informed care practices. Whereby the connection to early life experiences becomes apparent, and the consideration and understanding of the impacts of ACEs need to be deepened to provide more effective and relevant services that not only meet the needs but mitigate the development of more chronic or complex trauma leading to suicide ideation or early release. Finally, the human cost of military life will be explored through an analysis of the impacts of intergenerational effects of military life through the consideration of parental ACEs, career, and what that means for their children. The encompassing will provide a more robust understanding of the mental health experience of CAF members beyond enrollment screening and early release date.

The literature review will begin with background information regarding the topic followed by a methodology section and additional context to understanding the medical fitness screener procedures as well as insight into the demographics of Canadian military families. The first

portion of the literature review will explore literature relating to ACEs and military life impacts, including: the unique experience of military life, the current understanding of military personnel ACEs, as the idea of ACEs being a motivator for enlisting. The second portion explores the use of trauma informed care with military personnel and veterans and themes in the literature including: the need for the mental health sector to be more cognizant of trauma's prevalence and symptomology, the needs for TIC safety principle with military populations is multidimensional, and TIC principles of peer support can foster belonging and break isolation.

2.1 Background

Herzog et al. (2020) explain that 13.5-30% of Military populations have a diagnosis of PTSD. Military populations seeking mental health services for PTSD often coincide with other mental health concerns such as moral injury, difficulties with executive functioning, mood regulation and brain injuries (Currier et al., 2017; Landes et al., 2013). However, due to the concurring states, military populations experience high distress and treatment often primarily revolves around crisis management (Currier et al., 2017; Landes et al., 2013). It is essential to mention that many do not seek services. Some members wait until it is unbearable; they present to primary care or urgent care centers; due to fear of substantiating stereotypes, stigmas, and being afraid of any adverse effects of future career opportunities within the military (Gerber, 2019). The above, compounded with non-military-related traumas such as ACEs, place military populations at risk for higher rates of lifetime trauma and negatively associated outcomes. Research has created a link between ACEs and the military population and found that the ACE has not only placed military populations at greater risk for mental health difficulties, but high

ACE scores may have motivated enrollment in the first place (Ali et al., 2020; CDC, 2021; McGuinness & Waldrop, 2015).

The current review aims to explore how trauma-informed care (TIC) could serve the mental health needs of military populations. This review will build on the existing literature on Canadian and US military populations regarding meeting the mental health needs of military populations (including but not limited to reservists, active-duty members, veterans, and their families). The review seeks depth regarding applying the foundations of TIC and its guiding theoretical framework that focuses on strengths-based, trauma-informed and acknowledging the impact of trauma and adverse childhood experiences to meet the complexities of military populations' mental health needs. Needs encompass diagnosis, neurobiology, attachment styles, emotion regulation, and the attainment of basic needs and executive function. Historically, members have minimized their experience or avoided services altogether due to the discourse regarding mental health stigma and behavioural stereotypes of military members and veterans and fear of negative career implications (Ali et al., 2020; Currier et al., 2017; 2020; Gerber, 2019). As such, this review will explore; How trauma-informed care can meet the mental health needs of military populations through the use of a mad studies lens to destigmatize the experience of trauma and normalize ACEs

When reviewing trauma-informed care literature and its applicability to the military population, it was clear that there was a cohesive agreement regarding the prevalence of trauma and the need for service providers at every level to be aware of trauma, symptomology, and its impacts on people's lives. All the literature incorporated, in some way, some or all of the six guiding

principles of TIC outlined by the Substance Abuse and Mental Health Service Administrative (SAMHSA) or a similar variant of; safety, trust and transparency, peer support, collaboration and mutuality, empowerment, and cultural responsiveness, each paper also highlighted and placed the most emphasis on the principle of safety (SAMHSA, 2014). Similar themes emerged from the TIC for Military populations literature as outlined above. Furthermore, there had been cohesive findings regarding the ACEs as an underlying motivator for enlisting, specifically amongst men, despite the draft era. The draft era refers to military conscription time period in the United States circa 1940-1970, men were enrolled into military services when volunteer enrolment did not meet the demands of conflict (United States Government, n.d.). Themes throughout the research have consistently recommended screeners with intervention, the need for social support during and after deployment and better services for families.

2.2 Methodology

The following literature is comprised of two sections with a total of 26 articles retrieved with open access from Laurentian University Omni databases. When looking at the literature reviews regarding the applicability of trauma-informed care used with military populations, the following occurred; in any field locations, the keywords “trauma-informed care” were inputted, followed by the subject containing field needing ‘military’ or ‘veteran’ or ‘army’ or ‘navy’ or ‘air force’ or ‘solider.’ Filters for English and peer-reviewed were utilized as well as the date range set for the last decade (2012-2022). The filters provided the opportunity to encompass current, relevant, and English literature. English literature was used due to the understanding that mental health and trauma terminology does not translate well. As such, the essence and intent of the literature would not be misconstrued. Once the search result produced a focused outcome (n=74), the

literature was reduced by title to 18 articles; after reading the abstracts, introductions, and discussions/findings/conclusions sections, the articles would be included or excluded. Six articles were further eliminated due to various reasons, such as; using the TIC language out of this research context, focusing on physical health rather than mental health, and looking at first responders and only brief allusion to military populations. The remaining 12 articles provided a diversity of research, including quantitative and qualitative studies and theoretical and practice literature. Due to the limited number of articles available, there was no inclusionary/exclusionary criterion for the type of literature or study.

The second portion of the literature review seeks to understand the generational effects of ACE's and military trauma, which builds on the findings of trauma in the first section. The second section was utilized to understand certain gaps in literature and further the understanding of the theme of compounding trauma as it applies to this population. The following search terms were utilized; any field "Adverse childhood experiences," followed by the subject containing field needing 'military' or 'veteran' or 'army' or 'navy' or 'air force' or 'soldier'. Furthermore, the same filters of the original search were used for the same purposes, peer-reviewed, English, and current. However, the date range had to be extended to 20 years to capture a robust understanding of how ACEs and families have been affected by Military life. This is due to limited research in the military context regarding trauma over the lifetime. Despite the 20-year date range, an outlier was included Ginexi et al., (1994) as this is the starting point for analysis of identifying reasons for enlistment that pointed to leaving household dysfunction and chaotic environments in favour of the military and had been cited in multiple included sources.

2.3 Context of Military Enrollment and Demographics

The Canadian Human Rights Act (1985) Subsection 2 states that individuals will not be discriminated against on the grounds of "race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability, and convictions for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered" (2). This means that in the CAF application/recruitment/enrollments processes, an individual will not be discriminated against for any of the outlined points; however, the point of exceptions 15(9) in the CHRS (1985) sees the Universality of service for Canadian Forces; "Subsection (2) is subject to the principle of universality of service under which members of the Canadian Forces must at all times and under any circumstance perform any functions that they may be required to perform".

2.3.1 *Mental Health Screening in Canadian and American Military Settings*

Though the definitions are vague the CAF allows for reasoning and justification, and the screening process is one-fifth of that of the American military (Brockway, 2016). Assuming this allows for less discrimination, it also means that those with mental health challenges may be left without the proper support and be expected to perform to the levels of those less affected. Furthermore, understanding the trends in reporting mental health by gender and with the CAF being predominately males, it can be speculated that the level of reporting is inaccurate due to fears of occupational discrimination, fears of future occupational opportunities, believing it is in the past, or resolved (Brockway, 2016; Gottschall et al., 2021; Hoy, 2012).

The first point of screening in the CAF is during recruitment/enrollment, where preliminary medical and psychiatric testing are done (Sareen et al., 2021). However, there is no

evidence or information regarding the cut-off, recovery timelines or evidence of discrimination against certain mental health conditions/disorders/challenges and their impact on a successful recruitment/enrollment process. The Standards of Medical Fitness in the Department of the United States Army (2008) by comparison, does not adhere to equal opportunity when it comes to screening applicants and will disqualify applicants for; any treatment duration longer than six months (unclear if waitlist time is included), current mood disorders, history of symptoms consistent with a mood disorder that resulted in adaptation to school and work will be disqualified (Department of the United States Army, 2008). The US does not further investigate positive disclosures in their screening, whereby CAF enrollments provide the opportunity to obtain proof from civilian care providers to explain and prove medical and mental fitness which is further evaluated in the medical interview process (Brockway, 2016). Considering all factors of screening and disclosure above, then there are no specific instructions for employment limitations, as they remain "in development" under the Canadian Armed Forces Medical Standards (2017).

2.3.2 *Canadian Military Demographics and Family Composition*

Rowan-Legg (2017) combined information from Statistics Canada, Surveys of the Department of National Defense, as well as surveys of military spouses to report the following demographics as it relates to military families in Canada.

- 95% of military members are posted in Canada
- 59% of military members are married or living common-law
- 80% of RegF members have a civilian partner
- 20% are married to another CAF member

- 87% of military spouses are female
- 14.8% of the CAF are female
- 75% of military couples (With a minimum of one parent being a CAF member) have children. There are 57,000 CAF families and more than 64,000 children under the age of 18
- 32 military bases in Canada, often in geographically remote areas
- 85% of RegF families live in civilian communities, and 15% live on base.

Rowan-Legg's (2017) goal was to better understand the population to create recommendations regarding the special considerations of this population for future services. Incorporating these demographics serve the same purpose in this literature review.

2.4 ACEs and Military life Impact

There is a larger body of literature regarding the early life of American military members than that of Canadians, as such, the following claim is based on the American experience. Most of the research for this literature review reports that beyond operational stress injuries and PTSD diagnosis services, member experience the life stressors and challenges of the human condition similarly to all civilians.

2.4.1 *The Unique Experience of Military Life*

Research indicates, however, that even before joining the military, the experience of service members may be more traumatic. With the view of many service members, the military is a safe place to retreat away from family dysfunction, abuse, and unstable environments (Blosnich et al., 2014). That said, there are many factors and limitations to consider, and the additional cost of

military service impacts the spouses and children of active service people and veterans. The impact of ACEs ripples throughout all realms of life, from the ability to form meaningful relationships, the ability to perceive safety in the world and overall health, well-being and life expectancy (Ali et al., 2020; CDC, 2021; Gottschall et al., 2022; McGuiness & Waldrop, 2015). Findings from the ACEs literature suggests that growing up in a family where at least one parent is suffering from a mental illness places the families at risk for more mental health and health challenges (Ali et al., 2020; CDC, 2021; McGuiness & Waldrop, 2015).

Herzog et al. (2020), estimate that 13.5-30% of military personnel have a diagnosis of PTSD. Furthermore, Currier et al. (2017) and Landes et al. (2013) see that PTSD is not usually the only mental health challenge or diagnosis of those seeking services. As such, it can be assumed that the mental health toll on the military parent is absorbed and felt by their immediate family as well, from what we know about ACEs. The CDC (2021), explains that parental separations and inconsistency is also ACE and mental health challenge risk factor. With deployments lasting 1-15 months and 70% of military families having experienced at least one deployment, separation is a significant factor for families (Cramm et al., 2019; Thompson et al., 2014).

American and Canadian military life as analyzed by researchers offers a series of unique experiences, challenges, and opportunities to those serving and their families. Compared to their civilian counterparts, they are more likely to experience more relocations, more risk, and a more regimented lifestyle with sifting roles (Cramm et al., 2019; Easterbrook et al., 2019; Thompson et al., 2014). Along with the unique experiences comes a unique set of needs in health and mental health care (Cramm et al., 2019; Deschamps, 2015; Thompson et al.,2014). While the

serving member is often able to be offered continuity of care from federal services, the family members are often left to navigate provincial and territorial systems with a lack of continuity, quality, and accessibility (Cramm et al., 2019; Thompson et al., 2014). Resulting from frequent relocations, postings, absences, and the inherent risk of military service potentially resulting in illness, injury or death, the intergenerational impact of the previous factors and gendered experience of mental health, trauma, and family life, the toll of military life on families is apparent and require further research (Easterbrook et al., 2022; Thompson et al., 2014).

2.4.2 *Current Understanding of Military Personnel ACEs*

Adverse Childhood Experiences are common across all populations, with over 60%-95% reporting at least one experience (CDC, 2021; Katon et al., 2015). Though not captured in the scope of the current literature review, Canadian researchers Joshi et al. (2021), have found that Canadian adults populations report similarly with at least 60% having experienced 1 or more ACEs. ACEs include events and experiences of and related to family dysfunction, neglect (of all types), and physical and sexual abuse (CDC, 2021; Katon et al., 2015; Merrick & Giunn, 2018). ACEs then place the individual at greater risk for complications with physical injuries, including brain injuries, more susceptible to mental health challenges, including PTSD, unintended pregnancies, complications and fetal death risk are more common, the risk for infection and diseases, including comorbidities is increased, the misuse of substances and addictions is more common with a cumulative impact on education, occupational and income expectancy (CDC, 2021; Katon et al., 2015; Merrick & Guinn, 2018).

The scope of this literature review has highlighted that military populations may be an important subpopulation to consider for future ACEs research (Ali et al., 2020; Blosnich et al., 2014; Ginexi et al., 1994; Gottschall et al., 2021). ACEs have not only placed military populations at greater risk for mental health difficulties, but the exposure to ACEs may have motivated enrollment (Ali et al., 2020; Blosnich et al., 2014; Ginexi et al., 1994; McGuinness & Waldrop, 2015). Understanding that life in the military comes with the expectation of risk and traumatic work experiences, links between combat exposure and suicidal ideation have been made (Blosnich et al., 2014; Mitchel et al., 2012; Luxton et al., 2012). However, while Luxton et al. (2012) agree regarding the link between combat exposure and suicidal ideation among active duty and veteran in US military populations, they further confirm the consideration of ACEs, reporting that: "nearly half of suicides among active-duty personnel have been among persons who have never deployed to war zones, leading to further research of suicide risk factors that may be missed by health care professionals and military leaders" (p. 1042).

Across the literature, there was unanimous agreement regarding the theme of the unique experiences of military life (Cramm et al., 2019; Easterbrook et al., 2022; Thompson et al., 2014). There were significant gaps in the literature relating to the longitudinal data and impacts on families, specifically children and spouses (Cramm et al., 2019). Without this information the concrete evidence needed to create social policy to support the subpopulation will remain unchanged.

2.4.3 *ACEs as motivation for enrollment*

One American qualitative study was found regarding the evaluation of reasons for enlisting in the military, and this provided the first evidence of ACEs as a motivator for enrollment. Ginexi et al. (1994) claims that most enrollments are a result of economic and psychological reasoning; "family problems, a suffocating environment, a poor job market, or a broken relationship" (p. 15) was one of 1 or 8 repeating themes. Ten years later, Schultz et al. (2006) report that when comparing veteran women to civilian counterparts, 9 out of 10 veterans who had experienced sexual abuse in childhood listed their parents as perpetrators of their sexual abuse; 1 out of 10 civilians with the same experienced listed their parents as the perpetrators. Around the same time, Sadler et al. (2004) conducted research on women in the military and found that over half of women enlisted in the military samples of the study had experienced physical or sexual abuse. Of the women in the study over 4 out of every 5 women enlisted to escape distressing or abusive environments (Sadler et al., 2004).

We can conclude that there is evidence that experiences of household dysfunction and abuse plays a role in the pre-enrollment portion of military personnel lives (both active duty and veterans). There is no evidence or research found that differentiates or suggest a variation between RegF and ResF members (Ali et al., 2020; Bloshnich et al., 2014; Ginexi et al., 1994; Gottschall et al., 2021; Kelly et al., 2011; Luxton et al., 2012; McGuiness & Waldrop, 2015; Schultz et al., 2006; Sadler et al.,2004; Sareen et al., 2013). There are many limitations to the literature, such as the scarcity of studies, the sampling methods, and comparisons group and the studies were primarily conducted with American military personnel. Additionally, there are very few bodies of literature that directly link ACEs and military populations. As outlined above, studies have explored some of the experiences regarding elements of ACE as well as

environments and dynamics. A further limitation of the current research is that samples and research inquiries tend to analyse the experience of women. However, gender experience of mental health literature confirms that this may be due to the discrepancy in how men and women report, experience, conceptualize and understand trauma (Gottschall et al., 2021; Hoy, 2012). Katon et al. (2015) make the distinction that the prevalence of ACEs and adult health vary by gender and correlate it to those serving in the military. Blosnich et al. (2014) and Gottshall et al. (2022) find that for those with a history of military service, enlistment and commitment to military life may be an act of reclamation towards the powerlessness in household dysfunction or to escape the dynamic of said households.

Furthermore, when examining the prevalence of ACEs among males, Blosnich et al. (2014) differentiate the reporting of childhood experience by the era of enlistment categorized by all-volunteer era compared to the American draft era and hypothesize the possibility that "the influx of men from healthy homes caused by the draft mitigated detectable differences in ACEs between men with and without a history of military service" (p. 104). Making the argument that had it not been for the mandate of the draft, the men from 'healthy homes' would have not otherwise been driven to enlist (Blosnich et al., 2014). For the reasons above it, it makes it easier to detect ACEs among women in the military population, as there was no mandate for the draft for women (Blosnich et al., 2014). Blosnich et al. (2014) 's research also highlights that women may not have the same view of the military. Whereby men view the military as an escape from household dysfunction with stability and security for women who are survivors of violence at the hands of men may not see the safety in this option (Blosnich et al., 2014).

Beyond trauma intervention, the need for pre-work related injury of stress or trauma remains. All research pertaining to recommendations for service mention in some way the need for more points of intervention or prevention. To become truly trauma-informed and dismantle the medicalization and diagnosis of PTSD, the consideration of ACEs in deployment and the impact on military families must be considered (Sareen et al., 2012; Warner et al., 2011). Evidence has shown that there is an impact on the mood of the at-home parent and that when given the opportunity to receive mental health screen prior to deployment to receive support throughout the deployment, reductions in mental health diagnosis or experiences that impaired occupation in the military, fewer early releases or evacuations (research looks at experiences in Iraq) due to mental health reasonings, and lower levels of suicidal ideation (Sareen et al., 2012; Warner et al., 2011).

The research and resulting literature in this area confirm large ACE research regarding the relationship between ACEs and adult mood and anxiety disorders (Ali et al., 2020; CDC, 2021; Gottschall et al., 2021; Kelly et al., 2011; Luxton et al., 2012; McGuiness & Waldrop, 2015; Schultz et al., 2006; Sadler et al.,2004; Sareen et al., 2013; Warner et al., 2011). Sareen et al. (2012) and Warner et al. (2011) discuss the strengths of screening for mental health, such as, being aware of needs, and policy planning, as well as understanding the military populations overtime. Sareen et al. (2012) discuss that there are multiple points of screening in the Canadian Military structure seeking evidence of pre-existing, current and new mental health problems. Warner et al. (2011) reviews the effectiveness of providing a service for the outcomes of the screeners. The literature suggests that though the Canadian Armed Forces can screen for mental

health challenges and diagnosis, they fall short in providing the support (Sareen et al., 2013; Warner et al., 2011).

Despite the reason for enlisting, the prevalence of ACEs, family composition and all other factors, the rate of mental health difficulties appears exacerbated in the military context, as such a greater need for long-term social support for both the member and the family is needed. Extra support is especially needed during times of deployment (Blosnich et al., 2014; Sareen et al., 2013; Warner et al., 2011).

2.5 The Use of Trauma-Informed Care with Military Members and Veterans

The following section will examine where elements of trauma informed care with military members and veterans can be integrated. This is done in two ways, by reporting direct evidence of the themes and two by creating parallels in the gaps of the literature and the purpose of trauma informed care.

2.5.1 *Trauma's Prevalence and Symptomology*

Evidence of trauma in the military population emphasizes the difficulties related to the career and field, such as experiencing natural disasters, visiting war-ridden countries, death, danger, and the severity of war (Ali et al., 2020; McGuinness & Waldrop, 2015). Services are doing little to address ACEs, pre-military traumas, and non-military-related traumas (Ali et al., 2020; McGuinness & Waldrop, 2015). This is problematic as it mitigates and invalidates discussion surrounding structural inequalities, abuse and marginalization of adverse early life experiences that construct the base for stress tolerance, perceived trauma, and the ability to regulate emotions

and the use of executive functioning (Ali et al., 2020; Levenson, 2017; Sanders, 2019; Voith et al., 2020). If keeping the discussion and interventions strictly to service-related traumas, then ACEs cannot be contextualized into individual frameworks for understanding coping behaviours. Contextualizing respective frameworks highlights resilience, strength, and capacity despite adversity (Herzog et al., 2020; Landes et al., 2013; Xie, 2013).

There is agreement across the literature that supports the need for a widespread understanding by service providers of trauma symptomology to mitigate the risk of re-traumatization within the mental health sector. When using a trauma lens, it is vital to change the narrative from "what is wrong with you?" to "what happened to you?" and can be taken a step further with the use of strength-based "what is right about you?" (Levenson, 2020; Voith et al., 2020). The aforementioned is the first step in implementing TIC within a service (Currier et al., 2017). This type of language and suggested preparation for the mental health sector was effective for both Veteran Affairs and civilian community-based organizations, whether serving military populations.

Military populations seeking mental health services for PTSD often coincide with other mental health concerns such as moral injury, difficulties with executive functioning, mood regulation and brain injuries (Currier et al., 2017; Landes et al., 2013). However, due to the concurring states, military populations experience high distress and treatment often primarily revolves around crisis management (Currier et al., 2017; Landes et al., 2013). It is essential to mention that many do not seek services. Some members wait until it is unbearable; they present to primary care centers; due to fear of substantiating stereotypes, stigmas, and the adverse effects of

future career opportunities within the military (Gerber, 2019). The above, compounded with non-military-related traumas such as ACEs, place military populations at risk for higher rates of lifetime trauma and negatively associated outcomes. Research has created a link between ACEs and the military population. Research has found that the ACE has not only placed military populations at greater risk for mental health difficulties, but high ACE scores may have motivated enrollment (Ali et al., 2020; McGuinness & Waldrop, 2015).

Despite widespread agreement on the prevalence of trauma and the need for sensitivity and awareness, there is no universally accepted definition which makes research and literature seem ambiguous and diminishes confidence of the findings. The vague definition of 'trauma' causes the current literature to attempt to operationalize trauma's intensity and prevalence. By attempting operationalize an experience, it appears that researchers are trying to create a quantitative value of a subjective experience such as individual trauma to be replicated or measured in laboratory or clinical contexts. Despite efforts of operationalization and claims of subjective experiences of trauma and perceived trauma, the literature provided studies that were majority quantitative and removed the individual voices.

2.5.2 *The TIC Safety Principal with Military Population is Multidimensional*

Physical safety is only one consideration for the mental health sector working with military populations. The idea of safety in the helping sector is not new, however, the depths of considerations for working with traumatized people are reinforced by the cornerstone of TIC. With military populations, safety considers the environment, sensory stimuli, physical safety, emotional safety, fear, and privacy (Herzog, 2020; Kelly et al., 2014; Levenson, 2017; Voith,

2020). Safety at the basic levels looks to reduce exposure to triggers and stimuli that the individual could interpret as re-traumatizing (Hales et al., 2018; Levenson, 2017; Sanders, 2019; Voith, 2020). Literature suggestions for safety when working specifically with military populations look at the considerations of the replication of power and structures that violated boundaries and perpetrators abuse of power; and the inherent role of institutions in perpetuating trauma and hierarchical distribution of power (Currier, 2017; Kelly, 2014). Calling for clear and established roles and collaborative decision-making to rebuild physical and emotional safety; also includes making both the worker and member aware of potential triggers (Kelly, 2014). Kelly et al. (2014) claim that TIC may lower the need for physical restraints in veteran psychiatric facilities, fostering more self-actualization and control. Sanders (2019) applies the stress response to learning theory to understand how heightened stress or triggers may impede one's learning skills, memory retrieval and other executive functioning operations. TIC literature enforces the principle of safety as a cornerstone of TIC services, like Maslow's hierarchy of basic needs. Once safety is achieved, the potential for the remaining principles to form can occur.

Psychological and emotional safety enhancement is critical for Military members to regain control over their well-being and safety (Herzog et al., 2020; Kelly et al., 2014). This is critical due to the overactivation of the sympathetic response; in other words, the human stress response flight/fight/freeze (Herzog et al., 2020; Kelly et al., 2014; Sanders, 2019). When in combat or working in a highly stressful environment, this can be helpful for survival and physical safety; however, extended exposure to perceived threats inhibits the control of the response, and

repeated exposure to threats may create hyperresponsiveness to later perceived threats and triggers, even if actual danger is not there (Kelly et al., 2014).

Most of the articles alluded to psychological safety and the role of neurobiology with trauma and the impacts on the brain or the physiological responses that come with being triggered; however, only three distinctly discussed the consequences. Kelly et al., 2014 and Herzog et al. (2020) looked at the empirical evidence that described the sympathetic response and autonomic nervous system to describe the severity of combined danger and perceived danger compounded over time. In comparison, Sanders (2019) applied the previously described stress response to learning theory and how it inhibits learning and executive functioning outcomes. TIC-focused literature discussed the need for emotional and physical safety but did not elaborate much on implementation practices passed vague statements such as “environmental factors” and “mitigation of triggers.” The dichotomy of the understanding and depth of safety produces information that can be built on and added to by future research however does nothing to strengthen the empirical value of literature regarding TIC.

2.5.3 *The TIC Peer Support principle to Foster Belonging and Break isolation*

When reviewing the TIC-focused literature discusses the therapeutic alliance as a model for building trust, working through attachment injuries, and allowing individuals to regain a sense of trust in relationships (Hales et al., 2018; Levenson, 2020; Voith, 2020). The remaining literature speaks to connection and community to break isolation and build understanding. However, Ali et al. (2020) found that sharing stories amongst peers and trusted loved ones embraces peer connection and togetherness by fostering a sense of community when military populations are

allowed to share stories amongst peers and trusted loved ones. Isobel et al. (2021) looked at what participants wanted from TIC and found that all participants sought more peer support treatment options and peered designated roles due to the increased understanding of shared experience and language that normalized and validated individuals.

The combined suggests that supporting members of military populations to trust in others may open more extensive support networks. Furthermore, Veterans and Military populations often feel as though most civilian people cannot understand them due to the unique experience of military service and support for combat operations and programming not being designated to understand the trauma and needs of the military population (Gerber, 2019). The literature highlights that TIC calls for practical assessment, referral and waitlist times and military populations' needs for military, cultural competence, and specialized services for PTSD. TIC-focused research literature served seamlessly as a scaffolding for the needs outlined in the Military population trauma research. Though there still needs to be a universal way of implementation or framework for operationalization of the study of TIC implementation, this theme provided confident arguments for recommendations for future practice. Recommendations for operationalization and future research that can easily be construed into program analysis to measure effectiveness. The terms and definitions for community, peers and connections are also well-defined and reproducible in research.

2.6 Discussion and Conclusion

With the expectation of regiment and the abled body and mind of military soldiers, it is easy to forget about the support systems and the lives military personnel lead prior to military

enrollment. The literature reminds us that despite recent reviews and new programming, the need for a better understanding of trauma, the consideration of the effects on families, and pre-screening, as well as incorporating the expectation that most service members have ACEs, continues to fall short. In this way, the military mental health system remains under the jurisdiction of general health services, which continues to risk more diagnosis and risk stigmatization over the needs of the environment and experiences, restricting service providers and policies from exploring connections that include family background, socioeconomic and cultural factors as well as take in any structural ponderations (Blackburn, 2015).

When reviewing the literature to assess how TIC could meet the mental health needs of Military populations, it became apparent that TIC can serve as a conceptual framework for military population mental health needs. The use of TIC with military populations allows service seekers to access services that would mitigate the risk of re-traumatization and support their journey of reintegration and self-actualization following sequences of over-activation of the sympathetic response (Currier et al., 2017; Kelly et al., 2014; McGuiness & Waldrop, 2015). TIC has gained momentum and attention in the previous two decades as an emerging practice and has since plateaued as a conceptual and aspirational movement due to the lack of empirical data available to create a model and application concepts, despite researchers calling for more empirical research regarding this practice (Currier et al., 2017). The ambiguity of definitions regarding trauma, TIC and the lack of standardized tools for training and evaluation create barriers and obstacles for future researchers and clinicians. In conclusion, there was widespread importance placed on safety. The literature emphasizes safety and calls for awareness of current and early-life trauma symptomology, including physiological and neurobiological triggers. Peer support

may use suggestions for breaking isolation through connection and relationship-building with the military population as an effective support network.

The focus on Military populations creates an opportunity to refine the understanding of the importance of contextualizing trauma and understanding the unique needs of Military populations. For example, exploring the TIC principle of safety through the trauma lens associated with PTSD provided much more depth than previous guidelines for safety. TIC provided considerations for future practice with military populations, such as minimizing restraints, limiting triggers, and providing control of seating arrangements.

The literature outlines, and calls for, trauma symptomology to be better understood and emphasizes connecting the military population to peers and opportunities to express themselves. Clinicians must assess for operational traumas and seek to evaluate ACEs and non-military-related trauma to explain the presenting difficulties (Currier et al., 2017; Kelly et al., 2014; McGuinness & Waldrop, 2015). The outlined framework approach contextualizes the maladaptive or problematic coping behaviours or problems as survival tactics that once served the individual (Currier et al., 2017; McGuiness & Waldrop, 2015). Meeting the needs for safety in this way would allow for progress toward self-actualization (Kenrick et al., 2011).

Other considerations and recommendations for the implementation of TIC with military mental health practices would be to build awareness of trauma symptomology and streamline service delivery for trauma treatment. Using TIC, we allow for the narrative shift that flows seamlessly with strength-based approaches by reframing past survival strategies that seem problematic now.

It is essential to explore both ACEs and operational trauma. Current literature provides context for understanding the support for needing clearly defined clinical guidelines to ensure safety when working with Military populations. Calling for access and treatment options to be less ambiguous, offer more peer support, and for trauma and its prevalence to be more widely understood for effective referrals to specialized or standardized programs to be made. The foundations encompassed in both mad studies and trauma-informed care support these recommendations and less invasive methods and would allow for the implementation of recommendations with less stigma due to less pressure from bio-medical models. Using this perspective in placement explored the execution of the framework within the context of a counselling centre.

Furthermore, the understanding of the military members' experience of trauma cannot be limited to their career. The consideration of the impact of the service members' ACES must be acknowledged and supported as to mitigate the impact on military families. We understand that most people, both military and civilians, will experience at least one ACE before the age of 18 (CDC, 2021). The reality of military life is that the children will experience separation from their parents, displacement, and uncertainty; they are also at a greater risk of having a parent with mental health challenges and substance abuse. The partner is at a greater risk of developing anxiety or depressive disorder. All of which would increase the ACEs of the military family children.

Mental health services in military context, in this framework, cannot remain under the supervision of medical services. Medical services allow for a one-dimensional view of the

mental health experience whereby the de-medicalization and de-stigmatization, as well as allowing for a biopsychosocial approach to the understanding of the experience, including understanding the triggers and needs for both physical and psychological safety, would empower the service member and allow service providers to understand trends to better support and provide early intervention and preventative services to mitigate more complex needs, suicide ideation and early release.

Chapter 3

3 Practicum Environment, Learning, and Reflections

To fulfill the requirements of the Master of Social Work program of Laurentian University, I completed 450 hours as a social worker in a clinical counselling role at Connected Counselling Services in Pembrooke, Ontario from September 2022- December 2022. This section will discuss the environment of Connected Counselling services and my practicum learning goals as a student working in proximity to the military context. I chose this placement for its proximity to Petawawa's Canadian Armed Forces base. The proximity allowed for greater exposure to military clients and those supporting military personnel and their families, aligning with the experience, and learning goals listed above. This chapter will explore the environment and experiential learning opportunists through original learning goals and learning acquisition.

3.1 The environment of Connected Counselling Services

Connected Counselling Services offer both in-person and online counselling. Connected Counselling services offers access to high-quality services at an affordable cost. Clinical Supervisor Adrienne Carfagnini, BA Hons, MSW, RSW, has dedicated her private practice to becoming a teaching practice. Students in related fields "learn and grow in a supportive environment while also allowing access to low-fee and pro-bono therapy, consistently" (Connected Counselling Services, n.d., para. 3). This is relevant to my practice and area of interest as those who experience trauma often experience difficulties in other realms of life, such as socioeconomic status and health, making healing and therapy a lower priority, thus increasing the risk of their trauma leading to intergenerational trauma (Assari, 2020; Bargeman et al., 2021; CDC, 2021; Knight, 2014; Levenson, 2017).

Connected counselling service provides trauma counselling as one of its core services. Adrienne uses a holistic and trauma-informed approach combining emotion-focused therapy (EFT), eye-motion desensitization and reprocessing (EMDR) and dialectal behaviour therapy (DBT) and works from an anti-oppressive framework. Adrienne holds over 15 years of experience with civilian and military adults, children, and families. Adrienne is interested in relationship counselling, sex therapy and individual trauma therapy. I was provided with the opportunity to shadow her when she was working with military personnel. Furthermore, with Adrienne's supervision, I developed and delivered a 4-part psycho-social education trauma-informed group to support those supporting traumatized military personnel. Finally, I was assigned a small caseload of clients. My caseload consisted of at least 3 clients at a given time and up to 7 at its' busiest within this placement.

Most social workers and psychotherapists operate primarily online at Connected Counselling Services. Despite the disconnection of virtual work between co-workers and staff, Adrienne bridges the distance through dyads and triads in supervision, allowing for peer support and connection building. Supervision also happens bi-weekly on an individual basis and as needed. Adrienne offers trauma-informed, and person-centred approaches to supervision that are led primarily by the supervisee and guided by Adrienne's expertise and solution-focused collaborative interventions.

3.2 Professional Ethics Considerations

Throughout my practicum and early social work career, I have adhered to and use guiding principles and codes of ethics outlined by the Ontario College of Social Workers and Social Service Workers (OCSWSSW) Canadian Association of Social Workers (CASW). I ensure to always act in the client's best interest and work in collaborative ways that promote my clients' self-actualization, individuality, and inherent worth. Furthermore, I strive to continuously advocate for their needs in hopes of facilitating structural level consideration of change, upholding values of confidentiality and competency, to deliver the highest quality of care possible (CASW, 2005). I have paid close attention to the continuum of ethics and justice definitions and understanding among social work and military personnel, learning strategies to mitigate conflicting priorities.

During my advanced practicum experience ethics remained at the forefront of decision making. Learning how to participate it dyadic or triadic supervision session while maintaining confidentiality is the most frequent example of this placement. Learning to role of technology with clients had also been a point of exploration that pulls on ideas of confidentiality, ethics, and professional boundaries. I learned how to communicate roles and expectations clearly with my client as well as collaborate to create environments that made sense for both me and client in terms of communication outside of session, while using the tools of technology to enhance the experience for both.

The most difficult ethical point of my placement was regarding the duty to warn when a client needed emergency interventions. This situation called for me to act in the best interest of the client's immanent safety however I knew that despite the outcome the therapeutic relationship

will be destroyed. Not necessarily because of pulling in third party services into the confidential space as safety planning was an active part of our work together and the client was aware of the limits of confidentiality but because there would be no termination of services together as my placement ended and they remained in hospital. I know that this client has had negative past experiences with therapy and as dedicated as I was to attempt to change that narrative, they told me time after time if I brought them to the hospital, I would be just like everyone else. Despite this, the client's safety is paramount, and their perception of therapy is not the priority.

3.3 Learning Goals and Outcomes

Although I hold the title of second lieutenant social work officer within the CAF, I have not served a day of work on base or within that role. Instead, I am responsible for completing my Master of Social Work as my current duties. My exposure to military life, mental health services and delivery are based on literature, research, and a handful of conversations with military members. This practicum served as an introduction to the practical realities and beginning to understand how to serve military populations and their families with experiences of trauma, looking beyond career trauma and seeking the connection to pre-military life and its inherent social constructs to understand current challenges. My learning goals were driven by my theoretical framework of mad studies perspectives, an examination of the social construction of gender and military life, and by emphasizing the importance ACEs play in adult life.

When exploring avenues for completing the Master of Social Work program requirements at Laurentian University, the experiential learning seemed to align more with my learning style and goals. I wanted to increase my understanding of the military, their families and their experiences

with mental health and mental health services while deciphering the interplay of CAF on-base versus off-base services. I wanted to develop something with the knowledge I had acquired, creating a trauma-informed skill-building group for military spouses while furthering my knowledge of trauma-related military experience. The encompassing allowed me to gain a more robust understanding of the importance of critical consciousness and reflexivity in general social work and military contexts. Keeping in mind my theoretical framework, many of my learning goals focus on the experience of those affected or living with the trauma.

My first learning goal was to better understand the needs, experiences, and perspectives of those supporting military members. This goal was primarily explored through three avenues of my placement: (1) Through discussion in supervision; (2) through shadowing military couples sessions facilitated by my clinical supervisor, Adrienne Carfagnini; (3) through the interactions with the participants of my group and listening to their experiences and stories and with how they interacted with the material at hand.

When engaging in these avenues the needs were not clear right away. However, Adrienne has her students create and write case notes of shadowing sessions and through reflection and review of the case notes in preparation for supervision soon patterns and repetition of needs and feelings appeared. The confirmation of these themes could be seen through the reports and conversations held by the group members and in conversation with a military social worker who reported similar observations.

Overall, a theme that stood out to me was reports of feelings of isolation and grief. When I first thought of those two words regarding the military, I thought of isolation as a natural part of being posted to a remote area or not having others understand the struggle. When thinking of grief, I assumed the family had lost someone to combat or other military accidents. However, the truth was far more striking and heartbreaking. The spouses of military members felt isolation and grief within their relationships, and even more so following deployment. They often feel isolated as the needs of the military member are often put first, and their needs and lives are put on hold. They often report not knowing whom to talk to despite having support systems. They are not provided with the tools, skills, or preparation to mitigate the emotions and behaviours of someone returning from deployment, or who has been traumatized.

They report grief because their partners often do not come back as the same person, or they cannot rely on them the way they once did, and often they feel a sense of grief towards what the relationship used to be. The spouses are incredibly resilient and are more than willing and able to carry the burden of the military member. There is a clear need for increased social support and community connection throughout the deployment, pre-during-post. Programs such as the Road to Mental Readiness (R2MR), an education-based mental health model, are often used with various first responders and military groups. This offers training and supports pre-during-and post-deployment to increase mental health knowledge and skill-building resilience in a group setting with 2 of the four sessions, including family members. A significant first step, however, does little to address interpersonal and individualized struggles.

My second goal was to deepen my understanding of the interplay of CAF on-base services versus off-base services and the unique role of social work in both settings. This goal is more difficult to define its exercise within the placement itself as my understanding grew from research and conversationally. Through conversations with my clinical supervisor, I learned the role of off-base services and the procedures involved in registration and insurance. One of the primary qualifications for providing off-base service is a need to be registered with the blue-cross to provide services that the insurance of military personnel will cover. Furthermore, off-base services operate more freely. This was not information I could research, but it came from understanding the experience of on and off-base social workers and social work officers.

I learned through supervision and shadowing that off-base services may increase a sense of safety and the ability to explore more mental health challenges while mitigating the fear or anticipated risk of career backlash. To elaborate I will use the example of how child protection and cases of domestic violence case notes are created with more mindfulness of word choice and content in preparation for third party review when services are court mandated. My understanding is that when members are receiving on-base services they know the "right answers" and the things that they need to say that will allow them to continue working in their roles and not mitigate promotion opportunities. However, when accessing services outside of the military they can ease some of that tension while collaborating with the therapist who does not have a direct tie to the base and their military file.

Through informal conversations with a current social work officer and military mental health lead, I understood some of the realities of on-base services. It is often challenging to provide services to those on active duty as they are deployed to missions and training, sometimes with

very short notice; therefore, sessions can range from 7 days to multiple months apart, making intervention and in-depth exploration difficult. Therefore on-base services will often provide a more psycho-social-based service to address imitate needs rather than exploring the root cause, hence why the medical model remains in place and efficient. There is little interplay between on-and-off base services. However, mental health services from on-base centers may refer clients to consult off-base. This learning goal remains open as I navigate my professional role as a social work officer in the military mental health context. In social work programs we often talk about the ethical responsibility to not engage in dual relationships between client and worker, my current position is a dual relationship to the loyalty of the profession and the context of my careers, with social work being so vast and multidimensional the opportunities for careers are endless and not all positions can perfectly align with the goals, visions and ideals of the profession. This is a limitation of social work programing that has yet to be explore, implementing this type of discussion or preparation for students would be an interesting topic that allows students to think critically about ethical dilemmas, decision making and reflexivity to better position themselves within both the profession and their careers.

My third goal was to plan and engage with scholarly literature to prepare and facilitate a psycho-ed group to empower those supporting military populations. For this goal, it was critical to my learning to complete further research toward the goal of the group I wanted to create. To create the content for the group, I used the foundations of the literature review in chapter two to scaffold and mobilize the information, which was then compounded with the collaboration of intake questions and other literature. I came up with the content outline for the groups, which would then be altered to meet to group's needs as each session progressed. My supervisor was an

active collaborator when creating the outline for the program as she has valuable experience in this topic and with groups. The outline was created based on the information in the academic literature that was critically appraised and credible. Using the evidenced-based methods that had already been established I was able to use the foundations of a trauma-informed care structure to create the content as main themes for each week; Realize, Recognizes, Responds and Resist (SAMHSA, 2014). The learning goal aimed to dismantle the medicalization of PTSD and trauma symptoms, and my intent was never to take away the diagnosis or prove it wrong.

My goal for the group was to empower those supporting people who have experienced significant trauma with the knowledge to support them and create safety and trust in a way that would foster the individual to grow resilience to move towards healing or trauma recovery based on their experiences. This goal was completed as I created and facilitated four 90-minute sessions with four wives of military members who had primarily served in Afghanistan. The goal's success had intended to be measured by the qualitative and quantitative answers from a feedback form; however, to this date, no one has provided written feedback. Verbal feedback was given throughout sessions that guided to accord for the group's unique experiences and altered the content to meet their needs better. There was a high level of group cohesion and trust. One participant contacted me about long-term trauma counselling and provided written positive feedback in the same email regarding her appreciation for my approach and apparent knowledge of the subject. My supervisor also participated in the sessions; her feedback was supportive and positive. I was expecting more critical feedback and was pleasantly surprised when the most significant constructive criticism was that, at times, my pacing and content order could be improved. My scope focused on content and did not prepare or capture feedback, having gone

through the process I realize that there was not enough emphasis on this portion of group development and that in future renditions or opportunities the incorporation of a concrete evaluation strategy would lead to better outcomes in feedback participation.

My fourth learning goal was to increase knowledge regarding trauma-informed practice in general social work and military contexts. This goal was explored throughout the placement through my practice, shadowing, research, and program development. There were slightly more opportunities to explore this learning goal from a general social work perspective; however, the unique opportunities to align this goal with military context combined with critically engaging with the available scholarly literature allowed for a deepening and exploration of the approach. This goal will continue throughout my career.

My fifth learning goal is on-going and will continue as long as I am in the helping profession and mental health support field. That goal is to learn how to better engage with and implement critical consciousness and reflexivity with my social location in practice in the military and trauma context. As mentioned in my social location, I cannot even begin to imagine the trauma and challenges of military life firsthand. By reflecting on this standpoint with clinical supervision, I could move past the resistance of feeling inexperienced and imposturous in facing their challenges. Moving past my biases and points of resistance allowed me to take on a more client-centred approach, increase empathy and allow clients to be the experts without allowing my learning to take the front stage of my consciousness. Briefly, when I think of the military I think of power, unique experiences, and trauma. In October of 2021 I was enrolled into the military and committed myself and vowed to put my country before myself for as long as my

military career persists. The military has many ceremonies and rites of passages, however in the 18 months of my enrollment this is the only one that I have done, I have not completed basic military qualifications, on the job specialized training, or even worked 1 day in the military nor do I hold any first-hand experience regarding the military. What I do have is education in social work, I have the skills and capacity to take the experience of others and work with clients to deepen their understandings and narratives. I can help clients understand the physiological and psychological meaning to their experiences or find empathy and self-compassion for survival instincts that have turned into what appears to be maladaptive coping strategies. In the processes of realizing that my client and I do not need to have the same experiences or qualifications to work together helped me realized that I can bring something to the table as long as I am transparent about the interactions and roles. In some way this realization has allowed me to be better prepared to provide clients with informed consent to services. I am more aware of who I am in relation to the service as well as what capacities and qualifications I have to do so. The client holds the information that we can work through together however I do not need to feel inferior to their experiences to be an effective social worker.

Furthermore, I wanted to ensure a solid foundation for developing critical consciousness and reflexivity. I took time to create and implement a realistic and structured routine that incorporated self-care, exercise, and commitment to my wellbeing. I noticed areas of resistance and biases as noted above; these points were reflected on personally and processed in supervision. This proved particularly important when faced with the realization that my client's struggles will one day be my own and the current attempts at cultural change within the military. My supervisor was also an advocate for this learning goal. She shared the importance of self-

care, taking breaks, and ensuring that proper steps were taken to mitigate storing or ignoring the impacts when triggered. When triggered, she encouraged the body's movement to assist with somatic experiences and talk therapy with a supervisor to understand why or where the trigger may have come from, which would naturally turn into reflection, and growth when preparing for future sessions. Her approach fostered much trust and safety and an optimal learning environment. As elaborated below in the "Reflections on Advanced Practicum Experience" section the differences between military ethical obligations and social work ethics is an area that I spent a lot of time trying to better understand and position myself in. Neither social work nor military has a past that is void of oppression or mistakes however, understanding the current situations and the power dynamics of both and my role as a social worker has allowed for a deeper understanding of how the systems are so similar, yet preform extremely different and vital roles in our society.

My sixth learning goal was to experience and learn elements of military counselling from a shadowing perspective and understand best practices of off-base service delivery models with military members. Reflecting on this goal, my biggest takeaway is that there is no one way and no correct answer. Understanding that trauma is a subjective experience based in the perception of safety, I should have been more prepared to understand this because two individuals can be exposed to the same stimulus and have greatly differing experiences of the physiological, psychological, and physical impacts. My supervisor is very skilled in EFT, and EDMR and uses each approach to varying degrees. She introduces elements of the methods as appropriate. While shadowing her EDMR interventions with clients, I realized this approach might fit best within my framework. The client leads the approach. It allows for their experiences to be the primary

narrative. It reconstructs medical and ACE narratives to suit the client's current understanding and capacities while challenging cognitive distortions at their own pace.

Having shadowed in this capacity repetitively allowed for patterns and themes to naturally emerge through reviewing case notes and supervision discussions. A reoccurring theme of learning to work with military personnel is that they are often rigid and feel like they cannot show emotions. When someone has experienced ACEs, career trauma, or other trauma, vulnerability can be difficult as often fight or flight responses remain activated in some way. The previous makes accessing emotion regulation and reasoning difficult. Compound that with the conditioning of regimented military life where emotion can be interpreted as weakness, despite the on-going cultural change. The total may make that initial trust and safety difficult. Therefore, by using an EDMR approach where they can explore at their pace based in trust and safety such as in TIC it appears to provide an empowering experience for the clients.

Providing off-base services for the CAF members appears to mitigate some of the stigmas of fears of disclosure; however, there is a need to move past the initial "outsider" mentality. This understanding comes through shadowing, supervision and discussions with on-base social workers who have worked with members having received on and off-base services. CAF members feel an increase sense of emotional safety due their being less military surveillance provided by off-base service providers. However, often when disclosing trauma to civilians there is a sense of feeling that they would never understand, since they are not part of the military and have not experienced that trauma (van der Kolk, 2014). The learning goal further solidifies the need for more knowledge and skills related to trauma-informed practice, building on trust and

safety, and working collaboratively with peers to negate stigma and provide effective services to military personnel or veterans. Furthermore, suppose a mad-studies approach was used to destigmatize and normalize the experience of trauma from a biological and person-in-environment standpoint. Literature suggests that once someone can move past psychiatric labels to seek structural and environmental understandings of coping skills and mental distress, they can understand their current behaviours and feelings as protective mechanism that have turned maladaptive due to the decontextualization (Currier et al., 2017; Kelly et al., 2014; McGuinness & Waldrop, 2015). Decontextualization refers to the trauma stimulus being perceived in the brain rather than a physical threat. Providing education regarding a healthy nervous system and its function will in turn empower those to seek change rather than remain stagnant in psychiatric labels as they would feel an increase sense of safety (Kenrick et al., 2011).

In that case, we may see members being able to disclose their experiences and access appropriate and effective services more quickly. This streamlining in civilian life may be invalidating or traumatizing. It could also be beneficial with military life bringing a fast pace and accessing services with immediate solutions could be more stabilizing as it would mirror a more regimented way of thinking and doing as they have been conditioned. Furthermore, having services that meet their needs in both content and service delivery would provide fewer breaks in services, such as with deployments and training. The limitations are in having appropriate service providers and specialized training available.

My seventh learning goal was to increase my ability to practice and deliver effective trauma-informed, EFT, CBT services while keeping in mind the perspective of mad studies, TIC and

factors of ACEs and gender. There are two parts to this learning goal – the first in becoming a more effective service provider using specific approaches and the second being able to take on a theoretical framework of mad studies that would essentially de-medicalize symptomology relating to experiences of trauma and gender. I cannot confirm if I increased my ability to practice and deliver the specific service models; what I can confirm is that my understanding and appreciation for each of them has grown significantly. At the very least, the new understanding has increased my critical reflexivity and empathy toward others.

This learning goal is difficult to answer as no formal training or certificates were completed during practicum. TIC literature suggests when working with military members and veterans the need for emotional and physical safety are paramount; followed by collaboration and peer support (Herzog et al., 2020; Kelly et al., 2014). Due to the engagement with literature throughout this project this has been the foundation to engaging with all clients. Instead of moving straight into evaluations and treatment planning, I ensure to spend more time creating safety and trust in the therapeutic relationship. I also took the time to implement these principles into the therapeutic process as well. Ensuring that the client was engaged and informed throughout, I was transparent and realistic with goal setting due to the limited time constrains of a practicum. I frequently checked in with the client and structured sessions collaboratively with the client to increase consistency and predictability. Having a structure for each individual session provided safety during vulnerable moments and the client was empowered to ask to spend more or less time with each aspect. This included creating a grounding tool kit that we could pause and access at the client's discretion and at the beginning and end of each session. Clients reported feeling supported in this way and shared that they felt more in control. By

supporting the nervous system and engaging with learning theory, clients were able to feel safer both physically and psychologically when presented with more opportunities of predictability, consistency, and collaboration (Herzog et al., 2020; Kelly et al., 2014; Sandars, 2019).

When it comes to the trauma-informed case, this takes on a new level of client centred. It is about letting the client be the expert and assuming something happened to them. TIC moves from the "what is wrong with you" narrative to "something happened to you"; upholding the unconditional positive regard to increase safety and trust, to allow them to feel empowered to collaborate and connect (Voith et al., 2020). as well as consider all other factors of ACEs and intersectionality to have shaped every single one of their experiences (Voith et al., 2020). It is about understanding that no two individuals can see the world through the same lenses. Combining the elements and critical perspectives associated with mad studies with TIC with ACEs and gendered experiences, I was able to view everyone as having a truly unique identity. Each identity was related to power dynamics, collaboratively contextualizing oppressions and experiences and externalizing trauma's unequal exposure and distribution (Baines, 2011; Voith et al., 2020).

TIC was an approach I was able to implement with all interactions however the agency does work primarily with EFT & EDMR. When observing EFT, the difficulties many people have with expressing and communicating emotions was something I had not previously considered. The depth of seeing how hard it was when shadowing relationship therapy; was for life partners to look at each other and describe their feelings. This inspired me to incorporate more feeling words and check-ins into my practices. Furthermore, EFT, like TIC, starts with looking at life-

long experiences, and there are often attachment wounds and styles at play that can act as a barrier to sharing emotions and connecting with a partner in a way that feels safe. Putting myself in an empathic position to understand the dynamic allows clients to feel safe, trusted and protected by their environment. This way, the client and I can collaboratively understand what needs need to be met to build an effective, safe, trusting, collaborative therapeutic relationship. Having the experience to shadow an experienced and professional social worker, I was able to see all the elements of my social work education come together and meet the values and ideals of the field in practice.

I want to reframe my seventh learning goal from "increase my ability to practice and deliver effective trauma-informed, EFT, CBT services while keeping in mind the perspective of mad studies, TIC and factors of ACEs and gender" to using mad studies as a lens when providing TIC services and navigating the mental health field. A pivotal point of moving towards this approach and working in this framework is moving past limiting beliefs imposed by psychiatry and prioritizing lived experiences and promotion of understanding the brain and nervous system (Faulkner, 2017; Macdonald et al., 2018). A 450-hour full-time placement did not allow me to take on a caseload that would allow longer-term services to practice any one model long enough. The TIC approach pose "what happened to you" and the idea of mad studies looking at social and environmental systems and structures (Baines, 2011; Faulkner, 2017; Macdonald et al., 2018; Voith et al., 2020). The use of the two also contributed to developing my critical consciousness; that accessing therapy may pose a certain level of oppression, re-traumatization, or reaffirmation of cognitive distortions regarding something that is inherently wrong with the client.

3.4 Reflection on Advanced Practicum Experience

One of the main points of tension I experienced in this placement, and I wanted to explore further was the differences between military ethical obligations and social work ethical paradigms. After completing this placement, furthering my understanding of the literature, and having discussions with service members and social work officers, I do not think this question can be answered and not in the sense that there is no answer, but in the understanding that the comparison is not of equal factors. Whereby the Canadian Association of Social Workers (CASW) and CAF uphold very similar justice and ethical values, working towards inclusivity and addressing bias, creating equitable and safe environments, respecting all persons' dignity, and upholding the integrity and accountability of the professions (CASW, 2015; Government of Canada, n.d.). The distinction is in priorities, where social work's priority is the welfare and self-realization on a micro, mezzo, and macro level. The military application starts on a macro level; it is about the large-scale context and environment, it is about large social justice issues, it is about mitigating conflicts of interest and dual relationships with trade agreements and NATO, ensuring equal distribution of resources and safety to the country, not to the individual or groups of people. It is a massively unique and powerful institution designed to serve and protect. Where I went wrong in this analysis was trying to understand the parallels when I should have been seeking to understand the differences. By seeking to understand the difference, I am working within my framework rather than against it. Each are separate and unique entities, that serve distinct purposes and are the sum of historical changes in the field overtime. As with clients, I should have treated the analysis of the individual entities as parts of my identity rather than attempt to generalize the experience of being part of both social work and the military. Despite

both having striking similarities that will be discussed below, they remain and will always be separate.

Mental health services cannot run parallel on and off base and rarely run cohesively due to the encompassing macro level thinking of Canada and soldier first, the team mentality over the individual. They must always be ready to perform military duties and, on short notice, be able to deploy and relocate, go on the course for training or mission preparation. I have come to the understanding that there is so little literature and research about the military, its structures, and mental health because the military is not structured to think about the individual or provide services to an individual. It is structured to work together towards common goals selflessly.

The best way to summarize this thinking is in the way of philosopher Michael Foucault's work on *population, territories, and power*, explaining how governments are not interested in the wellbeing of individuals or even pockets of individuals; they are concerned with the survival of populations (Foucault, 2009). The military conditions its soldier to do everything in its power to ensure the survival and well-being of all Canadians and has a global-scale responsibility to each NATO country. In contrast, social work takes on similar duties and responsibilities on a much smaller scale, where they look at the individual or collective groups to address systemic oppression and discrimination and break down the barriers inhibiting equal distribution of resources, inclusion, and equity

3.5 Civilian Social Work and Military Social Work Roles

The role of the social worker within this body is to help facilitate some of the cultural shifts to input on the various considerations and to mobilize knowledge that de-stigmatizes mental health considerations; “as mental health subject matter experts and advisors to the chain of command, social workers are vital to military members’ mental health” (Government of Canada, 2022, para. 4). Social workers within the CAF are of officer rank which inheritably takes on leadership and administrative responsibilities. The CAF has identified that the most significant discrepancy between civilian social workers and military social work officers is the ongoing opportunity for international deployment. Conversations with military social work officers have taught me that many civilians are backfilling on-base mental health services to fulfill needs and demands that exceed the current capacity of social work officers. The social work officers must merge into the mental health leadership roles. My understanding of the civilian social worker's role in delivering off-base services does not significantly differ from services delivered to civilians. I assumed there would be more rules, restrictions, and reporting; however, the limitations take a more insurance-based structure, such as accessing physiotherapy, messages, or chiropractors.

3.5.1 *My Dichotomy Between Social work and Military*

As discussed in chapter one, it is difficult to honestly answer this question, having not served in military institutions. My values align with the CASW ethical standards of social work practice and the CAF ethos (figure 1). My most personal and impactful learning experience of this practicum and seeking answers to my outlined questions was understanding that I can merge the two into my identity rather than trying to make sense of their segregations. At the core, both values are similar; to demonstrate this in the most basic form, a chart comparison of the two’s values is outlined below (figure 1). In this way, we can better understand the micro, mezzo, and

macro explanation from earlier in which the similarities exist; however, the magnitude of focus is vastly different.

Figure 1

Comparison of CAF and CASW Values

CASW: VALUES & PRINCIPLES	**CAF: VALUES & ETHOS**
Respect for the inherent dignity & worth of persons	Respect the dignity of all persons
Pursuit of social justice	Obey & support lawful authority
Service to Humanity	Serve Canada before self
Integrity in professional practice	Integrity & Courage
Confidentiality in professional practice	Accountability & Loyalty
Competence in professional practice	Inclusion & Excellence

(CASW, 2015; Government of Canada, n.d.)

Coming to this realization has made it easier to form one identity. At the outset of this endeavour, the two bodies felt like far-reaching opposites, understanding a commonality of ethics and justice. However, after my experience with the advanced practicum, further examination of academic literature, and conversational learning in supervision, with community members, as well as speaking to social work officers, I understand that the aspects do not have to be as divisive as I once believed. I understand that these are ideals, and like in the social work field, ethical dilemmas do and will continue to arise. I expect the same to happen within the military context. It is also reassuring to know I am not the first person to navigate this path. However, it feels isolating in the university setting; having dual loyalty within the practice is feasible and collaborative. Instead of focusing on dual loyalty to the profession and my employer, I should seek to understand it as part of my identity. It will present significant

opportunities and challenges that may not be standard in civilian life but are equally exciting and unique. For the time being, I cannot answer the prompt to “How does military social work play out” as my understanding is that there is a wide array of opportunities for social work officers within the CAF as there are for social workers in civilian life.

3.6 Mad Studies Perspective in Practice

Trauma or PTSD can leave one feeling isolated and feeling like they are losing themselves or surrendering to madness; “after you have experienced something so unspeakable, how do you learn to trust yourself or anyone else again” this is true with the brain’s perception of safety and dangers (van der Kolk, 2014, p.13). In one explanation of a veteran lessons from van der Kolk (2014), the reorganization of perceptions and the de-medicalization of PTSD symptomology is encompassed perfectly “I think this man is suffering from memories” (van der Kolk, 2014, p.15). ‘Suffering from memories’ is a very simplified encompassment of all the somatic and neuro activity that is perceived; however, psychiatry and social constructs are removed from having a traumatic experience, it is only the memory that is left. Therefore, the summary of "suffering from memories" is an excellent example of the benefits of a mad studies framework and the power of language used when working with trauma. If we compare 'suffering from memories' versus 'post-traumatic stress disorder,' we see how one explains that something happened to the individual, whereas the other is not only a diagnosis but also emphasizes something wrong with the individual, a disorder.

Up to 30% of military personnel and veterans have PTSD diagnosis and mental health services are framed in a biological understanding of mental health (Beresford, 2019; Herzog et al., 2020).

When trying to apply a mad studies perspective to the military's current context, especially regarding trauma, it is difficult, as the medicalization of trauma often unlocks access to time and resources that an individual may need to recover and heal from traumatic experiences, especially acute phases. The military is slowly incorporating elements of survivor movements into their services and wellness programs, promoting prevention and access to various leaves and compassionate leaves to be more accessible and less procedural compared to past renditions (National Defence, 2022). However, the entire structure of the political body of the military and hierarchy makes it near impossible to implement or adopt a more bottom-up framework such as mad studies. Where I can see the most opportunity for the implementation of mad studies is through Veteran Affairs Canada. While very much incorporated into military service, much of their work is centred on accessing services, health, mental health, finance, family, employment, and housing.

By employing a mad studies framework to the understanding of trauma my understanding is that there would be a more inclusive and accepting attitude of nervous systems' responses to stress and trauma. This would allow an individual to understand seeing trauma as an experience and celebrate the nervous system responding as it should, providing training before events and supporting following. If the intervention came before acute or chronic trauma symptomology, accessing support would be less of a crisis intervention and more resiliency building and healing (Voith et al., 2020).

By de-medicalizing terms and language, the experiences and memories can remain what they are and provide access to care and resources as needed and prevention where possible (Beresford,

2019). The goal is not to undermine the individual and their mental health experience; however, it emphasizes that mental illness is constructed due to social conditions (Macdonald et al., 2018). In a domain where individuals are conditioned to focus on communal well-being rather than their own, undergo life changes, experience natural disasters, isolation from civilian life, visit war-ridden countries, and witness death, danger, and the severity of war, it is human that these social factors impact the individual (Ali et al., 2020; McGuinness & Waldrop, 2015). Expecting that mental distress can be diagnosed as an individual's biochemical defect under the constructs of military life and be treated with medication in the same way you would expect physical injury or disease is fundamentally unjust (Gottschall et al., 2021). Applying mad studies perspectives to the human condition within the military and environment would consider the social influence impacting individual functioning.

As of July 2022, the National Defence has presented its new strategic approach to wellness for the entirety of the defence team. The document is promising and places far more emphasis on the experience, prevention, and overall wellness promotion than previous documents while celebrating differences and emphasizing inclusivity; *Total Health and Wellness Strategy* (National Defence, 2022). The Minister of National Defence, Honourable Anita Anand shares:

> This strategy will help ensure that Defence Team members are confident, well-supported, prepared, and equipped to deal with the challenging work we ask of them by supporting the adoption of healthier lifestyles and creating healthy workplaces built around professionalism and an inclusive culture. We must continue to work together to build a workplace that is safe, free from racism and hateful conduct, and where every person is

> treated with the same dignity and respect that we protect and defend every day in service to Canada. (p.5)

Though the authors, nor the Ministry, do not follow mad studies perspective, due to current past systems and policies, as well as how the Canadian context values traditional status of professional knowledge (Faulkner, 2017; Macdonald et al., 2018), the experience of military members, survivors and those navigating health and mental health challenges are much more included than in previous renditions and provides a hopeful outlook for future generations of military personnel. The military cannot and will not adopt change overnight and therefore has committed to *Advancing with Purpose* through their modernization framework; it is understood that when matters pertain to today, it is an encompassing 0–5-year outlook to the future; the army of tomorrow is a 5–15-year outlook and the future framework spans 15-30 years (Government of Canada, 2021). As someone starting in social work within this structure, knowing that I am starting in a context that will see shifts toward a more holistic understanding and incorporation of wellness and mental health is highly motivating, especially when, historically, the reputation of the military has not been as conducive to supporting mental health and varying identities.

3.7 Gendered Experiences in Practice

The Canadian Military is made up of a work force where men account for 85% and women 15%. The previous chapters outline how the experience of trauma, and its potential outcomes is gendered, as are help-seeking behaviours (Gottschall et al., 2021; Hoy, 2012). To better serve, guide and develop practices and policies the gender identity must be considered (Gottschall et al., 2021; Hoy, 2012). Knowing that the military is a field that is vulnerable to being witnesses

and victims of trauma; understanding their desire to seek help is equally as important as understanding how to help them.

In the last decade, the CAF has begun using a Gender-Based Analysis plus (GBA+) strategy to plan and prepare for how various programs, services, practices, and policies may affect different CAF members (Government of Canada, 2017). The plus in this analysis tool stands for the intersectionality of identities relating to age, education, location, culture, and social wealth (Government of Canada, 2017). This is also essential for planning operations and global missions, as various crises may impact or target different genders to varying degrees (Government of Canada, 2017). It is not clear what this means on the individual level of care or for accessing mental health services; however, in the 2022 release of the CAF Modernization strategy *Total Health and Wellness Strategy*, the identification of women is listed as a social determinant of health and commitment to adapting a Women's Health Framework. National Defence Team (2022) outlines the following.

> The Women's Health Framework builds on the existing CF health Services evidence-based, best-practice clinical medicine standards for women. The framework focuses attention on sex and gender as contributing factors to health, injury, disease, and health care and aims to:
>
> - Increase our knowledge regarding every day and long-term health for women;
> - Optimize preventative medicine for women;
> - Support women's health care in the military context; and
> - Enhance women's occupational performance. (p. 28)

The proposed directions are promising and will take time to move through massive structures to provide cultural change and impact all levels of practice, policies, and procedures. There have been visible and tangible efforts that I have been able to participate during my placement such as information sessions offered by the CAF for recruitment and support of the experiences of *Women in the Forces.* The session walked through the contributions and strengths of women throughout CAF history followed by a question-and-answer period. The question-and-answer period was focused on the experience of being a woman in the forces and women's bodies, specifically about pregnancy, childcare, and menstruation. There is room for improvement as the facilitator was a man; however, he did a great job at addressing his identity in comparison, never speaking on behalf of women, and sharing where his point of view was coming from. He acknowledged that there were no female presenters available and that due to his proximity to many female service members and not wanting the session to be cancelled, he felt he could step in. He let the women be the experts and acknowledged that the presentation would have benefited more with a woman as a facilitator. As far as my placement itself goes, I cannot say anything was overtly segregated by gender. I interacted with mostly women and found out that most social work officers and women occupy many officer roles within the military compared to the proportions of women in other roles. This is impressive, considering that women have only been granted access to the right of equal opportunity in all positions since 2001 (Government of Canada, n.d.).

I had initially expected the gender factor to be significant throughout my placement; however, all couples I encountered were heterosexual relationships, with the man serving in the military or as a veteran. As such, I did not come across any practical differences in my experiential learning at

this time. What I can speak on is that the spouses of those serving appear to engage in a dynamic that you would stereotypically expect of decades ago, living life according to the man's work and catering to his needs which often took the form of walking on eggshells attempting not to trigger their husbands. This called into question the social conditioning of gender roles and how the application of patriarchal and institutionalized setting such as the military may exacerbate this thinking. As a future service provider within the CAF understanding that social constructs of gender-roles are still due to im-part the disproportionate distribution of men and women in the CAF as well as structural implications of patriarchal views in institutional settings such as the military, it will be important to continue to uphold GBA+ as well as prioritize the lived experience of women through the voices of women. Although this analysis is outside the scope of this project's original intent, it is an essential consideration for the well-being of military families, as they are often important components of the CAF member's or Veteran's support systems. Understanding the dynamic of these families may provide important insight into providing effective and relevant services.

3.8 Preparation and Facilitation of Group Social Work in Practice

Military members and veterans often have families, and over half have partners (Rowan-Legg, 2017). The decision to create and facilitate a psycho-ed group was motivated by the intent to empower military or veteran partners who are supporting their partners who have experience trauma. By empowering direct support systems with increased knowledge and understanding of creating safety and trust in ways that foster resilience in hopes of moving towards healing and trauma recovery. The preparation and facilitation of a psycho-ed group to empower partners of military members and veterans was easily the most challenging part of the placement. I have

carried caseloads and counselled clients, given presentations and speeches, facilitated group therapy, and been a support staff for other presentations and training. However, I still needed to create a group. Starting was the most challenging part. I knew I wanted to dismantle the medicalization, incorporate normalizing the impacts of early adversity, and keep in mind that many CAF members and veterans reach out for help once they can no longer manage on their own, often in crisis (Levenson, 2020; Voith et al., 2020). My goal was to introduce a new narrative that opened the partners thinking from the medical model "what is wrong with you" and move towards a "what happened to you; and what systems or social conditions allowed this to happen to you?" (Voith et al., 2020 p. 172).

The group was modelled after the four Rs of TIC; Realize, recognize, respond, and resist re-traumatization (SAMHSA, 2014). Though it is the final two R's that would provide the practical skills, the foundation of understanding the prevalence of trauma and recognizing how far-reaching its impact is was a necessary first step. It was equally heartbreaking and fulfilling. Seeing firsthand how these women could connect with information directly related to their experience, how they began to understand that trauma is not just the physical or visual symptoms but explains the changes in their partners, and above all, their reactions to understanding triggers and trauma reminders. When they understood the perception of safety and trauma, many realizations, connections, and understandings were developed. It was heartbreaking to see that these women have been struggling to make sense of "PTSD" and other mental challenges without explaining how profound reactions can be and how to support them. Trauma and adverse experiences are not an experience that is unique to the CAF, as trauma & ACEs affect most people; it is estimated that 60% of adults experience at least one ACE and 20% report

experiencing four or more (CDC, 2021). However, CAF members' careers and work inherently put them at risk of compounding their trauma or developing complex trauma, PTSD and other mental challenges (Cramm et al., 2019; Easterbrook et al., 2019; Thompson et al., 2014).

By allowing the partners to learn about trauma in safe and peer supported environment allowed them to explore the idea that trauma symptoms are healthy reactions, and the nervous system works to protect the individual. However, it is maladaptation to the protective factors that have translated to intruding everyday life that we want to work with to mitigate further harm to individuals and their environments. If we were working with a physical injury or illness, the support system and family would be given strategies to assist in the healing processes of the individual, care and tools, and there would be a multidisciplinary team working towards health. The same must be true for wellness. The military and veterans' families are craving the closeness they once had to their husbands; due to being unaware of the impacts of traumatic experiences. They shared that they often resort to isolating themselves and neglecting their needs to mitigate their partners' activation, reactivity, and behaviours. The combination is relationship turmoil and an injured sense of self.

3.8.1 *Reflections Following Program Development*

A hurdle for this group and placement was coming to terms with what felt like imposter syndrome. Imposter syndrome is a phenomena that describes feeling unworthy or inadequate of currently held positions, often leaving an individual failing to internalize accomplishments and despite objective indications of success fail to recognize capacities (Bravata et al., 2017; Urwin, 2018) throughout the placement, and especially during the facilitation of the group I had this

lingering feeling that I was not worthy of being in the position to create a group for a population I was not a part of. To mitigate and move past this feeling I had to remind myself that I was providing foundational psychoeducation to increase empowerment and deepen their understanding of their current experiences. I was not there to tell them what their experience was. Despite the reminder, a slight mental distortion of this sensation remained for the first sessions. I felt pressure and intimidation from the lack of intersecting identity with the women and from being an outsider to the military while simultaneously being a social work officer in training. I am enrolled; however, my primary and sole duty is to complete my Master of Social Work. I do not hold the lived experience they do, although they are not members. Above all else, as a student, it is difficult to disclose without justifying that it is a master's practicum, and not a bachelor practicum, so I did have more skills and the qualifications; and the second you say "masters", the hierarchy of education is visible. This called into question the need for self-disclosure; however, I felt it was unethical not to share that I was a student as I would be withholding information that ultimately led to the clients being able to make an educated decision on proving informed consent. There are both sides to the power differential. Understanding that I am a social worker, which will come with a certain about of power, and having access to post-secondary and graduate education is a privilege; however, the experiential knowledge of clients is invaluable, especially in a learning setting as such. The learning setting compounded with the framework of Mad Studies and TIC methods created an environment that allowed me to value this type of knowledge to make sense of my ability to move from theory to practice while upholding the values and basics of each approach.

Becoming comfortable with the back-and-forth of knowledge sharing was a monumental step. I learned to feel more at ease with clients looking up to me as a social worker, but I also need them to understand that their experience, strengths, knowledge, and skills are far more substantial and imperative to the work at hand. I learnt that that there is not a singular experience of power hierarchy, that knowledge, and credentials as well as identities are multidimensional, complex and change over time. The interplay of the varying factors and multidimensions of the relationship work together and create a unique setting that can foster safety and trust and collaboratively promote empowerment and resilience

When working with clients, especially in the group, a significant step to addressing this was when they asked questions about their personal experiences. I could tell they were seeking textbook explanations or reassurance of their experiences; often taking form of questions starting with “is it normal that…?” I ensured that my first step was to ask them what they believed, what they understood and what they were currently doing that worked or felt good, and we talked about barriers in systems on different levels as well as overarching narratives such as subliminal messages or social constructs that they may have fallen victim to due to stereotypes of military life. The steps ensured that I did not take on the expert role and that they, themselves as clients, could share their capacities and strengths. When considering this approach from a mad studies framework, removing the social work label from myself, and seeing the field as a tool to empower and support clients changed the dynamic. An example is the using inclusive language client led language and avoiding diagnostic language unless adopted first by the client allowed me to move out of the “expert” position. One participant stuck on the idea that their partner had PTSD, although never diagnosed and as the partner refused to access services in fear of career

backlash. However, the participant shared that by accepting that they had PTSD the participant was able to accept some of the exhibiting behaviours and find relevant resources and supports for herself living with him. In this case, I did not think it would be in the best interest of the client to correct and change her understanding of her experience.

Another point of reflection is understanding that I have structural and systemic power and that being a White social worker in the military and having access to graduate education in Canada provides me with a great deal of social wealth and privilege. The neoliberal context of Canadian society and structural conditions place my identity in a place that has merit and power. Merit and power do not come without some classifiable societal hierarchy, which ultimately results in oppression. Now as great as it would be to say it does not matter and I can try and mitigate the effects, I believe that not addressing it is even more problematic. Baines (2017), discusses how by not engaging with our own identities, we may miss out on many indicators of further harm to our clients due to the intersecting identities of both the worker and client. By acknowledging the differences between my positionality and that of my clients, we can acknowledge oppression's structure and social constructs, building trust and transparency toward a stronger therapeutic relationship (Baines, 2017). In the military, the chain of command and rank is often the number one indicator, and positionality is exhibited directly on the uniform. The client and therapist are aware of each other’s rank in the military context. With social work officers, this is in some ways similar to court-mandated civilian social work services, as outlined by Bogo (2018);

> Social workers do have power by virtue of the mandate of their organization, the role they perform, their access to resources, the knowledge they have, and the assistance they

> can provide. Social workers' assessments and recommendations have profound implications for individuals and their families (p.121)

In these cases, we see the social worker, who may or may not have a significantly different life experience from the client (military member), having to make decisions based on standardized assessments or medicalized models and ethical guidelines. Both trauma-informed care models highlight the importance of peer support and transparency compounded with a mad studies framework that understands the importance of the lived experience; mitigating the differences may be easier than in more traditional medicalized psycho-analytical therapies. Despite my recent learning experience, my social location and ability to reflect and engage with critical consciousness will change and evolve throughout my social work career.

3.9 Conclusion

When beginning the advanced practicum, I was looking for rigid and concreate answers to all my questions and learning goals. When I reflect on the environment and learning outcomes, I am proud to acknowledge that the growth both professionally and personally due to the experiential learning environment, support and feedback from my supervisor along with the preparation from the social work program for the engaging with evidence-based practices and opportunity to critically engage and appraise literature has allowed me to better understand the social work role more holistically. This chapter provided the space to reflect on the engagement of learning goals, understand the on-going commitment to critical reflexivity, moving theory to practice and attempting to work from a framework outside of the dominance of a medical model. The chapter provided an overview of my experience with each of these elements while incorporating specific

factors of Trauma, ACE and gender. The next chapter will build on this learning by reviewing implications, creating recommendations based on current learning, and conclude the report.

Chapter 4

4 Implications, Recommendations and Conclusion

Due to the current context of neoliberalism and colonialism resulting in austerity measures, social services and health care have become a question of quantity, not quality (Farnsworth & Irving, 2018). The trajectory of trauma services has followed suit, criticized for performative practices centred on institutional and organizational structures, relinquishing the original concerns with politicizing social and historical systems (Birnbaum, 2019). The pitfall of this shift results in the use of trauma language to lump all subjective symptoms and experiences to be called trauma, including those with more invasive symptomology. Birnbaum's (2019) critique states that the most severe cases have been "shunted aside under the cover of TIC language, which renders their acute needs invisible by submerging them under vague definitions of trauma that can include virtually any self-reported subjective sense of injury, victimization or loss" (p. 477-478). TIC continues to perpetuate that trauma exists and affects individuals rather than promote the idea that oppression exists throughout childhood, career, and social order, including gender, causing the traumatic experiences to begin with (Birnbaum, 2019). The following chapter will incorporate elements from the previous chapters, learning outcomes, and academic literature to review implications, pose recommendations based on the learning experience and conclude the report.

4.1 Implications for Social work

Historically, but also perhaps more rampant in the current service context, psychiatric labels and symptoms continue to scare populations without outrage to the systems causing it (Birnbaum, 2019). Anti-psychiatry and mad studies call for reviewing the current structures and

pathologizing of healthy nervous systems. The perspective understands that the responses to stimuli have been regarded as trauma symptomology in contemporary medical discourses (Birnbaum, 2019; Macdonald et al., 2018).

Mad studies and anti-psychiatry perspectives understand that dominant voices can frame trauma in societies in ways that call for social action; In contrast, it could steer the collective responsibility away (Birnbaum, 2019). Mad studies and anti-psychiatric perspectives would challenge language to ask more specific questions rather than the current vague ones of TIC. Birnbaum (2019) suggests the following, “who did this?”, What structures and policies enabled this?” and “What must be done so that this will not happen again?”. This way, historical and social perpetrators are highlighted, and individual suffering is politicized (Voith et al., 2020; Birnbaum, 2019). As such, the future will have to implement teaching not only the clinical realities of the impacts of trauma; but also learning about the conditions causing the symptoms that need to be critically engaged and challenged, looking back to childhood ACEs and social orders of power and hierarchy (Birnbaum, 2019). Individual responsibility regarding language, power, and structures of language production also needs to be challenged, accepted, and more widely understood.

4.2 Implications for Military Social Work

Furthermore, when narrowing in on the implications for military social work services specifically, with the assistance of the analyses of their modernization strategies and *Total Health & Wellness Strategy* there are a few points that stand out. The implications are that social work officers could be placed in a consulting position to help guide policies and practices. I

believe there is a need and recognition of need for more preventative training, normalizing mental health and trauma, and overall promotion of self-awareness and resilience. However, hoping or believing that individual services will change remains challenging. This is through no fault of any institution or application of any one model; this is because military members will continue to need to be deployed, continue to be relocated, and be put on course or last-minute training to meet the collective needs of the country first. The second ethical principle of the military is "Serve Canada before self: CAF personnel prioritize service to the country, the military, and their teammates ahead of themselves as a personal commitment to mission success. Military professionals place service before self to maximize team effectiveness" (Government of Canada, n.d.).

With this idea, I explored families as micro teams and how we can prepare them to ensure the effectiveness of CAF personnel. When the military emphasizes readiness, bringing mental wellness and resilience into perspective may allow for a more effective approach that aligns with the modernization strategy timeline and work toward the idea of the *Total Health & Wellness Strategy.* Military Personnel has the professional expectation of committing to 'readiness'; the Government of Canada (n.d.) explains that committing to 'readiness' includes a balance between personal and professional life and communicates needs honestly to ensure the balance. Suppose military social workers can develop a sustainable practice of training or support for military families. In that case, we may be able to support military members' readiness from a foundational level, increasing feelings of trust and safety in various environments; Increased safety and trust foster resilience and trauma recovery in civilian and military settings (Gottschall et al., 2021; Herzog et al., 2020; Landes et al., 2013). By normalizing and validating trauma

throughout life instead of focusing on the military career trauma alone, we allow for connection and understanding among the families. If we have more people that understand how ACEs impact individuals' stress tolerance, perception of danger and safety as well as their ability to regulate their emotions, then we have more empowered families that can create environments that foster readiness for their military members (Ali et al., 2020; Gottschall et al., 2021; Levenson, 2017; Sanders, 2019; Voith et al., 2020). Furthermore, a healthier and more trauma-informed environment may serve as an overall preventative or protective factor of ACEs for children (CDC, 2021).

4.3 Implication for the Consideration of Gender in the Military

An interesting pattern of exploring the gender consideration for experience with mental health and the military of what emerged from completing the advanced practicum and through the analysis and research conducted for this final report in the context. The pattern I noticed is that the primary focus of data reported is that of women experience, which is interesting as the military is comprised of 85% men. The literature regarding the gendered behaviours of help seeking and reporting mental health is consistent with this, as women are more likely to participate and report feelings of mental distress, and men are less likely to seek intervention or report similar feelings (Gottschall et al., 2021). Based on the literature reviewed throughout this practicum experience it appears that women’s experiences are often analyzed and quantified. However, the research regarding men remains concluded with vague language and a recommendation for further research more frequently than women-focused literature. When noticing this pattern with military social work and knowing that women make up only 15% of the population (Rowan-Legg, 2017), it leaves many gaps in fully understanding the scope of

needs and the experience of most of the population and, therefore, the ability to provide services to meet needs effectively would then be assumed to be reduced. The encompassing has created evidence consistent with literature findings that support detrimental health outcomes for men, including the completion of suicide (Hoy, 2012). The implications for continuing research with samples by convenience means that the policies and practices will be reflective of the outcomes of the research, therefore men may continue to face health detriments as women appear to offer and participate more willingly in mental health conversations and interventions. This is a consideration for both military and civilian social work. More research regarding the exacerbation of this phenomena by social conditioning of gender-roles and career stereotypes may be beneficial for future policy, programing, interventions, and social-work training.

4.4 Recommendations

Themes and barriers emerged throughout this advanced practicum experiential learning opportunity, literature, supervision, and interdisciplinary conversations. The barriers included pathology and stigma regarding the medical model of care, the assumption of weakness with mental health diagnosis, a widespread non-understanding of lifetime trauma, and structural/environmental considerations. The following three recommendations are made based on the learning experience from my advanced practicum; (1) Normalizing conversations regarding ‘readiness’ and lifetime traumas for military members, especially with men, to gain insight into understanding symptoms of distress and well-being, (2) De-medicalizing psychiatric labels and seeking structural and environmental understanding of mental health for military members (3) Providing an overall generalized understanding of the prevalence of trauma without

pathologizing healthy nervous systems reactions through the understanding of protective behaviours that once serve the individual have become maladaptive through decontextualization.

4.4.1 *Reflections on Recommendations*

Because of the limitations of time constrains and access to clients I do not feel that I can apply the recommendations to address one gender or another. However, I hope that more validation and normalization regarding such conversations will allow men specifically to feel valiated and gain an understanding of mental health and trauma impacts. Furthermore, the recommendations were made considering the military context. In contrast, micro-level recommendations could be made and provide better-individualized services allowing for individual empowerment towards self-actualization. However, the recommendations incorporated provided practical implications and feasibility. Part of the learning from this placement is the understanding of team mentality and military structure. The idea that any social worker can make a case for a mental health system overhaul is not realistic, so I chose to frame recommendations where they could be applied to a current military practice, policy, and align with current values. This learning also showed me that much of what emerged on this micro/mezzo level of experience mirrors the macro-level changes the military is already attempting to make. Furthermore, understanding the size of the military with over 65,000 members, cultural change will take time. The military is an immense powerhouse that has many levels and barriers of professions to navigate before cultural level changes can begin to create a ripple.

In this advanced practicum experience, I attempted to incorporate the framework of the mad studies perspective, enhance the emphasis on ACEs and lifetime traumas and consider the

implication of gender on military members. I have created a group that sheds light on the outcomes of creating a better understanding of trauma that focus on safety and trust to foster resilience and healing. I wanted to de-pathologize trauma and maladaptive behaviours or attitudes to address military members' and their families root causes and needs. As trauma is a highly subjective experience that can be traced back to childhood and attachment, it is also an experience that is widely shared. A better understanding of trauma for all can create environments that enhance connection and collaboration rather than isolation. However, the medical model of care and the prerequisite of diagnosis for treatment rather than preventative approaches in current mental health services makes mad studies and trauma-informed approaches seem radical.

4.5 Conclusion

The advanced practicum experience has ended, the literature has been reviewed and mobilized, and the reflections of the final report have been one of the most remarkable feats of reflexivity in my social work career. The advanced practicum at Connected Counselling service has increased my knowledge of trauma and military social work. The first chapter sets the scene to explore the experiences of trauma and mental health needs of the military and their families by providing background and exploring the theoretical framework of mad studies. Mad studies framework was then applied to the considerations of the pervasiveness of military social work, including gender, ACEs, and TIC. The chapter also gave context into my social location, which provides readers with an understanding of where I am writing from and what lenses may affect my work.

The second chapter provided the opportunity to broaden the horizon on understanding the current mental health military context and gain insight into special considerations such as gender, ACEs and TIC, which took the form of a literature review. The literature reviewed highlighted themes; the first portion explored ACEs and military life impacts, including the unique experience of military life, the current understanding of military personnel ACEs, and the idea of ACEs being a motivator for enlisting. The second portion explored the use of trauma-informed care with military personnel and veterans, and the themes in the literature include; the mental health sector must be more cognizant of trauma's prevalence and symptomology, the need for TIC safety principle with military populations is multidimensional, and TIC principles of peer support can foster belonging and break isolation.

The third chapter outlined the advanced practicum environment, including personal and professional reflections on learning goals, experiences and supervision encountered throughout the placement. The fourth chapter mobilized the information from the first three to understand the implications this learning could have on the social work profession, followed by a subsection on the feasibility of application in military social work and concluded with recommendations, reflections and concluding remarks.

The next step in my learning and professional career is only going to take me deeper into the understanding of the interplay of the medicalization of mental health, power structures, and trauma within the military context. This experiential learning opportunity provided me with an amazing learning experience and the practical foundations for personal and professional growth within a setting directly applicable to my next professional chapter. I am beyond grateful for the

opportunity to explore learning in this setting while deepening my understanding of my social location and how it fits into the larger context of care and power in civilian and military social work. Regardless of modality, reflecting on social location is ongoing, learning to engage deeper with critical reflexivity continues and both change and evolve with time.

I have elaborated on many facets of mental health and military families, and a thought that continues to reside with me is how systems are not using the opportunity to not only support but use military families as agents of support that would foster the well-being of military members. While military members continue to serve Canada before themselves, we fail to create systems and environments that support their healing. The inherent risk of military careers should not have to come at the cost of mental well-being or intergenerational mental health challenges. I hope to respond further to this need throughout my military career in social work. The advanced practicum setting, and report allowed for the unique experience of continuously bridging theoretical and experiential learning while collaborating with the expertise of supervision to understand its feasibility. All my learning goals and questions have been opened to a growth mindset and shed light on valuable considerations of gaps, discrepancies, strengths, further application, and future research. All of which will continue to guide my personal and professional learning in an open, growth-minded, and reflexive ways towards developing my identity within the military and as a social worker.

References

Ali, A., Wolfert, S., McGovern, J. E., Nguyen, J., & Aharoni, A. (2020). A trauma-informed analysis of monologues constructed by military veterans in a theater-based treatment program. *Qualitative Research in Psychology*, *17*(2), 258–273. https://doi.org/10.1080/14780887.2018.1442704

Assari, S. (2020). Family socioeconomic status and exposure to childhood trauma: racial differences. *Children, 7*(57). 10.3390/children7060057

Baines, D. (2011). *Doing anti-oppressive practice: Social justice social work*. Fernwood Publishing.

Birnbaum, S. (2019). Confronting the social determinants of health: Has the language of trauma informed care become a defense mechanism? *Issues in Mental Health Nursing*, *40*(6), 476–481. https://doi.org/10.1080/01612840.2018.1563256

Bargeman, M., Smith, S., & Wekerle, C. (2021). Trauma-informed care as a rights-based "standard of care": A critical review. *Child Abuse & Neglect, 119*(1), 104762. https://doi.org/10.1016/j.chiabu.2020.104762.

Blackburn, D. (2015). Social work in the military: Considering a renewed scope of practice. *Canadian Military Journal, 16*(1), 34- 43. http://www.journal.forces.gc.ca/vol16/no1/PDF/CMJ161Ep34.pdf

Blosnich, J., Dichter, M.E., Cerulli, C., Batten, S.V., & Bossarte, R.M. (2014). Disparities in adverse childhood experience among individuals with a history of military service. *JAMA Psychiatry, 71*(9), 1041-1048. doi:10.1001/jamapsychiatry.2014.724

Bravata, D. M., Watts, S. A., Keefer, A. L., Madhusudhan, D. K., Taylor, K. T., Clark, D. M., Nelson, R. S., Cokley K. O. & Hagg, H. K. (2017). Prevalence, predictors, and treatment

of imposter syndrome: A systemic review. *Journal of General International Medicine, 25*(4), 1252-1275. doi: 10.1007/s11606-019-05364-1

Bunbury, S. (2019). Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination. *International Journal of Discrimination and the Law, 19*(1), 26-47. https://doi.org/10.1177/1358229118820742

Canadian Association for Social Workers. (2005). *Code of ethics*. Canadian Association for Social Workers. Retrieved from https://www.casw-acts.ca/sites/caswacts.ca/files/documents/casw_code_of_ethics.pdf

Canadian Forces Morale and Welfare Services. (2018). Profile of military families in Canada: 2017 Regular force demographics. *Department of National Defence. https://www.cafconnection.ca/getmedia/7b46894d-91aa-421b-912f-6293b0cab4b9/Profile-of-Military-Families-in-Canada-2017-RegF-Demographics-Report-FINAL-June-2018.pdf.aspx#:~:text=Of%20all%20Regular%20Force%20personnel,female%20and%2016%25%20are%20male.*

Center for Disease Control and Prevention [CDC]. (2021, April 6). *About the CDC-Kaiser ACE study*. U.S. Department of Health & Human Service. https://www.cdc.gov/violenceprevention/aces/about.html

Clary, K. M., Shaffer, P. M., Gaba, A., Pinals, D. A., & Smelson, D. (2020). Comparing the treatment needs of participants with co-occurring mental health and substance use disorders in drug and veterans' treatment courts. *Journal of Substance Use*, *25*(3), 277–283. https://doi.org/10.1080/14659891.2019.1683905

Currier, J.M., Stefurak, T., Carroll, T. D., & Shatto, E. H. (2017). Applying trauma-informed care to community-based mental health services for military veterans. *Best Practices in Mental Health, 13*(1), 47–64. Retrieved from file:///Users/morgan/Downloads/Applying_TraumaInformed_Care_t%20(2).PDF.

Connected Counselling Services. (N.D.). Welcome. *Counnected Counselling Services.* Retrieved from: https://www.connectedcounsellingservices.com/.

Cramm, H., Mahar, A., Maclean, C. & Birtwhistle, R. (2019). Caring for Canadian military families. *Canadian Family Physician, 65*(1), 9-11. Retrieved from https://www.cfp.ca/content/65/1/9.long.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846-861. https://doi.org/10.1016/j.cpr.2012.09.007

Department of the Army. (2008). Standards of Medical Fitness. *Military Services, Army Regulations 40-501,* p. 1-116. Retrieved from: https://www.qmo.amedd.army.mil/asthma/ArmyReg.pdf.

Deschamps, M. (2015). External review into sexual misconduct and sexual harassment in the Canadian Armed Forces. *Government of Canada.* Retrieved from: file:///Users/morgan/Downloads/era-final-report-april-20-2015-eng.pdf

Easterbrook, B., Brown, A., Millman, H., Van Blyderveen, S., Lanius, R., Heber, A., McKinnon, M., & O'Conner, C. (2022). The mental health experience of treatment seeking military members and public safety personnel: a qualitative investigation of trauma and non-trauma related cocnerns. *Health Promotion and Chronic Disease Prevention in Canada: Research, Police & Practice, 42*(6), 252-250. https://doi.org/10.24095/hpcdp.42.6.03.

Faulkner, A. (2017). Survivor research and mad studies: the role and value of experiential knowledge in mental health research. *Disability & Society, 34*(4), 500-520. https://doi.org/10.1080/09687599.2017.1302320

Farnsworth, K., & Irving, Z. (2018). Austerity: Neoliberal dreams come true? *Critical Social Policy, 38*(3), 461-481. https://doi.org/10.1177/0261018318762451

Gerber M.R. (2019). Trauma-informed care of veterans. In: Gerber M. (eds) *Trauma-Informed Healthcare Approaches*. Springer, Cham. https://doi-org.librweb.laurentian.ca/10.1007/978-3-030-04342-1_6

Ginexi, E. M., Miller, A. E., & Tarver, S. M. (1994). A qualitative evaluation of reasons for enlisting in the military: Interviews with new active-duty recruits. *Department of Defence.* Retrieved from: https://www.researchgate.net/publication/235039259_A_Qualitative_Evaluation_of_Reasons_for_Enlisting_in_the_Military_Interviews_with_New_Active-Duty_Recruits

Gottschall, S., Lee, J., & McCuaug Edge, H.J. (2021). Adverse childhood experiences and mental health in military recruits; Exploring gender as a moderator. *Journal of Traumatic Stress, 35*(1), 659-670. DOI: 10.1002/jts.22784

Government of Canada. (2014*). Key developments: Addressing sexual misconduct.* https://www.canada.ca/en/department-national-defence/services/benefits-military/conflict-misconduct/sexual-misconduct/key-developments.html

Government of Canada. (2017). *Gender-based Analysis Plus (GBA plus).* https://women-gender-equality.canada.ca/en/gender-based-analysis-plus.html

Government of Canada. (2021). *Advancing with purpose: The Canadian army modernization strategy.* https://www.canada.ca/content/dam/army-armee/migration/assets/army_internet/docs/en/national/2021-01-canadian-army-modernization-en.pdf.

Government of Canada (2022). *Social Work in the Defence Team*. https://www.canada.ca/en/department-national-defence/maple-leaf/defence/2022/08/social-work-defence-team.html

Government of Canada. (n.d). *Values and Ethos.* https://forces.ca/en/values-ethos/

Hales, W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2019). Trauma-informed care outcome study. *Research on Social Work Practice, 29*(5), 529–539. https://doi.org/10.1177/1049731518766618

Healy, K. (2014). *Social work theories in context: Creating frameworks for Practice.* Palgrave Macmillan.

Herzog, J. R., Whitworth, J. D., & Scott, D. L. (2020). Trauma informed care with military populations. *Journal of Human Behavior in the Social Environment*, *30*(3), 265–278. https://doi.org/10.1080/10911359.2019.1679693

Hoy, S. (2012). Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help seeking. *International Journal of Men's Health, 11*(3), 202-226. http://dx.doi.org.librweb.laurentian.ca/10.3149/jmh.1103.202

International Federation of Social Work. (2018, July 2). *Global social work statement of ethical principles.* IFSW. https://www.ifsw.org/global-social-work-statement-of-ethical-principles/.

Isobel, S., Wilson, A., Gill, K., & Howe, D. (2021). “What would a trauma-informed mental health service look like?” Perspectives of people who access services. *International Journal of Mental Health Nursing, 30*(2), 495–505. https://doi.org/10.1111/inm.12813

Joshi, D., Raina, P., Tonmyr, L., MacMillan, H. L., & Gonzalez, A. (2021). Prevalence of adverse childhood experiences among individuals aged 45 to 85 years: a cross-sectional analysis of the Canadian Longitudinal Study on Aging. *CMAJ open, 9*(1), E158–E166. https://doi.org/10.9778/cmajo.20200064

Kane, R.A. (1982). Lessons for social work from the medical model: a viewpoint for practice. *Social work*, 27(4), 315-21. https://doi.org/10.1093/sw/27.4.315

Katon, J.G., Lehavot, K., Simpson, T. L., Williams, E. C., Barnett, S. B., Grossard, J.R., Schure, M. B., Gray, K. E., & Reiber, G. E. (2015). Adverse childhood experiences, military service, and adult health. *American Journal of Preventative Medicine, 49*(4), 573-582. https://doi.org/10.1016/j.amepre.2015.03.020

Kelly, U., Boyd, M. A., Valente, S. M., & Czekanski, E. (2014). Trauma-Informed Care: Keeping Mental Health Settings Safe for Veterans. *Issues in Mental Health Nursing*, *35*(6), 413–419. https://doi.org/10.3109/01612840.2014.881941

Kenrick, D. T., Griskevicius, V., Neuberg, S. L., & Schaller, M. (2011). Renovating the pyramid of needs: contemporary extensions built upon ancient foundations. *Perspectives on psychological science: a journal of the Association for Psychological Science*, *5*(3), 292–314. https://doi.org/10.1177/1745691610369469

Knight, K. (2014). Trauma-informed social work practice: practice considerations and challenges. *Clinical Social Work Journal, 43*(1), 25–37. https://doi.org/10.1007/s10615-014-0481-6

Landes, S. J., Garovoy, N. D., & Burkman, K. M. (2013). Treating complex trauma among veterans: Three stage-based treatment models. *Journal of Clinical Psychology, 69*(5), 523–533. https://doi.org/10.1002/jclp.21988

Levenson, J. (2017). Trauma-informed social work practice. *Social Work, 62*(2), 105–113. https://doi.org/10.1093/sw/swx001.

Levenson, J. (2020). Translating trauma-informed principles into social work practice. *Social Work, 65*(3), 288–298. https://doi.org/10.1093/sw/swaa020.

Little, W. (2016) *Introduction to Sociology: 2nd Canadian Edition.* Pressbooks.

Luxton, D.D., Osenbach, J.E., Reger, M.A., Smolenski, D.J., Skopp, N.A., Bush, N.E., & Gahm, G.A. (2012). Department of Defense Suicide Event Report Calendar Year 2011 Annual Report. National Center for Telehealth & Technology.

Macdonald, S. J., Charnock, A., & Scutt, J. (2018). Mad studies and social work: Conceptualising the subjectivities of service user/survivors who experience significant mental health problems. *Social Work and Social Sciences Review*, *19*(3), 98-118. https://doi.org/10.1921/swssr.v19i3.1193

McGuinness, T. M., & Waldrop, J. R. (2015). Adverse childhood experiences and the mental health of veterans. *Journal of psychosocial nursing and mental health services*, *53*(6), 23–26. https://doi.org/10.3928/02793695-20150527-55

Merrick, M.T. & Guinn, A.S. (2018). Child abuse and neglect: Breaking the intergenerational Link. *American Journal of Public Health, 108*(9), 1117-1118. doi: 10.2105/AJPH.2018.304636

National Defence. (2022). *Defence team: Total health and wellness strategy.* https://www.canada.ca/content/dam/dnd-mdn/images/thaw/DGM-24820-

L0S_The%20Defence%20Team%20Total%20Health%20and%20Wellness%20Strategy_v26_EN.pdf

Olson, M.D. (2018). Exploring military social work from a social justice perspective. *International Social Work, 6*(1), 119-129. https://doi.org/10.1177/0020872815606792

O'Rourke, E. (2012). Exploring the experience of receiving Canadian armed forces' mental health services. *Program of Social Work, Ryerson University.* Retrieved from https://mail.google.com/mail/u/0/?tab=rm&ogbl#search/bdavies1%40laurentian.ca?projector=1&messagePartId=0.1

Poole, J., Jivraj, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., & Reid, J. (2012). Sanism, 'mental health', and social work/education: A review and call to action. *Intersectionaities, 1,* 20-36. Retrieved from: https://journals.library.mun.ca/ojs/index.php/IJ/article/view/348/227

Rowan-Legg, A. (2017). Caring for children and youth from Canadian military families: special considerations. *Canadian Paediatric Society, 22(2), 1-6.* doi: 10.1093/pch/pxx021

Sakamoto, I. & Pitner, R. O. (2005). Use of critical consciousness in anti-oppressive social work practice: disentangling power dynamics at personal and structural levels. *The British Journal of Social Work, 35*(4), 435–452. https://doi.org/10.1093/bjsw/bch190

Sanders, J. (2019). Teaching note-trauma-informed teaching in social work education. *Journal of Social Work Education, 57*(1), 197–204. https://doi.org/10.1080/10437797.2019.1661923

Sareen, J., Henriksen, C. A., Bolton, S.-L., Afifi, T. O., Stein, M. B., & Asmundson, G. J. G. (2013). Adverse childhood experiences in relation to mood and anxiety disorders in a population-based sample of active military personnel. *Psychological Medicine, 43*(1), 73–84. https://doi.org/10.1017/S003329171200102X

Schultz, J. R., Bell, K. M., Naugle, A. E., & Polusny, M. A. (2006). Child Sexual Abuse and Adulthood Sexual Assault among Military Veteran and Civilian Women. *Military Medicine, 171*(8), 723–728. https://doi.org/10.7205/MILMED.171.8.723

Sudom, K. (2010). Quality of Life Among Military Families: Results From the 2008/2009 Survey of Canadian Forces Spouses. Director General Military Personnel Research and Analysis. *National Defense, DGMPRA TR, 17*.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* U.S. Department of Health & Human Services. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Thompson, J.M., Zamorski, M. A., Fikretoglu, D., Vantil, L., Sareen, J., MacLean, M. B., Carrese, P., Macintosh, S., & Pedlar. D. (2014). Out of the shadows: Mental Health of Canadian armed forces veterans. *International psychiatry, 11*(4), 85-87. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6735134/

United States Government. (n.d.). History of the selective service system. *History and Records.* Retrieved from: https://www.sss.gov/history-and-records/.

Voith, L., Hamler, T., Francis, M. W., Lee, H., & Korsch-Williams, A. (2020). Using a trauma-informed, socially just research framework with marginalized populations: Practices and barriers to implementation. *Social Work Research, 44*(3), 169–181. https://doi.org/10.1093/swr/svaa013

Warner, C.H., Appenzeller G.N., Parker, J.R., Warner, C.M., & Hoge., C.W. (2011). Effectiveness of mental health screening and coordination of in-theater care prior to

deployment to Iraq: A cohort study. *The American Journal or Psychiatry 168*(4), 378-385. https://doi.org/10.1176/appi.ajp.2010.10091303

Xie, H., (2013). Strengths-based approach for mental health recovery. *Iranian journal of psychiatry and behavioral sciences, 7*(2), 5-10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939995/