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DISSONANCE, DISCORD AND THE DISCOURSES OF MILITARY TRAUMA: LISTENING DIFFERENTLY TO "DISORDER"

BY

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Dedication

I would like to dedicate this paper to my long-suffering and tirelessly supportive husband and children, who have cheered my progress, stepped up to household responsibilities, and accepted the countless evenings, weekends and holidays when I was locked away from them in my tiny home office. Rob, Liam, and Catrionagh, I love you more than you can imagine.

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Abstract

Posttraumatic stress disorder (PTSD) is a pressing concern among members and veterans of the Canadian Forces, and the issue attracts chronic conflict. Diagnosis and treatment is dominated by the psychiatric definition; however, that model is not a pure distillation of biomedical epidemiology, but also the product of specific sociocultural and political discourses. Although the phenomenon of prolonged mental suffering in response to adversity is universal, the experience is narrated differently across different cultures. I investigated the discourse of military PTSD among (predominately Canadian) military members and veterans on social media. Participants spoke from a collectivist worldview, narrated PTSD as a disorder of progressive alienation and isolation, and prioritized loss of identity and connection over symptom checklists. They sought to claim a collective identity in which PTSD was congruent with their military role, rather than a disease of the individual brain, and they prioritized interconnectedness as the route to healing.

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Chapter I - Significance of the Problem

This thesis was the product of decades of personal and professional experience inhabiting multiple cultural worlds and being curious about the profound misunderstandings and conflicts that arise between good people acting with the best of intentions. I am a family physician who married a military pilot, worked on contract for the Canadian Forces (CF) for a time, and followed my growing interest in mental health and posttraumatic stress disorder (PTSD) into a graduate degree program in counseling psychology, a practicum in military trauma therapy, and most recently, a psychiatry residency. Although a certain degree of conflict and tension is inevitable in health care teams, what I encountered in the arena of military psychological trauma was striking: an exceptional degree of urgency, dedication, and high emotion running headlong into conflict and cross-purposes. I was curious, and I suspected that understanding the conflict could be a key prerequisite to facilitating more effective care and support for an extraordinarily vulnerable population. As I inhabit multiple cultural and professional identities relevant to the field, it was perhaps inevitable that I would find my way to discourse analysis. In this thesis, I will begin with an overview of psychological trauma in the Canadian Forces, trace my journey through the trauma literature, explain my rationale for choosing discourse analysis, and discuss the specifics of my methodological approach. Finally, I will present the findings of my study and discuss its implications.

The Canadian Forces have a long history of intensive war-fighting and peace-keeping missions around the world. The last Canadian veteran of the First World War died in 2010 (CBC News, 2010) but many Second World War vets continue to

deal with both the physical and psychological scars of war, as do veterans of Korea (Pedlar & Thompson, 2011) and the Gulf War (Statistics Canada, 2005). Canada's contribution to the war in Afghanistan has exacted a heavy price, with 158 soldiers killed and 635 wounded in action (Government of Canada, 2014). Peace-keeping missions have often been the most distressing of all, as soldiers have been forced to bear witness to genocide and other atrocities, with severe restrictions on their ability to intervene. Some of the worst of these missions have included Rwanda, Somalia, and the former Yugoslavia (Lamerson, 1996; Sareen, 2010). As of late 2014, Canada was involved in a diverse array of operations, including active combat in Iraq, de-mining in the Baltic States, North Atlantic Treaty Organization (NATO) operations in Central and Eastern Europe, and an array of peacekeeping operations in locations such as Haiti, Kosovo, Cyprus, Democratic Republic of the Congo, Darfur, and Republic of South Sudan (National Defence and the Canadian Armed Forces, 2014).

Stressors faced by military personnel include combat experiences, witnessing atrocities, grief over the loss of comrades, isolation, inability to respond to problems with family back home, physical wounds and chronic injuries, and feelings of betrayal by the institutional response to their distress (Garber, Zamorski, & Jetly, 2012; Ray, 2009; Sareen, 2007; Thompson et al., 2011). As a result of the difficult missions they carry out, and the nature of the stressors to which they are exposed, CF members and veterans are subject to serious mental health issues, such as depression, PTSD and anxiety (Thompson et al., 2011). Boulos and Zamoski (2013) studied 30,513 CF personnel deployed to Afghanistan before January 2009 and found that over a 1364 day follow-up period, 13.5% had a mental health disorder attributable to

the deployment, and the majority of these were PTSD. The CF Mental Health Survey found the one year prevalence of depression among regular force members to be 7.6% in 2002 (Statistics Canada, 2002), and 8.0% in 2013 (Statistics Canada, 2014); however, the one year prevalence of PTSD rose from 2.8% to 5.3% over that time period. The Canadian Forces Cancer and Mortality Study (Statistics Canada, 2011) found that males who had left the CF were one and a half times more likely to commit suicide than males in the general population. Involuntary or medical release increased the risk of suicide, as did poor physical health (MacLean et al., 2014). Alcohol abuse commonly co-occurs with PTSD in CF members and veterans, often facilitated by group coping norms post-combat (Fetzner, Abrams, & Asmundson, 2013; Skomorovsky & Lee, 2012). Homelessness has been identified as a significant concern among CF veterans, with mental illness a significant contributing factor, although the full extent of the problem has not been adequately studied and comprehensive statistics are lacking (Ray, 2011; Ray & Forchuk, 2011).

A decade ago, I spent three years working on contract for the Canadian Forces as a civilian family physician, and became highly involved in addressing the emerging concerns around PTSD in the organization. I worked in a multidisciplinary team environment and developed working relationships with civilian psychologists, the military ombudsman, senior officers of the local infantry battalion, the air force base which employed me, senior personnel in National Defence Headquarters (NDHQ), my own chain of command, and a healthcare team with widely divergent opinions on PTSD. Many of these entities had conflicting mandates and culturally disparate belief systems. I observed emotionally polarized discourses between

caregivers and leaders, as well as shame, stigma, misunderstanding, disbelief, disconnection, feelings of betrayal, and frustration among patients. Ten years later I have returned to the field, and observe that there are vastly more programs and resources devoted to the issue, but the fundamental conflicts remain, though some have evolved into new arenas.

These conflicts impede relationships with patients, interfere with treatment, fragment caregiving teams, and divert precious resources. Given the urgency of need and the serious consequences of failing to adequately address it, understanding the sources of conflict is imperative. This was the starting point for my research question: Why, in a field full of deeply committed and well-intentioned people, with a vast amount of scientific research devoted to PTSD, is the process of addressing post-traumatic distress in military members and veterans so conflicted?

Chapter II - Review of the Literature

Due to the course sequence of the Master of Counselling program, I completed an extensive literature review relating to my research interest prior to choosing my research methodology. During my aforementioned military clinical experience, I saw that the primary approach to psychological trauma tended to be formulated by civilian experts with very little knowledge of military culture. I observed that their recommendations were often culturally incongruous to a degree that provoked confusion, frustration, and sometimes wholesale dismissal of the value of mental health care by both the patients and their chain of command. I thus began with the working hypothesis that the conflicts I observed and experienced in the field of military psychological trauma care were primarily related to inadequate cultural

adaptation of mainstream psychiatric knowledge. I set out to review the rationales for each of the *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association [APA], 2013) criteria for PTSD, in order to ascertain where specific cultural adaptations might be required for the military context.

In order to organize the large volume of papers I was reviewing, I utilized NVivo software, which was designed to facilitate qualitative analysis via thematic coding. To my surprise, I had difficulty organizing the cultural incongruencies within the categorical confines of diagnostic criteria as I originally planned. Instead, broader socio-political discourses emerged as key sources of conflict in the arena of psychological trauma. I thus arrived quite naively and naturally at the fundamental premise of grounded theory. Tweaking or translating an existing dominant theory (the psychiatric definition of PTSD) was not going to be sufficient to answer my question, and a fresh theory of process would be required (Glaser & Strauss, 1967, Chapter 1). I also realized that contesting the validity of the psychiatric definition of PTSD was in a sense, missing the point. It was best treated as a discourse – powerful and ubiquitous, but still one discourse in a large and complex conversation about mental suffering and adversity. The conflict I was interested in was located in the multiplicity of conversations, not the rightness or wrongness of a single discourse.

The organization of the literature review closely follows my aforementioned exploratory process. I begin by discussing the social, political, and cultural beliefs and assumptions that inform the psychiatric concept of PTSD. The acronym appears to have acquired a ubiquitous presence in the popular media as a shorthand for mental

suffering caused by adversity, and it invokes the authority of Western biomedicine to render such suffering real and valid (Kienzler, 2008), whether or not the precise diagnostic criteria are met. I begin with the history of PTSD as a psychiatric diagnostic entity and then review some of the rationales and discourses informing elements of the diagnostic categories. Thanks to the relatively recent publication of *DSM-5* (APA, 2013), there was an abundance of fresh debate in the literature. I then discuss the pitfalls of imposing a dominant discourse of trauma without understanding how it may be taken up within the existing trauma discourses of different cultures and contexts. Finally, to set the stage for the array of discourses relevant to my study, I present an overview of key stakeholders in the complex social, political, and cultural arena of psychological trauma in the Canadian military context.

Historical Evolution of the Diagnostic Entity of PTSD

The project to define PTSD as a diagnostic entity has ostensibly been guided by systematic investigation and cataloguing of symptoms, but it has been powerfully motivated and informed by cultural norms, political need and an evolving Western discourse about the nature of human adversity (Rechtman, 2004).

The theme of innocence and culpability recurs again and again in the historical evolution of the PTSD diagnosis. Suffering is more sympathetic if it is involuntary and out of the sufferer's control and less sympathetic if the sufferer causes, or has the power to avoid or rectify the problem. The innocence or culpability of the suffering individual thus influences the determination of society's responsibility to provide assistance. Socio-cultural norms and beliefs dictate acceptable responses to personal and communal adversity and impose moral

judgments on whether an individual "ought" to be distressed by a given event (Rechtman, 2004).

In the 19th and early 20th centuries, social beliefs about the nature of war and expectations of the warrior's sense of duty to his nation generated explanatory judgments of cowardice and moral failure against soldiers who were psychologically unable to return to battle (Jones & Wessely, 2007; Rechtman, 2004). As casualties accumulated and physicians began to identify symptom profiles, DaCosta's syndrome (American Civil War), shell shock (First World War), traumatic neurosis, combat fatigue, and battle stress (Second World War) were some of the diagnoses which recognized and legitimized traumatic reactions as an externally inflicted injury rather than a moral fault or deficit of character (Jones & Wessely, 2006; Loughran, 2012; Young, 1995).

The shift from internal to external responsibility prompted the need to explicitly define social liability. Shell shock, for example, was divided for pension purposes into that which was caused by enemy action and that which was not (Loughran, 2012), and worries about secondary gain began to inform the debate over definitions of war-related psychological suffering (Jones & Wessely, 2007).

Innocence and culpability were also important determinants of social validation and acceptance. American Vietnam veterans, conscripted to fight in a deeply unpopular war, often suffered severe psychological trauma, but unlike veterans of the two world wars, they faced a hostile civilian populace when they returned. PTSD was included as a diagnostic entity within *DSM-III* (3rd ed.; *DSM–III*; APA, 1980, p. 236-238) in response to persistent lobbying by suffering Vietnam

veterans and the dedicated organizational and political efforts of their psychiatrists (Jones & Wessely, 2007; Rechtman, 2004; Scott, 1990). Whereas prior definitions of war trauma had been minimized for fear of undermining morale, the PTSD diagnosis in *DSM-III* (APA, 1980) drew political attention to the horrors of war (Jones & Wessely, 2007) and assigned the weight of culpability for veterans' suffering to government (McHugh & Treisman, 2007; Muldoon & Lowe, 2012; Scott, 1990).

As the PTSD diagnosis conferred validation of socially inflicted suffering, it naturally became a means of challenging power inequities in the context of interpersonal trauma. Feminist movements contested the male, veteran-centred focus of PTSD research and diagnosis, and drew attention to domestic violence, rape, and childhood sexual abuse (Brown, 2004; Smith, 2014). Feminists contested the *DSM-III* definition of a traumatic event as "outside the range of usual human experience" (APA, 1980, p. 236) and the assumption that an event must be extraordinary, uncommon, and publicly visible to be traumatic, asserting that violence against women was socially ubiquitous and commonly hidden (Brown, 1991). Since sexual violence was (and still is) often trivialized, and victims commonly disbelieved or accused of inviting the assault, the PTSD diagnosis could leverage the power of biomedical authority to validate suffering and redress oppressive formulations of innocence and culpability (Brown, 1991; Smith, 2014).

As international aid efforts of the 1990's increasingly focused on mental suffering, the PTSD diagnosis began to be employed as a means of documenting and legitimizing war-time atrocities (Howell, 2012; James, 2010; Kienzler, 2008; Muldoon & Lowe, 2012). James (2010), for example, described the "political

economy of trauma" (p.107) that evolved in Haiti. The use of the PTSD diagnosis as a means of moral validation has also spawned backlash when research findings failed to align with the goals and assumptions of advocates. McNally (2003) described the furor that resulted when a meta-analysis by Rind, Tromovitch, and Bauserman (1998) found that adult survivors of childhood sexual abuse showed much less evidence of post-traumatic dysfunction than had previously been assumed. Despite independent review and validation of the study's methodology, the US Congress took the step of formally condemning the study and its authors on the grounds that their findings constituted a moral endorsement of childhood sexual abuse (McNally, 2003).

In short, the diagnostic formulation of PTSD as found in successive iterations of the *DSM* (APA, 1980, 2000, 2013) has not evolved as a purely epidemiological nosology of traumatic adversity. It has always been informed by Western society's need to adjudge the correct response to adversity and to define which types of adverse events (particularly those of an interpersonal nature) would be socially legitimized as significant. While mental suffering caused by adversity is an undeniably real phenomenon, the boundaries and uses of PTSD as a diagnostic entity are the product of complex discourses informed by cultural norms, political agendas, and contested terrain of power and privilege.

Diagnostic Criteria: Defining Trauma

PTSD is a unique diagnostic entity within the psychiatric nosology because its etiological definition rests on the explicit identification of a triggering event, rather than being confined to the patient's symptomatic presentation (McNally, 2003; Rosen & Lilienfeld, 2008). In the *DSM-5* nosology (APA, 2013, p. 271), Criterion A

defines the qualities of traumatic stressors; i.e., events significant enough to cause the symptoms of PTSD. The B criteria represent the array of symptoms that characterize PTSD – formerly grouped into three clusters in *DSM-IV-TR* (4th ed., text rev.; *DSM–IV–TR*; APA, 2000), and now reorganized into four clusters in *DSM-5* (APA, 2013)

The goal of Criterion A is to define a set of events that show clear causal correlation with the PTSD symptom clusters. The result, however, is effectively a dualistic definition of human experience as traumatic or non-traumatic, and the generation of such a definition has been a complex and continually contested task (Friedman, 2013; Friedman, Resick, Bryant, & Brewin, 2011; Weathers & Keane, 2007). As a result, the parameters of Criterion A have shifted considerably since PTSD was first defined in *DSM-III* (APA, 1980).

A number of difficulties have emerged. Imminent and severe personal threat to life and limb is clearly traumatic, but the severity of a perceived threat is not necessarily a direct function of the statistical likelihood of concrete physical harm. Many cultures hold spiritual or social losses to be at least as dire as bodily harm, and sometimes more so (Hinton & Lewis-Fernandez, 2011; Kohrt & Hruschka, 2010). Feminism has had to work hard to make the case for less visibly injurious forms of sexual boundary violation as legitimately traumatic (Brown, 1991; Brown, 2004). Severe threats and stressors are not necessarily discrete events but may appear in chronic forms such as hunger and poverty (Panter-Brick, 2010).

Observing death and injury is deemed traumatic, but social media and 24-hour television news coverage have necessitated clarification of that clause so as not to be over inclusive (Friedman, 2013; Friedman et al., 2011), and Western social tolerance

for the spectacle of gruesome death has varied dramatically over the centuries (McNally, 2012). Even the conventional formulation of victim and perpetrator is inadequate, particularly in military trauma. Killing another human being can be an extraordinarily traumatic experience (Grossman, 2009; Maguen & Litz, 2012).

The simple matter of who rates the event in question as traumatic or non-traumatic raises significant concerns. External "objective" ratings of event significance may not correlate with the individual's perception of the event (e.g., Cameron, Palm, & Follette, 2010; Rubin, Berntsen, & Bohni, 2008; van Rooyen & Nqweni, 2012). The salience of a given experience to a given individual is highly influenced by both context and culture (Hinton & Lewis-Fernandez, 2011; van Rooyen & Nqweni, 2012). Vulnerability and resilience are prominent topics of research and debate (Howell, 2012; Lee, Sudom, & Zamorski, 2013) and raise questions such as how to define "normal" susceptibility to trauma. Certain populations and social groups face far more chronic adversity than others (Muldoon & Lowe, 2012), and it is difficult to isolate the contributions of multiple traumas, chronic socioeconomic adversity, and acquired vs. inborn temperamental and physiological vulnerabilities (Kienzler, 2008; Zoladz & Diamond, 2013).

In an attempt to acknowledge differences in individual perception, *DSM-IV-TR* (APA, 2000) incorporated criterion A2, which specified that the subject needed to endorse an immediate reaction of "intense fear, helplessness, or horror" (p. 467) in response to the event in question. Researchers have subsequently recognized that other emotions such as anger, disgust, or sadness may be equally potent responses to trauma (Hathaway, Boals, & Banks, 2010; Kilpatrick, Resnick, & Acierno, 2009).

Furthermore, professional training or cultural conditioning may cause individuals to suppress their emotional responses in the moment, but experience distress later on (Friedman et al., 2011). Because of this variability in individual response, the A2 criterion has been dropped from *DSM-5* (APA, 2013; Friedman, 2013).

Memory is another key issue, as the event in question is frequently accessible to the clinician only as the client's self-reported memory (Rubin et al., 2008), fueling debates over the accuracy of traumatic memory (Herlihy, Jobson, & Turner, 2012). The selective telling of memories is highly influenced by cultural expectations and narrative templates (Jobson & O'Kearney, 2008; Kalinowska, 2012; Lilgendahl, McLean, & Mansfield, 2013; von Peter, 2009). Memory is a key means of constructing identity, both individual and collective (Webb & Jobson, 2011) that is subject to culturally and contextually created cognitive schema about the self that differ significantly between independent and interdependent cultures (Berntsen & Rubin, 2007; Collura & Lende, 2012; Jobson, 2009; Jobson & O'Kearney, 2008; von Peter, 2009).

The rationales for retaining the stressor criterion in a relatively narrow and externally defined form are closely linked with the social and contextual uses of the PTSD diagnosis. Friedman et al. (2011) asserted the importance of honouring the significance of extreme adversity, and the fear of trivializing the PTSD diagnosis or opening the door to frivolous claims. Legal definitions of liability and culpability have come to rely heavily on the distinctions made by Criterion A, with significant implications for access to treatment and financial compensation (Kilpatrick et al., 2009; Long et al., 2008; Nidiffer & Leach, 2010).

In short, adverse events are represented largely as personal narratives subject to a variety of discursive forms and constraints. The parameters by which psychiatry in turn adjudges them to be legitimately traumatic are negotiated within competing discourses of social justice, power, politics and finance. It is little wonder that traumatic stories commonly become contested social objects, subject to appropriation and judgment by stakeholders such as peers, advocates, media, and governmental institutions (Colvin, 2006; Herlihy et al., 2012; Kalinowska, 2012).

Diagnostic Criteria: Defining the Symptomatic Experience

The four symptom clusters of *DSM-5* (APA, 2013) define the essential experiences and behaviours that must be present in order to determine that an individual is suffering from PTSD. Intrusive symptoms include memories, nightmares, flashbacks, and intense emotional distress or physiological reactivity in response to traumatic reminders. Avoidance behaviours may relate to either internal (thoughts and emotions) or external (events or situations) trauma-related cues. Changes in mood and cognition may include dissociative amnesia, exaggerated negative expectations about oneself and the world, powerful feelings of shame, guilt, horror, anger or fear or conversely, emotional numbness, social estrangement, and withdrawal from previously cherished activities. Alterations in arousal and reactivity include hypervigilance, irritability, impulsivity or recklessness, hyperreactive startle, poor concentration and sleep disturbance (APA, 2013).

Given the largely White American populations on which factor analylsis has been performed to arrive at these symptom clusters, their cultural universality has been frequently contested. Hinton and Lewis-Fernandez (2011), Bracken, Giller, and

Summerfield, 1995), and many others have argued that identifying the presence of a given symptom across cultures is not the same as proving the universality of its meaning and salience. Elhai and Palmieri (2011) noted a lack of studies evaluating PTSD factors across samples that are heterogeneous for trauma type, gender, social context and culture, which implies that the cross-cultural and multi-contextual relevance of the prevailing model has not been adequately established. Some PTSD symptoms, such as hyperarousal and reactivity, appear to be physiologically consistent across cultures (although the conceptual interpretation may vary considerably), while other symptoms such as avoidance behaviour, traumatic memory phenomena, shame, and guilt, are profoundly shaped and determined by cultural narratives and schema (Fessler, 2004; Hinton & Lewis-Fernandez, 2011; Jobson, 2009).

Many culturally specific and clinically relevant "idioms of distress," (Nichter, 2010) such as physiological syndromes, are missing from the DSM symptom criteria altogether (Hinton & Lewis-Fernandez, 2011). Somatic syndromes are not included in the DSM criteria for PTSD, but represent powerful culture- and context-specific responses to trauma that incorporate physiological phenomena into an explanatory framework with social, political, and spiritual elements (Hinton & Lewis-Fernandez, 2010, 2011). Examples include Cambodian khyâl attacks (Hinton, Pich, Marques, Nickerson, & Pollack, 2010), and *nervios*, *ataques de nervios* and experiences of altered somatosensory perceptions in US Latino populations (Lewis-Fernandez et al., 2010). Gulf War Syndrome has also been proposed as a somatic trauma syndrome specific to military context and culture (Greenberg & Wessely, 2008; Kilshaw, 2008).

Finally, many authors (e.g., Hill, Lau, & Wing Sue, 2010; James, 2010; Kienzler, 2008; Muldoon & Lowe, 2012; Panter-Brick, 2010; Young, 1995) have argued that when suffering in response to adversity is defined as a localized individual disease process, the social, political, and systemic causes of trauma are overlooked, and politically dangerous questions about oppressive power structures and social injustice may be sidestepped. Since most trauma is interpersonal in nature, PTSD is fundamentally a social, political, and cultural experience (Muldoon & Lowe, 2012; Panter-Brick, 2010).

Post-Traumatic Suffering as a Culturally Specific Discourse

Diagnosis and treatment of PTSD has been one of Western psychiatry's most prolific global exports in the field of international relief, and though done with the best of intentions, it has also created problems. Cultural variability in the description of post-traumatic distress is conceptual, not merely semantic (Nichter, 2010). Translating psychiatric formulations into local terminology without fully understanding the local social and cultural context can be perilous. The PTSD label is associated with the validating power of Western biomedicine and is frequently re-appropriated into discursive meanings and socio-political purposes that were never intended by those who envisioned it as a culture-neutral introduction of modern science (e.g., Abramowitz, 2010; Kohrt & Hruschka, 2010). Some symptom clusters and/or the terms that accurately describe them in a technical sense are far more stigmatizing in some cultures than others, and the clinician may create social barriers to care or provoke therapeutic ruptures when attempting to use psychiatric nosology to explain to clients the nature and meaning of their experiences (Abramowitz, 2010;

Kohrt & Hruschka, 2010). Psychiatry locates PTSD in the brain of an individual sufferer, but collectivist and individualist cultures often have very different conceptual models for explaining mental suffering and the meaning of adversity (Du et al., 2013; Jobson, 2009).

Cultural idioms and discourses of distress commonly possess conceptual coherence that is distinct from psychiatric nosology, is clinically useful, and has potent social and political meanings (de Jong & Reis, 2010; Hinton & Lewis-Fernandez, 2010; Lewis-Fernandez et al., 2010; Nichter, 2010). Appropriating local idioms as metaphors and translational devices for psychiatric concepts needs to be done cautiously and to be informed by an intimate understanding of the socio-political and cultural implications (Abramowitz, 2010; Nichter, 2010).

As has been illustrated in the historic evolution of PTSD, the institutions of Western psychiatry and psychology carry enormous power and weight. The PTSD label has been appropriated globally for a variety of purposes, particularly validation of adversity and access to resources (Herlihy et al., 2012; Howell, 2012; James, 2010; Kienzler, 2008). When professional caregivers engage in intervention, programming, and advocacy without understanding the social discourses and power dynamics they are tapping, they may unintentionally initiate or aggravate social conflicts, tap into political forces that do not ultimately serve the needs of their clients, or create barriers to care such as stigma and therapeutic rupture (Abramowitz, 2010; Kohrt & Hruschka, 2010; Nichter, 2010). In the final section I provide an overview of the multiple cultures and stakeholders in the arena of psychological trauma in the

Canadian Forces, and consider whether an examination of their discourses about trauma might plausibly provide insight into the conflicts in the field.

Discourses of the Canadian Forces: An Overview

The Canadian Forces possess a culture that is distinct from the civilian public of Canadian society. In order to fulfill its unique mandate and foster esprit de corps, the CF explicitly ascribes to and indoctrinates the cultural values of duty, loyalty, integrity, and courage, known collectively as the military ethos (McPherson, 2011). The concept of duty comprises a collectivist hierarchy of priorities that places the needs of the country and the mission above all, one's colleagues next, and the member's own needs last (Canadian Defence Academy [CDA], 2007). The most extreme expression of this duty is found in the principle of unlimited liability, which means "CF military professionals can be lawfully ordered into harm's way in conditions that could lead to injury or the loss of their life" (CDA, 2007, p. 18). Loyalty comprises obedience to lawful orders (with severe penalties for disobedience), as well as the reciprocal and comprehensive caretaking provided by leadership (CDA, 2007). The mandate of operational secrecy (McPherson, 2011) restricts not only the public's knowledge of military life, but also the member's options for complaint or redress. Integrity encompasses honesty, honour, and ethical virtue, as well as adherence to institutional values and standards (McPherson, 2011). The final core value is courage, both physical and moral (CDA, 2007; Gabriel, 2007). Thus, although the military are recruited from, and serve the needs of, a largely individualist civilian populace, the military ethos and the context and constraints of

military life shape its members into an insular and deeply collectivist culture (Bryan, Jennings, Jobes, & Bradley, 2012; Irwin, 1993; Kirke, 2009; Winslow, 1999).

Ongoing membership in the CF is contingent upon compliance with the principle of universality of service, which means in addition to the member's fitness to perform the duties specific to their occupation, they must also be able to perform a broad range of operational duties and to deploy at a moment's notice to locations with minimal supportive resources (National Defence and the Canadian Forces, 2010, 2011). The prospect of admitting to impaired psychological functioning not only tends to contravene the culture of stoic altruism, provoking both self- and peer-stigma, but may well entail the loss of career, and thus the loss of community (Daigle, 2012; Dickstein, Vogt, Handa, & Litz, 2010; Neuhauser, 2011; Ray, 2009).

Transitioning to civilian life, especially involuntarily, is often an enormous stressor and culture shock. Military veterans may find themselves with an ambiguous identity, separated from the camaraderie and community of the military, and with a set of deeply ingrained values and formative experiences that set them apart from the civilian world to which they ostensibly now belong (Black & Papile, 2010; MacLean et al., 2014). Military families occupy a similarly ambiguous identity, grieving the loss of loved ones, bearing the brunt of caregiving for wounded, suffering the constraints and hardships of the military lifestyle, but never fully belonging to the organization (Daigle, 2013). PTSD in a military member or veteran inevitably permeates the dynamic of the family system: Family breakdown is common and supports are lacking (Daigle, 2013).

The Canadian public has historically been both ambivalent and ill-informed about its military (Hobson, June, 2007; Winslow, 2003). Although militaries often perform humanitarian functions and support domestic needs, a military's

> "primary function requires organized social violence in which the sacrifice of its members in pursuit of the community's right to self-protection is often demanded. Moreover, it requires the deliberate taking of the lives of other human beings, and sometimes results in the deaths of completely innocent others, in the conduct of legitimate military operations." (Gabriel, 2007, p. 1)

What a government needs to do for national security, what it wants to do for political survival, and what its citizens will tolerate, creates a complex web of constraint and secrecy around the recognition and validation of adversity within the military occupation (Hobson, 2007, 2011). Furthermore, cost containment is an ever-present and contentious factor in military mental health care (Daigle, 2012).

In short, the field of Canadian military psychological trauma comprises a complex array of stakeholders with powerful, volatile, and often-conflicting needs and agendas. Different cultures operate from significantly different worldviews, the flow of information is tightly controlled by both political agendas and the pragmatics of national security, the stakes are high, needs are dire, and budgeted resources are in perpetual short supply.

Canadian military PTSD is a significant concern: The numbers are growing, the resources to address it remain inadequate, and the field is plagued by conflict and controversy. The diagnostic formulation of PTSD as found in the *DSM-5* (APA, 2013) is a dominant discourse informed by specific social concerns, political agendas,

and cultural interpretations. Although the fundamental concept of post-traumatic suffering is sound, and the needs of the sufferers often extreme, there is considerable global precedent to suggest that ignoring the discourses of politics, culture, and social context when designing programs and embarking on interventions may lead to ineffective or even iatrogenic outcomes. The field of Canadian military trauma contains a complex web of conflicting social, political and cultural discourses that suggest ample possibilities for study.

Chapter III - Theoretical Framework

Following the literature review, I conceived the ambitious idea that I could understand the conflicts in the world of military PTSD by analyzing all the conversations at once, and thus discover an underlying theory of process that might illuminate how PTSD is talked about. As with the literature review, my journey towards selecting a methodology was heavily influenced by the sequence of coursework. My use of NVivo software had naturally led me to the kind of categorical coding characteristic of grounded theory (Glaser & Strauss, 1967) and it seemed that "talking about trauma" might lend itself to a theory of process. As classic grounded theory was the form taught in my qualitative methods course, I began by immersing myself in Glaser and Strauss (1967).

Origins and Evolution of Grounded Theory

In their original book, The Discovery of Grounded Theory, Glaser and Strauss (1967) lamented the fact that sociology was so engrossed in the verification of existing "great-man theories" (p. 10), that it possessed a limited capacity to respond to practical sociological problems. They sought to make theory development more

widely accessible by formulating systematic inductive processes for generating sociological theory from empirical social research. Over the intervening years, grounded theory has split into a classic camp, championed by Glaser (e.g., Glaser, 2005) and an evolving array of constructivist and postmodern approaches (e.g., Charmaz, 2012; Clarke, 2005). Classic grounded theorists argue that being "grounded in the data" is a sufficient condition under which all relevant themes and voices will emerge. No special measures, beyond diligent application of its inductive methods, are required to counteract the effect of power, privilege, or researcher bias, and in fact, any such measures would constitute a pre-supposed theoretical framework and thus be antithetical to the fundamental principles of grounded theory (Breckenridge, 2012; Glaser, 2005).

The split began as Strauss and Corbin challenged this positivist view of data and theory as having a separate objective existence that could be "discovered" by the researcher (Hall, Griffiths, & McKenna, 2013). Successive iterations of Straussian grounded theory have evolved steadily towards constructivism (Cooney, 2010). Corbin (Corbin & Strauss, 2008) noted she has been increasingly and collaboratively influenced by Charmaz's (e.g., Charmaz, 2012) constructivist perspectives, and by Clarke's (2005) postmodern situational analysis.

Straussian grounded theory is rooted in symbolic interactionism, an epistemology describing the ways humans interact via symbols, both linguistic and non-verbal, which stand in for social objects, concepts and ideas (Corbin & Strauss, 2008). Grounded theory is essentially a system of exploring these patterns of

symbolic interaction and inductively deriving their layers of meaning (Milliken & Schreiber, 2012).

Discovering Situational Analysis

In my ambitious early phase, I thought it might be possible to analyze the multitude of discourses with textual data alone, given their prolific presence on the internet. As I began to take stock however, it became clear that some voices were much more powerfully represented than others, and that this was more than a technicality; it could skew the analysis in ways that had significant ethical implications. In particular, the voices of the patients whose suffering was at the heart of the conversation were significantly underrepresented. It seemed clear that I was going to have to make explicit decisions about how to balance representation, and I needed some methodologically rigorous guidance in how to go about that, since that kind of selectivity was ostensibly at odds with classic grounded theory. I began to branch out in, reading about ethnographic inquiry (Saukko, 2003), and ultimately followed the trail to social constructionist variations of grounded theory expounded by Charmaz and Clarke.

Charmaz (2012) noted that in order for grounded theory to incorporate social justice, it needed to account for "concepts such as power, privilege, equity, and oppression" (p. 5). Clarke (2005) likewise, sought to take symbolic interactionism beyond an individualistic perspective to tackle complexity, "messiness" and social structures. She argued that researchers have an ethical responsibility to design every aspect of their methodology to open the doors of possibility to what is silent, hidden, or marginalized, and advocated for the incorporation of "sensitizing concepts"

(Blumer, 1954, p. 7) to guide the kinds of data they seek to collect, and the kinds of information they are open to finding within it.

Situational analysis (Clarke, 2005) offered significant advantages for my research topic, as the military context abounds with hidden and marginalized discourses (Daigle, 2012, 2013; Hobson, 2007, 2011). Because the field of psychological trauma is dominated by psychiatric theory, and war and soldiering tap into powerful sociopolitical ideologies, I needed a methodological approach that could account for, but resist being defined by, such hegemonies. The idea of "sensitizing concepts" (Blumer, 1954; Clarke, 2005) became a central framework for me in the pursuit of methodological rigour, allowing me to actively identify discursive elements I was open to hearing (and conversely, narrative forms I might be prone to impose). Furthermore, there was a strong ethnographic component to my investigation, and situational analysis offered the analytic tools and flexibility to systematically incorporate elements of cultural inquiry (Seaman, 2008).

Finally, as I began to work with grounded theory coding methods early on, I found that the linear, hierarchical categories of classic grounded theory simply didn't work for my data, and I wound up drawing diagrams to try to capture the relationships between emerging categories. I fumbled around with a number of modeling strategies, but it was all very messy and I kept starting over. Clarke's (2005) mapping approaches were exactly what I had been looking for, and gave me guidelines for proceeding in a way that was both flexible and rigorous.

As I fit the proposed territory of my analysis into Clarke's situational maps, I realized I was looking at an extremely large arena of concern and analyzing the

multitude of discourses all at once would be far too large a project for the thesis. I was going to have to start with one, but that itself was not necessarily problematic, because analyzing each discourse separately would be a solution to the problem of subjugated and silenced voices. Attending to a discourse individually was a way of listening closely to a voice that might otherwise be drowned out.

Chapter IV - Methods

Having settled on situational analysis as a methodology, I stepped back and redefined the boundaries of my data set and clarified the design of my study. I chose the discourse that my initial survey suggested was least represented and most in need of representation: the discourse of military veterans with PTSD talking about their own experience.

Study Parameters and Ethical Considerations

I chose social media as a rich source of textual data and a vibrant location of active discourse. In order to work with minimal risk extant secondary data, I selected a large (currently sitting at over 135, 000 members) publicly visible and open Facebook site created as a grass-roots peer support movement by and for Canadian military veterans with PTSD. I chose the group out of a larger pool of veterans' advocacy sites and other open military groups I was following, cross-referencing the moderators of this group to verify their identities and relying on my personal knowledge of CF culture to help me identify legitimate military discourse. My immersion in online military discourse also helped to sensitize me to political currents within the veteran community and to choose a group that was not

institutionally governed or funded, but also not narrowly focused on a single advocacy issue.

As the group was originated by Canadian military members and veterans, it had a distinctly Canadian focus and participant base, although as time went on, additional moderators were recruited from other NATO nations, and the group made an effort to be globally inclusive of all military members experiencing PTSD. As the group was open, there were also civilian participants, although it was relatively easy to pick them out from the military. The group's mission was ostensibly to function as peer support, but warnings were posted from time to time to remind participants that their entries were subject to scrutiny by entities such as the military chain of command.

By choosing an open and publicly visible group, I was able to observe a vibrant and highly active conversation without intruding as an outsider presence or inviting interactions from a vulnerable population whom I did not have the means to follow or support. Given the sensitive nature of military conversations, an open group also afforded me the assurance that I would neither be compromising national security nor compromising my participants when I published my findings. As outlined in the following discussion, I endeavoured to follow a rigorous analytic process by adhering to the procedures and principles of situational analysis and grounded theory.

I have already discussed the logistics that lead me to begin with a literature review, but since the role and timing of a literature review can be a key point of contention (Bryant & Charmaz, 2007; Dunne, 2011) for grounded theorists, I will

expand on that point. Glaser and Strauss (1967) were originally concerned that familiarity with the literature and theory pertaining to the research topic would contaminate analysis with categories that did not emerge from the data. Few researchers arrive at their topic as a blank slate, however, nor do academic research procedures generally condone planning a study without background information (Clarke, 2005; Stern, 2007). Corbin and Strauss (2008) noted that judicious use of the academic literature may identify gaps in knowledge in the planning stages and stimulate lines of questioning in analysis. Diligently documented reflexivity is a key safeguard with which the researcher may identify external influences (McGhee, Marland, & Atkinson, 2007; Urquhart, 2007). Finally, there is precedent in the literature for the process I followed in utilising the pre-study literature review to highlight the inadequacies of existing theoretical frameworks, and thus enhance, rather than undermine, the fidelity of the grounded theory approach (Marland & Cash, 2005; McGhee et al., 2007).

Data Sources and Theoretical Sampling

Many forms of data may be collected and analysed within a single project, from "live" formats such as observation, interviews and focus groups, to documents, artifacts, and autobiographies (Corbin & Strauss, 2008; Glaser & Strauss, 1967). My choice of social media textual data was well within the bounds of grounded theory. Initial sampling seeks data that seem likely to shed light on the research question (Corbin & Strauss, 2008; Draucker, Martsolf, Ross, & Rusk, 2007); however, once analysis begins, ongoing sampling becomes increasingly purposeful, seeking to answer questions, fill in gaps, and ultimately, refine the emerging theory (Cooney,

2010; Morse, 2007). Theoretical sampling and concurrent collection and analysis are thus core elements of grounded theory methodology (Corbin & Strauss, 2008). In theoretical sampling, I used the search feature in NVivo occasionally to find additional conversations about a given topic, or to compare uses of a given term, but generally tried not to utilise computer algorithms to drive the analysis. Theoretical sampling was particularly well-suited to social media discourse, with its multiple threads and continually evolving conversations.

Data Analysis

Coding is an interactive process of "deriving and developing concepts from the data" (Charmaz, 2012; Corbin & Strauss, 2008 p. 65). In essence, the researcher breaks the raw data into units of meaning, then reassembles those units of meaning around conceptual themes (Corbin & Strauss, 2008). In keeping with the philosophy of grounded theory, researchers strive to discover rather than impose conceptual themes (Milliken & Schreiber, 2012), and while the researcher's perspective is inherently present, a variety of strategies and techniques may assist the quest to listen closely to the data. In vivo coding (using participants' words verbatim) is one strategy for preserving nuance and avoiding premature conclusions about meaning (Elliott & Jordan, 2010; Milliken & Schreiber, 2012). I used in vivo coding extensively as a safeguard against imposing my existing professional and personal knowledge onto the discourse via premature categorization. This lead to a very messy-looking model, but leaving the participants' words intact and the categories loose and provisional for as long as possible was invaluable for me to avoid clustering the codes according to my medically trained habits. In particular, this

strategy helped me to realize that symptom lists were referenced, but were not the most salient organizing feature of the discourse. Other analytic tools which I applied at various times included coding in gerunds (Charmaz, 2012), and questioning the data: asking who, what, when, where, and how; mulling over multiple possible linguistic meanings; considering what the opposite of a statement might imply; and looking for temporality, emotion, absolutes, unquestioned assumptions, exceptions, and incongruities (Corbin & Strauss, 2008).

Constant comparison is a key grounded theory strategy, employed at all levels of analysis: "Grounded theorists compare data with data, data with codes, codes with codes, codes with categories, and their finished analyses with relevant theoretical and research literatures" (Charmaz, 2012, p.4). Starting that process early helps to accurately tease out shades of meaning (Elliott & Jordan, 2010) while also providing the opportunity for researchers to systematically identify pre-existing biases and theoretical influences (Walls, Parahoo, & Fleming, 2010). Rich (2012) noted the importance of context in ascertaining the conceptual meaning and significance of data. I did draw on my extensive exposure to the military, both personal and professional, in understanding the context of the discourse, although I also endeavoured to account for the vantage point of my position as a military spouse and physician, rather than a soldier. A personal knowledge of military history and culture often helped me to interpret some of the unspoken customs, norms, and historical injuries referenced in conversation. In addition to selecting chunks of data for line by line analysis, I also followed the Facebook conversation longitudinally which sensitized me to broadly recurring rhythms and themes.

Memo writing is a critical aspect of grounded theory analysis that occurs from the very beginning of the research process (Charmaz, 2012): It facilitates "unconstrained musings on what is happening" (Rich, 2012, p. 4), creates "a place to consider, question, and clarify what you see as happening in your data" (Charmaz, 2012, p. 9) and documents the inner meaning-making dialogue of the researcher (Milliken & Schreiber, 2012). It is important for the researcher to capture impressions, reflections, and ideas as they arise, in order to capture the most powerful analytic insights (Maz, 2013). Memos may be written as an ongoing free-form journal, and also attached to specific components such as data sources, codes, and emerging concepts (Corbin & Strauss, 2008). As theoretical integration proceeds and the storyline of process takes shape, memos may themselves be sorted and re-examined for conceptual themes and theoretical clues (Corbin & Strauss, 2008; Holton, 2010). Memos do not have to be narrative in form: Corbin and Strauss (2008) employed charts, diagrams, and matrices, and Clarke (2005) has developed a number of sophisticated mapping strategies that facilitate a visual approach to analysis. Such strategies provide visual means of questioning the data, provoke theoretical insights with a "birds-eye" view, illustrate webs of power and influence, and generate a visual representation of theoretical gaps and discursive silences that offer clues to the location of marginalized narratives and entities (Clarke, 2005). Memos, maps, and diagrams thus serve as an audit trail of the researcher's thought process, an analytic tool, and an intermediate state between coding and the eventual research report (Corbin & Strauss, 2008). I wrote reams of memos from the very beginning of the project, as a natural extension of my compulsive journaling habit,

and kept them organized by date within the data analysis software. I also experimented continually with diagrammatic means of representing the emerging analysis.

Clarke's situational analysis offers a number of mapping tools that assist the researcher in visually situating the data relative to each other and to the larger context (Clarke, 2005; Mills, Chapman, Bonner, & Francis, 2007). Situational maps "lay out the major human, nonhuman, discursive, and other elements" (Clarke & Friese, 2007, p.370) so the researcher can diagram their complex relationships. Social worlds/arenas maps examine negotiations between social entities, and positional maps graph the range of positions on various issues of concern (Clarke, 2005; Clarke & Friese, 2007). I quickly realized that the situational map for military PTSD was enormous, and would be far too complex to tackle as a single project. Taking my cue from Clarke's admonition to be flexible and do what works for the data, my coding strategy evolved into a variation of her positional map (Clarke, 2005). I placed masses of largely in vivo codes on the map and drew links to signify thematic relationship. This resulted in a messy network diagram, but as it grew, thematic code clusters emerged, and the relationships between these clusters also coalesced into consistent themes.

Analytic Endpoint

The practice of concurrent collection and analysis can make the endpoint of a grounded theory study somewhat challenging to determine (Dey, 2007). Holton (2010) asserted that "one stops when one no longer needs to continue. The challenge is in how to recognize that the need no longer exists" (p.32). Theoretical saturation

may be described as "the point in analysis when all categories are well developed in terms of properties, dimensions, and variations" (Corbin & Strauss, 2008, p. 263) and little new is emerging from ongoing data collection. As Dey (2007) pointed out, however, the constructivist understanding of saturation is more an interpretive decision than an objective endpoint waiting to be "discovered".

A social media discourse presented particular challenges to choosing an endpoint, because another enticing topic of conversation was always just beginning. In that sense, my stopping point effectively generated a data set representing but a small snapshot in time. What emerged as theoretically consistent was less about specific opinions of specific events and more about the foundational perspective from which the discourse was conducted. I believed I had reached a viable stopping point, not because no new factual information was emerging, but because the terms of conducting the discourse were starting to appear consistent.

Situational analysis provided me with a methodology that combined the analytic rigour of grounded theory with the means of explicitly attending to issues of power and privilege. I appreciated Clarke's mapping strategies and found her discussion of common problems encountered in analysis to be highly pertinent, providing me with the means to be creative and responsive to the demands of the data, while still following a rigorous and consistent process of analysis. Publicly available social media discourse provided a safe, ethical, and rich source of data in the form of a vibrant and active conversation.

Chapter V - Results

The intersecting themes of the discourse revolved around a central idea of wrestling with identity and belonging. Military PTSD was narrated as a process of progressive alienation and identity loss, and remediation of PTSD was correspondingly framed as a project in reclaiming the collective identity and re-establishing interconnectedness. Military participants consistently spoke from a cultural perspective in which collectivist norms and values (specifically the norms and values of the military collective) represented the paramount definition and experience of self.

As noted earlier, coding the discourse resulted in a network diagram, rather than a linear hierarchy of events and priorities. Furthermore, the conversation was a snapshot of a nascent grassroots work in progress, and participants were engaged in a fluid process of wrestling with paradox and contradiction. For those reasons, I found it challenging to generate a tidily ordered written narrative without imposing artificial hierarchies of priority, or losing the rawness of ambiguity coupled with intense emotion. I was also acutely aware that the dominant professional discourse of PTSD is very linear, and I feared that at this late stage I might obscure the voices I worked so hard to hear by retrofitting them into a dominant narrative form.

I ultimately compromised with a 3 x 3 grid of intersecting themes. Along the first axis, the discussion of military PTSD coalesced into three core processes: defining the ideal qualities of a collective military identity, discussing the forms and progression of alienation and identity loss via PTSD, and calling for remediative action by reclaiming and strengthening the collective identity and affiliations. Along

the perpendicular axis, identity parameters fell roughly into three core domains of concern: boundaries that defined in-group and out-group status, roles and attributes that defined the collective, and expectations of interpersonal responsibilities and obligations within the collective. The narrative of findings could be plausibly organized around either axis; however, after attempting both, I settled on the first axis as the best fit.

Essentials and Ideals of the Collective Military Identity

A great deal of conversation was given over to discussing, defining, reifying and refining an ideal collective military identity. This process was simultaneously a means of asserting continuity with what had been, a backdrop for lamenting what was lost, and an emergent process of resolving ambiguity by prioritizing certain attributes as more essential than others, and renegotiating the terms on which those attributes could be expressed.

Boundaries. Military membership is legally defined by a contract and visibly defined by a uniform. One of the most potent aspects of the military contract is the principle of unlimited liability, which means "CF military professionals can be lawfully ordered into harm's way in conditions that could lead to injury or the loss of their life" (CDA, 2007, p. 18). Participants highlighted this ultimatum as a key factor separating military from even the riskiest civilian professions and often referenced it as a sacred marker of identity: "When we swore our Oath, we agreed to defend this nation up to and including the cost of our own lives. This is our sacred trust." Another participant asserted: "I've dedicated my adult life to something bigger than myself and I goddamn didn't do it for money… I fight for my brothers and sisters,

and still manage to keep the faith with the oath I swore. Salary? Yeah - that's what the rest of the selfish, self-promoting masses live for. I believe in something bigger than myself."

Having sacrificed their individual freedoms to be part of something greater, participants jealously guarded the visible markers of that belonging. "Stolen valour" was an emotional topic of discussion, in which the illicit appropriation by civilians of the external markers of military belonging and achievement was viewed as an unpardonable moral offense that far outstripped its illegality. One participant asserted, "it pisses me off when some select douchebags spout off about being a Vet and having PTSD when the only battle they've seen is which model in the Sears catalogue they were going to jack off too [sic]. It makes me batshit crazy when they exploit women in the process of stolen valour." During the time period under analysis, a dedicated website was started for the purpose of tracking down and exposing civilians pretending to be veterans: "Don't wear rank, unit insignia or patches et al, if you aren't one of them, if you didn't earn it, don't put it on or you are gonna deal with the crew at Stolen Valor and Stolen Valour Canada for sure!"

Participants prized their sense of separateness from civilians and described the set-apart qualities of their collective identity as something that was both voluntarily chosen (implying strength of character) and difficult to achieve (implying superior qualities of strength and competence). A great deal of discussion was devoted to defining and solidifying the differences between veterans and civilians and to avowing that a veteran could never revert to being an ordinary civilian. At times the discourse contained elements of disdain for civilians, as well as reactivity against

perceived anti-military discrimination. As one participant stated, "after military service, our standards for friendship, companionship, and loyalty are higher than most civilians will ever understand. So we choose not to associate with low quality personnel who do not share the same mindset." The ambiguity of this position was highlighted by occasional push-back from other participants: "We are a part of the society we all protect. ...for better and for worse..." and "there is a tendency for troopies to see everyone outside as 'civies' that are totally fucking helpless. This isn't always the case."

Roles. The military is concerned with national defense, a protective role often described by participants as that of the sheepdog. The sheepdog is smarter, faster, and more cunning than the sheep (civilians), and can never be one of them. Unlike the obliviously grazing sheep, the sheepdog understands the harsh realities of the world, must be continually alert and vigilant, and is required to engage in behaviours antithetical to the nature of a sheep. Within this metaphor, participants cautioned civilians that they lacked both the insider knowledge and moral position (having chosen to remain safely at home) to criticize military activities: "Sheep should not concern them selves with what or how the sheepdog provides. If you were not there do not speculate."

The role of the military collective is also fundamentally sacrificial, as described by the core hierarchy of priorities: mission, team, self. Those who risked and sacrificed the most in the performance of their duty were held up as exemplifying the highest ideals of the group. The fallen figured prominently within this discourse, and were "kept alive" by acts of remembrance both public and private.

Courage and exceptional competence were the other core identity markers related to role. Impossible feats could be accomplished through the collective's teamwork, but "carrying one's weight" was critical as well. Extensive discussion demonstrated the disdain for cowardice and for those who didn't carry their weight – literally and figuratively. There is a powerful, albeit officially unsanctioned, hierarchy of worth embedded in military culture that is stratified by proximity to danger, level of skill and competence, participation in combat, and concretely demonstrable courage. This hierarchy was both reinforced and challenged in discourse. The ideals were cherished, yet military PTSD crossed these strata, and moderators strove to defuse the stigmatizing forces of competitive trauma that wounded and demoralized many members whose experiences had been deemed "lesser" by peers.

Interdependence. Interpersonal obligations were a defining aspect of the collective military identity and permeated the discourse. These could be divided roughly into horizontal and vertical forms of responsibility. Horizontal relationships were characterized by brotherhood, interpersonal loyalty, and "having each other's back", and emerged as one of the highest and most cherished ideals of the military as a collective identity.

Regarding vertical lines of responsibility, expectations of leadership and the fundamental duties of a leader also occupied a great deal of the discussion of military ideals. While soldiers were expected (and legally obligated) to obey leadership unto the point of death, leaders had an explicitly defined duty to understand and care for the well-being of their subordinates. This duty, in its ideal form, transcended

legalistic contractual definitions and was conceptualized as a sacred trust, an inviolable moral obligation imposed by the soldiers' agreement to lay down their lives when asked. The expectations of leadership behaviour extended all the way up the chain of command and included the responsibility of government to the military as a whole. Considerable time was devoted to identifying instances of both exemplary and inadequate leadership, and to lamenting the contamination of military leadership ideals with civilian corporate and managerial strategies.

Summary. The Canadian military is in the unique and paradoxical position of being a created collectivist identity that is drawn from, embedded within, and existing to serve and defend, a primarily individualist society. Participants formulated the ideals and essentials of the military identity as contrasting with those of civilian society. Membership was formally defined by a contract and a sacrificial oath, and its visible markers (uniforms, medals, and artifacts) deemed sacred. Civilian safety and freedom was something precious to be protected by the military, but at the same time, civilians were seen to lack the courage, competence, and sacrificial altruism that defined the ideals of the military. Finally, inviolable brotherhood and devoted leadership were elevated as collectivist values that separated the military from the weak and selfish individualism of civilian society.

Alienation and Identity Loss via PTSD

Participants described profound and progressive alienation and identity loss as the key consequence of PTSD. They lost external markers of belonging, were excluded from cherished roles, and most poignantly, lost the interconnectedness that marked their membership in a collectivist identity.

Boundaries. Release from the military represented a fundamental form of identity loss. Some members with PTSD hid their condition and left voluntarily, while others were medically released. Leaving the military meant becoming a civilian, a difficult and isolating cultural transition. One participant declared that "living a 'normal' civilian life after combat is in many ways one of the most difficult things we will ever do. There are no rules and regulations; nothing to fall back on to determine our proper path. It is often lonely and rarely do veterans come across others who understand which furthers the feeling of isolation." Veterans groups offered a semblance of continuance of the collective, but many were formed with political agendas that generated restrictive criteria for inclusion and exclusion; furthermore, many groups formed alliances with civilian business interests that were seen to dilute and corrupt the values of military culture.

Roles. Leaving the military often meant exclusion from the familiar role of protector and defender. Some found employment in professions such as policing, while some reprised the role by picking fights and engaging in risk taking behaviours. As PTSD deteriorated, participants experienced progressive exclusion from social roles and locations: disciplinary consequences, medical release from the military, unemployment, divorce, homelessness, and jail. In this way they lost their sense of self: "I no longer recognized myself," and "I'm not the same person I was."

Interdependence. Involuntary medical release for PTSD was a particularly painful route to the loss of formal identity, and participants often experienced it as rejection and betrayal by the collective. As one participant noted: "It's hard to this day to come forward and do the right thing by seeking help, but while the lip service

is given in ‘support’ of your decision, you've written your career obituary on your way to civilian life. Once out, now the support system that the military has given is gone, and soon so are those that knew you.” Stigma and rejection by peers was also a means by which participation in the collective identity was threatened. One participant recounted his experience: “A former friend who is still serving asked if I needed my Service Dog because ‘I had bad dweems’. He then berated me for being a faker. Nobody eats their own like the military, I'll give him that. The stigma is alive and well.” Another described a key spokesperson with military PTSD: “He has had his life under a microscope, been ridiculed and deserted by people he thought had his back”.

Much discussion centred around betrayal by leadership. An unsupportive supervisor was described as having “no accountability for his damaging leadership. I hear he continues to treat people like shit while my 3B release is in 4 months”. Betrayal by government was a recurrent topic, particularly the handling of pensions and disability awards, and the closure of Veterans Affairs offices. “We put out [sic] signature on a contract to pay the ultimate sacrifice if we were asked to do so....now its time for them to make us a contract on future care.”

A particularly bitter experience of betrayal involved the use of military members as promotional objects.

> “Before I was exposed to the ways of charitable business I was victim to it and used as a monkey. A few months after deployment, a bus load of us got tasked… to go to a gala and mingle with stars and drink for free etc. so here we are, all dressed up in our uniforms, they unleash us to the crowd of

> Canada's elite, celebrities, athletes, business people, and their families. We were exposed to every stupid question ya can think of. Did you kill anyone? How did it feel to lose friends? Are you ok? Blah blah blah. Just show me to the bar and leave me alone right? Nope. We were told to mingle and not bunch up, they had people there who kept us whipped into shape, we had to take it and take it like fricken monkeys on display, it's what the sponsors paid for so it's what they get. FINALLY the curtains opened and all those classy folk went off to dinner and we got herded out like sheep, hardly any of them looked back at us as we left."

Individuals also lost their own ability to enact the values of brotherhood, as their capacity for social engagement was impaired and they descended into substance abuse and acting out. They often saw themselves as betraying their peers with their behaviours and were the subject of disciplinary action. Those that made the transition to civilian employment lamented the lack of collectivist values in civilian workplaces – they no longer knew what was expected of them, or who to trust. One participant described the internal sense of isolation as being "behind the wire of our minds". Participants experienced increasing difficulty initiating or sustaining relationships, and often cited a lack of faith that understanding was possible, given the extreme nature of their experiences.

Family were not described as a marker of the primary collective identity, but their loss marked the late stages of descent into alienation and isolation. From one participant: "The worst time in a vets life is often when our significant other leaves.. telling us its our fault because we changed... ya we did.. and its like a final nail in the

coffin of all the reasons we feel we don't count or belong back here in the civilian world..” Another stated: “You spend more time hurting your loved ones… and… no matter how many times you try to fix it the love and trust of your child will never be regained. With each passing second you see from within yourself your old self slipping between the cracks. The more that fades away the more it becomes harder to find yourself.”

Suicide was the tragic endpoint of this alienation. Suicidality was heightened by intolerable internal pain, but the lost sense of connection was often the prompt that made it seem inevitable. Participants described believing that they were a liability to friends and family, that they were all alone, that there was no one who could possibly reach them, or connect with their experience.

Summary. The relative length of the three sections is not coincidental. Within this discourse, by far the greatest injury inflicted both directly and indirectly by PTSD was the loss of interconnectedness. With release from the military, participants lost the daily proximity and belonging of the military family, and did not find civilian social norms an adequate substitute for the collective bond. Participants periodically listed their individual PTSD symptoms, but invariably described the most debilitating effect of these as the progressive loss of ability to reach out and engage with others. Participants progressively withdrew or were excluded from the social roles and connections that had defined them, and lost their sense of self in a downward spiral of alienation and isolation.

Remediation of PTSD

The chief remedy for PTSD promoted by participants was to reclaim the military identity in ways that explicitly incorporated PTSD, and to leverage the strengths and values of the collective to counteract isolation. Members wrestled with the ambiguity of strengthening an exclusive identity, while advocating for inclusivity and compassion to counter the stigma and rejection attached to PTSD.

Boundaries. Participants sought to enhance their differentiation from civilians via participation in veterans' organizations. Veterans taking charge of their own care and support was a particularly strong theme, highlighting the uneasy relationship between corporate funding of veteran-targeted charities and encroaching civilian values. At the same time, participants also sought assistance with finding viable roles in civilian life.

Roles. The roles and attributes that separate military from civilian have a great deal in common with the roles and attributes that create an informal hierarchy of worth within the military and contribute to the stigmatizing phenomenon of competitive trauma. Participants defined combat as the defining role of the military identity, yet many military participants experienced PTSD from non-combat traumas. There was thus an implicit ambiguity in promoting the values of brotherhood and mutual responsibility as including all military personnel, regardless of role or experience. "The battle of PTSD shouldn't be focused on just armed forces service members that have seen combat… service members can be signed up for 6 years, never see combat, and have deaths in their family, and still have PTSD." Conversely, "only the few, who have been through the hell called war, know these feelings...".

And from another participant, “never undersell you're [sic] commitment to your country, part-time or full-time we are all brothers”.

Physical exceptionalism and visible courage remained a core aspect of discourse regarding differentiation of military from civilians. Participants often idealized wounded and disabled military members who triumphed over adversity by performing feats of athleticism and bravery in sporting or advocacy contexts.

One key avenue to reclaiming a viable military identity was to reframe PTSD as a marker of military service rather than a pathology. Much time was spent arguing that PTSD was a battle wound, and not a disorder or disease, even invoking the authority of the psychiatric definition. “Thousands of us have struggled for decades to overcome this nasty inner injury, known now as PTSD. Yes its an injury. If you are unsure take the time to read the American Psychiatric Associations wording on this. It's not up for debate.” Some advocated for changing the name to PTS, leaving off any reference to disorder. A great deal of importance was attached to framing PTSD as congruent with physical combat injuries. “Those of us with PTSD are wounded in the mind just as those who have lost limbs. None of us choose the wounds we get. We just want to be acknowledged for our sacrifice equally. Not shelved as being depressed or bipolar or some other disorder.” The primary discussion of “what is PTSD” centred not on the checklists of symptoms (though these were occasionally listed as individuals recounted their personal experience) but on the key semantic sticking point of whether it was a disease or an injury. Injury was clearly the preferred definition, as it could be incorporated into the cultural paradigm of honourable battle wounds.

The discourse sometimes went a step further to redefine PTSD as a marker of worthwhile military experience. Many of the symptoms of PTSD, such as hypervigilance, were interpreted as a sign of high level training, a positive identity marker that signified exceptional competence rather than weakness. Other symptoms such as nightmares and flashbacks were acknowledged as debilitating but narrated as "still being at war", a state that was both honourable and identity-congruent. In this way many of the symptom clusters of PTSD were framed as markers of the military identity, forms of special knowledge conferred by the burden of the protective role, rather than disease processes that disrupted it.

Interdependence. Participants unceasingly invoked the values of brotherhood as the most important remedy for PTSD. Conventional combat practices and slogans for ensuring the safety and cohesiveness of the team were repurposed as rallying cries in the collective response to PTSD. Living with PTSD was reframed as a mission, which made it subject to the military strengths and competencies of courage, resilience, and teamwork. Exhortations to reach out and check in with "battle buddies" were relentless: "No man or woman gets left behind - EVER!"

Suicide was formulated as a wound to the collective. Even the fallen were enlisted in the collective effort. Participants exhorted one another that staying alive and "completing the mission" would honour the memory of the fallen and ensure their sacrifice was not in vain. "No matter how dark things may seem… live thru those that never made it home. They would want it that way." The fallen were also "kept alive" in the grief and memory of their comrades, and in that sense some of the

pain of PTSD was positively reframed as a sacred burden carried for the collective good.

Remediation also included demands for exemplary leadership at all levels. "Lieutenant General Romeo Dallaire came forward …, he changed the stigma that came with PTSD... That is leading from the front." Participants frequently called on government to step up and fulfill their financial obligations to veterans. Expert treatments and treatment providers were viewed with varying degrees of mistrust. Some participants had excellent experiences, and some had horror stories to tell. Medication was viewed with great suspicion. Moderators appeared to struggle with the dilemma of making space for cynicism and anger while encouraging sufferers to come forward and "seek help". Participants recurrently asserted that finding a clinician who understood the uniqueness and importance of the military identity was the most critical determinant of satisfactory expert treatment.

Summary. The remediative response to the PTSD was overwhelmingly formulated as a project in identity recovery, and most importantly, the recovery of the interconnectedness that characterized a military identity. Cultural shifts towards inclusivity and understanding were thus defined as strengthening, rather than diluting or replacing, the military identity.

Chapter VI - Discussion

Although Clarke (2005) grants a considerable degree of latitude and flexibility regarding the final form and endpoint of analysis, a grounded theory study really ought to generate a theory of process that goes beyond descriptive categories (Corbin & Strauss, 2008). The most ethical way to present that theoretical synthesis is a

question I wrestled with, however. A discourse analysis is concerned with the diverse particularities of voice and language, but as a written product for academic consumption, critical discourse analysis has a dense insider language all its own, a language that bears little resemblance to the voice of the participants. I expended considerable effort to detach my listening ear from the pervasive influence of a dominant psychiatric discourse, in order to genuinely "hear" my participants, and was unexpectedly chagrined to discover that the end result of analysis fell with such ease into another set of jargon, that of postmodernism. I feared I had succeeded only in blindly imposing a different voice of power; and worse, that I had done so for personal gain - to align myself favourably within a dominant academic narrative.

I recognize that this reticence is, in part, a function of my position as an "implicated researcher". I have both a personal affiliation with the military and a professional attachment. I cannot help but picture past colleagues, patients, and clients as proxies for the participant voices in my study, and wince at the reception I know the academic jargon would receive. I am mindful that within the study itself, participants complained bitterly about civilian efforts to sanitize their cultural expressions, and about politicians and corporations who used them as props for personal gain. Nevertheless, my personal ambivalence also mirrors the larger practical implications of the findings. The issue of how to conduct a collaborative synthesis between very different voices is highly pertinent to the therapeutic setting, and to the conflicts that pervade the field. For that reason, I have elected to present the academic formulation intact, as a backdrop for discussion.

Theory of Process

This veteran discourse about PTSD could be viewed as a project in identity construction and reclamation that resisted the worldview of a dominant system of classification while simultaneously leveraging its validating power. This resistance took place on two key fronts. First of all, the symptomatic experience of PTSD was reorganized into priorities of salience that differed substantially from the psychiatric formulation. Participants' experience was organized around a collectivist conceptual framework, which prioritized threats to interconnectedness and markers of collective belonging above the private symptomatic experiences that form the conceptual backbone of the psychiatric formulation.

Secondly, participants resisted the dominant paradigm of a brain disorder located solely within the individual, and reformulated PTSD as integral to the roles and experiences that characterized their collective identity. In other words, they reformulated PTSD as coherent with their identity, rather than as an alien disease process, and in so doing, destigmatized their experience and opened up the possibility of leveraging cultural strengths and attributes rather than relying solely on outside expert intervention. Participants did not labour over cognitive syntheses of the many paradoxes inherent to military trauma, but rather subsumed ambiguity under the ineffable nature of experience, rejecting any explanation or commentary not rooted in that experience.

Finally, it is important to note that this project of resistance was knowingly conducted under the scrutinizing (albeit silent) gaze of those with the power to write the official narrative, and could thus also be construed as explicitly performative.

From that perspective, the discourse contained elements of both defiance and appeal as participants crafted and acted out their preferred script.

Implications

I originally set out to investigate the sources of discord between the various stakeholders who figure prominently in the discourse of PTSD. This study certainly highlighted elements of conflict between the discourses of military veterans and those of government, the civilian populace, and the psychiatric establishment. I am particularly interested in the implications for the therapeutic environment. The majority of therapists and psychiatrists treating military PTSD are civilians, and as explored in the literature review, the dominant professional diagnostic paradigm for PTSD is aligned with an individualist disease model, locating the disorder within the brain, and relegating social dysfunction to one line in a long symptom list. This study suggests that therapists working with military would do well to explore the possibility of alternate conceptual frameworks that may be more salient to the individual. Interestingly, the findings aligned with my own recent experience in a trauma therapy practicum (which occurred after the analysis was largely complete). The dominant evidence-based models for trauma therapy are cognitive processing therapy (Resick, Monson, & Chard, 2008) and prolonged exposure (Foa, Hembree, & Rothbaum, 2007), both working from an individual-focused cognitive and behavioural perspective. As I settled into therapeutic work however, I was repeatedly impressed with the significance of disrupted capacity for attachment as the core wound, with ripple effects throughout the family and social system of the individual. It could be

that this is predominately true of clients from a collectivist worldview, but it could also represent an under-recognized aspect of psychological trauma in general.

The primacy of the military collective identity suggests that civilian (and indeed, military) therapists should carefully consider the implications of their own cultural positionality relative to their clients, and seek to provide care from a stance that accounts for the limitations and expectations of their role. Therapists might also consider directing focused therapeutic attention towards rebuilding the client's social world and capacity for attachment. Treatment plans could prioritize group and family therapy to build and stabilize relationships, rather than relegating such functions solely to the domain of lay-support groups (as important as those are).

More broadly, this study adds to the body of cross-cultural trauma research supporting the central importance of culture, context and fundamental assumptions about the world and the nature of the self (e.g., Hinton & Lewis-Fernandez, 2011). It supports the growing concern in the mental health field that checklists of private symptoms may not be the most salient aspect of the patient's experience (e.g., Nichter, 2010).

In regard to trauma, this study supports the argument (e.g.,Panter-Brick, 2010) for looking at trauma at the level of relational and systemic phenomena. It potently demonstrates that the experience of trauma is shaped by social structures and conceptual frameworks about the social self, and that the possibilities for expressing the social self are in turn shaped by the effects of trauma. The study findings suggest that, even from a psychiatric, biomedical perspective, it may be well worth giving

more priority to addressing the disrupted capacity for social engagement and attachment as a salient symptom and target of intervention.

Limitations

The study had some limitations. Participants were drawn from a very specific and open social media group. They were thus self-selected and influenced by responses to and by civilians. The group was actively moderated with the goal of creating a safe and welcoming environment, which may have suppressed some forms of discourse, and although the group was created and substantially utilized by Canadians, both participants and moderators were drawn from a multinational military cohort. As I am aware from clinical practice, not every veteran with PTSD desires the same kind of identification with their career or their diagnosis. There would likely be considerable variation in the discourse of different military subgroups, due to the differing nature of roles and relationships. This group was explicitly aware that it was being closely followed by senior military officials which seemed to incite both caution and defiance. Discourse in closed groups might reveal concerns not safe to be expressed openly, although observing such a group would also impose ethical concerns in publishing findings.

Future Directions

There is ample possibility for future study. I found discourse analysis to be an exceptionally useful way to step back from paradigmatic professional assumptions and consider the experience of mental suffering from the patient's perspective. Discourse analysis provided new perspectives on the conflicts arising around the process of diagnosis and intervention, calling into question the unexamined

assumptions underpinning these processes. A larger scale discourse analysis of the other stakeholders in the arena of military psychological trauma could examine military families, government, mass media, various military subcultures, and various therapeutic schools and professions. Adding more voices to the conversation would add nuance to the analysis and likely illuminate still more hidden assumptions that lead to misunderstanding and conflict.

Chapter VII - Conclusions

This thesis project grew from my curiosity about experiences of systemic conflict encountered during clinical practice with military psychological trauma. Although a comprehensive explanation of the conflict was far beyond the scope of a single project, I believe the findings of this study demonstrated the power of discourse analysis as a lens through which to view profound suffering in the midst of a complex landscape of competing interests.

I began the project with some assumptions of my own; most potently, the idea that the psychiatric definition of psychological trauma was conceptually universal but required better translation into the language of the military, a distinct culture under-recognized as such by civilian caregivers. The cultural disconnect between military and civilian held, but my assumption about the foundation of the problem was overturned early on in the process of completing the literature review. It became clear that while mental suffering arising from adverse experience is a universal phenomenon; describing, legitimizing, explaining, and responding to such suffering is the product of complex, variable, and highly contested discourses (e.g., Kienzler, 2008). Conceptual models of post-traumatic suffering are shaped by social and

cultural beliefs about the nature of suffering and the self, and the protocols and boundaries for validation and remediation are powerfully influenced by social power and privilege (Brown, 2004; Panter-Brick, 2010). Adversity tends to be deemed significant when it happens to those whom society deems significant, under circumstances which those writing the dominant narrative are willing to acknowledge (Brown, 2004).

The term PTSD appears to have become a global shorthand for mental suffering caused by adverse experience. The acronym carries the validating authority and power of Western biomedicine, and yet the psychiatric diagnostic entity as formulated and revised from its first appearance in *DSM-III* (APA, 1980) to its latest form in *DSM-5* (APA, 2013), is the product of very specific cultural, social, and political discourses. Cross-cultural trauma studies demonstrate that similar symptom clusters may be organized into substantially different systems of meaning, with deep roots in the specific cultural worldview and sociopolitical landscape (e.g. Kohrt & Hruschka, 2010). There are numerous examples of harm done when the Western psychiatric model of PTSD was imposed without accounting for its sociocultural implications (Abramowitz, 2010). I chose to treat the diagnostic entity of PTSD as a particular discourse, and to examine the discourse of military veterans with PTSD on its own terms, as a conversation that referenced the psychiatric diagnosis, but was the product of its own cultural conceptual models. Situational analysis (Clarke, 2005), a social constructionist evolution of grounded theory (Glaser & Strauss, 1967), provided an excellent methodological framework for conducting the discourse analysis.

The findings of my study revealed a conceptual framework of PTSD that was organized from a primarily collectivist worldview, and that prioritized interconnectedness and markers of collective identity as the most profound losses of the disorder. From this perspective, PTSD was a disorder of progressive isolation and alienation, and the remedy was therefore largely relational in nature. The discourse challenged the individual brain disease model, reframing PTSD as a natural consequence of the risks and challenges of the roles that embodied the collective identity. The experience of post-traumatic suffering was thus reclaimed as identity-congruent and therefore subject to the strengths and competencies of the collective. The discourse was conducted on a publicly visible Facebook group, and was known to be scrutinized by the military chain of command. It thus served not only as a private arena of peer support but as a performative re-narration of the disorder and a means of resistance.

This thesis adds to the growing body of research that supports the view of PTSD as an experience of suffering given conceptual meaning within specific sociocultural discourses and societal patterns of power and privilege. It is imperative that therapists consider how their preferred conceptual framework relates to the client's worldview and retain a sense of curiosity and openness to collaboration. On a larger scale, studies such as this, that demonstrate alternate conceptual models of mental suffering, open up new landscapes of possibility that could inform or reform dominant models of diagnosis and intervention. Discourse analysis provides a powerful practice with which to listen deeply to our clients and to make visible the intersections of our social worlds.

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